

1 Friday, 2 October 2026 2 (10.04 am) 3 PROFESSOR ANNE-MAREE FARRELL (continued) 4 PROFESSOR KIERAN WALSHE (continued) 5 DR FAY GILDER (continued) 6 THE CHAIR: Good morning. 7 Questions by COUNSEL TO THE INQUIRY (continued) 8 THE CHAIR: Good morning, everybody. Welcome back. We're 9 ready to resume, Mr Dawson. 10 MR DAWSON: Thank you, sir. Good morning. A couple of 11 questions about some matters that we covered yesterday 12 just to tie them off, if I can put it that way, before 13 moving on to some new areas today. 14 If I could start with a couple of matters for 15 Dr Gilder, if I may. 16 The first two matters I wanted to raise with you 17 both have a foreign component to them. The first was 18 you gave some evidence yesterday about the ways in which 19 healthcare systems might wish to approach doctors 20 commencing work in a UK who have some element of foreign 21 component to their training and in responding to our 22 questions, I think you gave us what was a hypothesised 23 example from, to an extent, your own experience involved 24 in end of life care, where you told us, I think that -- 25 you imagined, I think that, for example, in a country Page 1	1 have created a situation where the general public had 2 been misled by my statement. 3 Q. Of course, that's very clear. The other aspect of what 4 I wanted to ask you about also has a foreign component 5 to it actually. You helpfully answered some questions, 6 as did Professor Walshe, in connection with the system 7 involved in voluntary erasure of a doctor's name from 8 the GMC medical register. We talked about the systems 9 involved in that and we talked about the 10 responsibilities which you felt would be incumbent upon 11 a hospital or individuals within a hospital to bring 12 certain matters to the attention of the GMC. And 13 I think it was Professor Walshe that pointed out there 14 would perhaps be a difference between someone being able 15 to remove their name voluntarily or situations in which 16 it might be more appropriate for a disciplinary 17 procedure to take its course and then, whatever the 18 outcome of that, it might lead to a different 19 conclusion. 20 I think Professor Walshe pointed out there were 21 perhaps some issues with the way that system works even 22 now, which may require attention. 23 Could I just take you to -- you explain this, 24 I think, in your evidence already but it might be 25 easiest to do this by reference to another report. If Page 3
1 like Egypt, it might be they may have a different 2 approach to end of life care and so, if one were 3 considering the possibility of appointing a doctor, in 4 particular a consultant, to a role which involved end of 5 life care, care would need to be taken around making 6 sure that that doctor understood that whatever the 7 systems or attitudes that were prevalent in their 8 practice in Egypt -- the hypothesised Egyptian 9 example -- it would be important that doctor would 10 understand that facilities, attitudes, systems here 11 perhaps work differently. 12 I just wanted to clarify with you, am I right in 13 understanding that that was a hypothesised example, we 14 weren't actually talking about anything specific to this 15 Inquiry or any specific -- 16 DR GILDER: (Overspeaking) Nothing specific to this Inquiry. 17 It was more to illustrate the cultural sensitivity we 18 need to put in place when we are supporting doctors who 19 are adapting to our own culture. 20 Q. Understood. Egypt was a random example, I think, of 21 a country. You weren't actually telling us anything 22 about the Egyptian end of life care service? 23 A. No, and in fact, just in case that was 24 a misunderstanding, palliative care is an emerging 25 sub-specialty in Egypt because I was concerned I might Page 2	1 we go to paragraph 25.1, please. 2 This is confused slightly by the fact that Dr Gilder 3 has spoken to this, as has Professor Walshe, and I think 4 this is a question that was technically allocated to 5 Professor Farrell in the allocation. So it may be that 6 different people have different perspectives on this. 7 But if I can start with Dr Gilder who has already spoken 8 about it, this is where you're addressing what 9 responsibilities a health board, or individuals within 10 a health board, might have in the scenario we are 11 talking about. And the particular passage I was 12 interested in, which I think you reflected in your 13 evidence is the bit towards the end of the passage, over 14 to the next page, please. 15 You said, starting at the words "In addition", about 16 six, seven lines up from the bottom: 17 "In addition, the Health Board must formally 18 indicate its position on the VE application [the 19 voluntary erasure application]. If concerns exist, then 20 the Board has a clear governance duty to formally object 21 to the VE of the doctor in question. It has 22 a responsibility for advocating that the doctor remains 23 on the register so that a full GMC fitness to practise 24 investigation can proceed, if appropriate. If no such 25 concerns exist, then the Health Board may support or Page 4

1 remain neutral toward the VE application, if the 2 retirement or departure of the doctor is standard or 3 clear of clinical risk." 4 And you refer there to the regulations, at the 5 bottom, and say that that establishes the ongoing 6 statutory duty of the RO to co-operate with the GMC 7 regarding a doctor's fitness to practise status. 8 I think that passage, in the generality, is 9 consistent with what you told us yesterday, Dr Gilder, 10 about your understanding of the responsibilities, in 11 particular given that you have held the role of 12 responsible officer. And indeed, I think you told us 13 about a recent example in which you had, in fact, 14 intimated a position or objection to this happening in 15 relation to a doctor who had worked for you a couple 16 of years before, but you had concerns about whether they 17 did actually intend to return to practice and so you had 18 actually followed that through in real life. 19 The question I have, and I open it up to everyone 20 because you all may be able to contribute is, is it the 21 case that the obligation that's set out there comes from 22 the regulations? The reason I say that is we struggled 23 to find where that is in the regulations, so effectively 24 I'm looking to find out what the source of that 25 obligation is. Page 5	1 a concern that an individual or individuals or the 2 public may be at risk from the practice of a doctor, it 3 is my responsibility to raise that concern and it is 4 this context that would be my responsibility to make 5 a recommendation that voluntary erasure is not enacted. 6 Q. Understood and obviously because even in the situation 7 you told us actually about where someone had worked for 8 you some time in the past, the GMC would have access to 9 less information about that person and their intentions 10 and their life and what they were doing than people who 11 had actually worked with them, is that right? 12 A. I think it depends if they're under a fitness to 13 practise investigation or not. 14 Q. Right, so in those circumstances it would be the case 15 the GMC would likely have more information? 16 A. Or as much information. 17 Q. Indeed, okay. So it would depend -- because as 18 I understand, the fitness to practise investigation 19 would be reliant, to a significant degree, on previous 20 employers not necessarily one hospital, maybe 21 a number -- 22 A. Multiple, yes. 23 Q. -- to provide that information, is that right? So it 24 would perhaps depend on what information had been 25 provided to that point? Page 7
1 PROFESSOR FARRELL: Can I just say, obviously that's 2 a supporting regulation that would sort of broadly 3 outline it, so I did want to provide that supporting 4 reference to the tribunal. 5 Q. Thank you. 6 A. And then through discussions with my colleagues, we 7 looked at practical experiences and examples and so it 8 was really on that basis. 9 Q. That's very helpful because the regulations are 10 obviously relevant to this area and many others we've 11 discussed, they tell us what responsible officers are 12 required to do. But it may be one doesn't find it 13 expressly in the regulations but it may be understood to 14 be, or in practice to be, what is done. So that's what 15 I'm trying to investigate. So it may be then for 16 others, Professor Farrell, Dr Gilder or Professor Walshe 17 to address that question. 18 A. Can I just add it was really through the experiences of 19 Dr Gilder that we did add that additional information, 20 so I'll pass over to Dr Gilder. 21 DR GILDER: So the responsible officer's role is to ensure 22 high standards of medicine are maintained and within 23 that is to ensure that the public is protected. So in 24 terms of how the regulations can be interpreted, and 25 certainly how I interpreted them, is that if I have Page 6	1 A. Yes, correct. 2 Q. Understood. 3 A. And in this particular example, I knew more about they 4 did than the intentions of that individual because that 5 individual this made them clear. 6 Q. Understood. Anything to add to that, Professor Walshe, 7 on that? 8 PROFESSOR WALSHE: I'd just have one point which is when 9 revalidation was created there was quite a discussion, 10 quite a policy debate about what information the General 11 Medical Council should hold about doctors. And they 12 opted I think for a minimum position in which all the 13 information that is provided to -- the only information 14 that's provided to the GMC normally is the 15 recommendation. So the records of appraisal and the 16 discussions about the revalidation decision and so on 17 sit locally. In Scotland I think that's all in the SOAR 18 system, in England there isn't a single system so there 19 are a number of proprietary systems that employers use. 20 But that does mean that the GMC doesn't hold information 21 about the practice record of doctors unless there have 22 been complaints and it will then have complaints and it 23 will have its investigation records. 24 So in consideration an application for erasure, 25 unless they seek further information from employers, the Page 8

1 information they've got is pretty limited. 2 Q. I see. That's very helpful, thank you. Returning then 3 to another aspect of discussion we had -- 4 THE CHAIR: Sorry, Mr Dawson. That tends to lend rather 5 sharp focus to the point you just made because it may 6 well be that in a hypothetical scenario you have 7 a doctor whose treatment has, for various reasons, been 8 broadly sub-standard but hasn't triggered complaints but 9 it has triggered concerns in the mind of the responsible 10 officer and in that situation, in the absence of any 11 detailed information lying with the regulator, you can 12 see why it would be very important to make that known? 13 DR GILDER: And we are expected to declare that, so if that 14 individual is subject to local investigation, at the 15 time of the request for voluntary erasure, you are 16 expected to make that clear. 17 THE CHAIR: Right. Okay. Thank you. 18 MR DAWSON: Thank you. I wonder if we could return to 19 another topic that we touched on yesterday, namely -- 20 I think again, this was in the afternoon, so it was 21 Dr Gilder and Professor Walshe that were contributing, 22 although everyone, feel free to contribute at this 23 stage. This was to do with the arrangements for 24 clinical supervision and I think we had a useful general 25 discussion about various considerations but there are Page 9	1 I think you're proposing that practice should work, 2 which may bleed into considerations about clinical 3 supervision. But I think the first thing that you are 4 saying there, we touched a little bit in a difficult 5 question that I asked Dr Gilder I think yesterday 6 morning, we talked about the possibility that there 7 might in a hospital or in a department within a hospital 8 be a kind of deference towards older doctors in 9 thinking: well, they know what they're doing. Whereas 10 you point out here that colleagues age, surgical as well 11 as patient complexity increases, so there needs to be 12 a level of support and oversight by other people and not 13 an assumption, as I understand what you're saying here, 14 that senior members of staff will be practising 15 optimally; is that correct? 16 PROFESSOR WALSH: I think so. I think the point being made 17 there is much more about MDTs and their effective 18 operation and it's become -- and Dr Gilder is probably 19 better placed to comment on this than me because she's 20 got far more experience of living through it, but there 21 has been a focus on -- and I think we reference some of 22 the guidance on MDTs, a focus on ensuring that cases, 23 particularly complicated cases, are always discussed 24 through an MDT where you will have doctors from 25 different medical specialties. So perhaps surgeons but Page 11
1 some specific matters, I think, that are addressed in 2 this regard in the statement. I think it was 3 Professor Walshe that covered this part. It's at 4 paragraph 14.7. Am I right in thinking this is 5 Professor Walshe's passage? I think that's right. You 6 say: 7 "While a consultant is an independent medical 8 practitioner, it must be understood that international 9 knowledge and experience advance clinical practice over 10 time, against a background where colleagues age, and 11 surgical, as well as patient, complexity increases. 12 Therefore, a system of professional boundaries and peer 13 review must exist to ensure that complex or high-risk 14 cases are validated by a broader clinical team, such as 15 would take place through a Multi-Disciplinary Team 16 (MDT). The key objectives in doing so are to eliminate 17 isolated clinical practice; to ensure clinical practice 18 is up-to-date; to remove variation of care; to promote 19 collective multi-disciplinary ownership of high-risk 20 surgical plans; and to support transitional consultants 21 or those returning to practice after a prolonged 22 absence." 23 So although, professor, what you have said there is 24 under the heading, if you like, clinical supervision, it 25 is in fact a broader statement of the way in which Page 10	1 also anaesthetists and also, where relevant, positions 2 jointly discussing the cases, along with diagnosticians 3 such as radiologists and pathologists, jointly 4 discussing the cases and jointly agreeing the proposed 5 plan of treatment, to avoid a situation in which 6 individuals may kind of practice in a way that is 7 isolated from their peers. 8 DR GILDER: And I would also say I think the way we 9 interpreted this question was not about supervising 10 a surgeon in training, it was more about opportunities 11 in which to observe each other's practice, and to 12 receive support in the more difficult cases. 13 Q. Yes. 14 A. So I think it is perhaps slightly open to 15 interpretation, the wording "clinical supervision" 16 because it might be interpreted as, you know, actually 17 an individual, but as a consultant you don't expect to 18 be clinically supervised. But these are all 19 opportunities in which to observe each other's -- one 20 another's practice and also where perhaps differences in 21 practice opinion and perhaps contemporaneous 22 contemporary best practice would be observed. 23 Q. Thank you. And I remember asking you very early on 24 yesterday, Professor Walshe, it may seem a long time ago 25 now, but there was a particular phrase you had used in Page 12

1 one of the parts of the earlier passages where you had 2 focused in I think on the high-risk specialist nature of 3 neurosurgery and I'd asked you: well, is there 4 a particular reason why all these clinical governance 5 requirements apply to that than perhaps other areas? 6 And you clarified these were all general requirements 7 perhaps applying even more so in a situation of 8 speciality and high risk. Again, here, that appears to 9 be part of the answer in the sense that you're saying, 10 in particularly complex, high-risk situations, although 11 multi-disciplinary practice is something that has become 12 part of the picture, would it be the case that that 13 might require to apply all the more because there are 14 harder decisions to take with higher stakes and they 15 require a multiplicity of different views? 16 PROFESSOR WALSH: Yes, I think so and the operation of MDTs 17 is all about kind of seeking a consensus and 18 a collective decision-making. And if you kind of think 19 about it from the other side, in cases of concern that 20 I have been involved in, in writing about and in 21 studying, dysfunction in the clinical team, poor 22 relationships amongst doctors and so on is often 23 reflected in a breakdown of a multi-disciplinary team 24 and either the MDT not really working very well, people 25 feeling they can't speak freely in the MDT or MDT Page 13	1 perform the function of oversight, making sure that 2 people are making the right decisions and following the 3 right practices. Is that an accurate interpretation of 4 at least some of the purposes that they serve? 5 PROFESSOR WALSH: I think so and perhaps a really useful 6 kind of canary. You know, A good functioning MDT is 7 a sign of a good functional clinical team and 8 clinical department and the MDT provides a prospective 9 function, but at the same time there should be what are 10 often called mortality/morbidity meetings or death and 11 complication meetings, where doctors generally gather 12 regularly to review cases that have been treated and 13 particularly where there have been adverse outcomes and 14 to discuss them. And again, the quality of discussion 15 in that debate, the willingness of people to be frank 16 and open and constructive in that discussion is a sign 17 of a well functioning clinical department. 18 Q. Thank you. You mentioned all of the things that might 19 be indicators that there are issues in the functioning 20 of a clinical department. I don't think you mentioned 21 this but one other thing that, I think, would logically 22 follow is the possibility that people don't attend them, 23 would that be another sign that perhaps things aren't 24 going well? 25 A. Absolutely, yes. Page 15
1 meetings not taking place and cases not being brought to 2 the MDT. And that can happen because of issues between 3 individuals and consultants, it can also happen because 4 some consultants are not very keen to participate in 5 those MDTs. And MDTs are, I think, Fay, you may be 6 better placed, they are relatively recent. You know, 7 it's the last 20 years or so, particularly since the 8 arrival -- 9 DR GILDER: (Overspeaking) Yes, came in with cancer. 10 PROFESSOR WALSH: -- cancer networks and things like that. 11 So people who have been in practice for a long time will 12 have been used to a model in which they made their own 13 decisions and they didn't have to discuss those 14 decisions with others. 15 DR GILDER: (Overspeaking) Or defend them. 16 MR DAWSON: Indeed. So the system of MDTs, it sounds like, 17 performs a number of different functions. Actually, they 18 are trying to bring different perspectives to the table, 19 that might even be different perspectives of different 20 people say within the neurosurgical team, if I can focus 21 on neurosurgery, but also different perspectives from 22 other disciplines and analyses of the relevant 23 information. Then the objective of that is to try and 24 make the best decisions, one would imagine, in the 25 individual case. However, by dint of that, they also Page 14	1 Q. Because those people are (a) not engaging in the useful 2 opinions of others to try to make good decisions, but 3 also that might be an indicator of a fact they don't 4 wish others to be able to express an opinion about what 5 they're doing? 6 A. It could be and it's also worth -- without wanting to 7 pursue the point too much, I'm conscious of time -- 8 saying that in a large specialty it's easier to do this 9 because you have plenty of other doctors in the same 10 specialty. In small specialties and sub-specialties and 11 in areas where there may be only perhaps two consultants 12 in the hospital working in the same way, your MDTs may 13 need to be multi-organisational across an area in 14 order to bring together more expertise and more 15 externality, if you like, to the discussion. 16 Q. I see. So we talked yesterday with Dr Gilder about 17 sub-specialties and what you're illustrating there 18 I think is the fact there might not be many other people 19 who are able to express an opinion on the surgery you're 20 doing because you may be the only one that does it, but 21 I don't think that would diminish the need to seek other 22 opinions and involve other people, is that fair? 23 A. Absolutely. 24 DR GILDER: I just think there's another point is that if 25 the condition is rare, so you will have a multi-site MDT Page 16

1 which is a video MDT where colleagues with an interest 2 in, for example gastroenterology talking about 3 oesophageal cancer, those surgeries are done centrally 4 but the participation would be from all the referring 5 hospitals. So it's another learning environment and 6 with the patient at the very heart. I think 7 a multi-disciplinary team has the patient and the best 8 interests of the patient at the very heart of it and 9 it's that individual patient that is being discussed by 10 a range of specialists in terms of determining the most 11 appropriate pathway of care. 12 Q. Understood. That's helpful. You mentioned there 13 the possibility of videos. Again, to try and contextualise 14 this in the period we are looking at, I mean it's not 15 the Middle Ages, it's not that far back, but perhaps 16 there were different ways of doing this. I don't know, 17 would you have had some -- when were these -- nowadays, 18 we all use video calls for everything, but was it 19 perhaps -- did it work slightly differently -- 20 A. (Overspeaking) They would, certainly in examples 21 I'm aware of, the doctors would move from site -- they 22 would occur in one place before technology -- the 23 technology you described. 24 Q. I see, so meetings took place and businesses at that 25 time, so doctors had meetings as -- Page 17	1 working and meetings? 2 A. Yes, because the cases are that much more complex. I'll 3 go back to my example of a hernia. A hernia is 4 a straightforward procedure. You might want -- it's the 5 patient themselves that might not be, with complex 6 medical conditions. So it's really when the complexity 7 of both the condition or the patient requires 8 alternate -- you know, additional input in terms of 9 securing the best outcome for that patient. 10 Q. One area that has come up in some of the evidence that 11 we've looked at, which will feature in lots of medical 12 areas, particularly in surgery perhaps, is the use of 13 radiology and the need for there to be a reliance on the 14 skill of radiologists, neuroradiologists in the field 15 we're looking at, in interpreting scans in order to make 16 decisions about what the best course, surgically, might 17 be. Is that the sort of thing that might be discussed 18 in a multi-disciplinary meeting or a multi-disciplinary 19 setting so that different sides of the fence can come to 20 a consensus about the best way to do things? 21 A. Yes, they are -- the radiologists are fundamental to 22 anything that requires imaging in terms to make a diagnosis. 23 Q. For example, in a situation where -- it's possible to 24 hypothesise, I think, a situation where a neurosurgeon 25 might be looking at a scan and a neuroradiologist might Page 19
1 A. (Overspeaking) Things evolved remember. I mean, the 2 whole point of centralising care, all of this has 3 evolved -- for high-risk cases over 20, 30 years, 4 recognising that the best outcomes for patients for 5 operations that are not regularly performed or routinely 6 performed means that you centralise the care to a small 7 number of centres in order you have a small group of 8 individuals who are highly expert at that particular 9 procedure which ensures a higher likelihood of a better 10 outcome and fewer complications. 11 Q. If I could, just for our purposes, try to particularise 12 this a little bit just to neurosurgery. From our 13 neurosurgical group one of the questions we asked them 14 is: what are the types of medical specialties beyond 15 neurosurgery with which neurosurgeons tend to interact? 16 And we then got from them about a list of every kind of 17 medical specialty, frankly, I had ever heard of. So it 18 was inherent in neurosurgery that one required to work 19 in a multi-disciplinary way, whether one was running 20 meetings like this or not, it was necessary to work with 21 anaesthetists and neurologists and radiologists, 22 et cetera, et cetera. So in a field like that, where 23 one requires, by the nature of the work one is doing, to 24 have multiple perspectives, is there an even greater 25 requirement to place an emphasis on multi-disciplinary Page 18	1 be looking at a scan. I think for lay people sometimes 2 people think: well, you look at a scan, it's just 3 a photo and you see what you see. But there's a real 4 skill in interpreting what you're able to see and that 5 is, I think you're saying, fundamental to the 6 decision-making about what you do next. 7 A. And you go back to the point about triangulation. Those 8 two individuals will be discussing the images and the 9 best way to approach and: do we need other imaging, do 10 we have enough information to make a decision? 11 Et cetera, et cetera. From the perspective, it's more 12 than one person, it's multi-disciplinary, but those 13 conversations don't have to involve a huge number of 14 people, but they do need to involve the individuals who 15 are expert in, like sub-specialty neuroradiology for 16 example, sub-specialty neurosurgery, for example, but it 17 may be -- there will also maybe be a neuropathologist in 18 that conversation if it's about: what do we do with this 19 particular operation? Rather than the patient's more 20 general health. So they would -- that would be 21 multi-disciplinary even though it's not how we would 22 necessarily describe a multi-disciplinary team setup 23 these days, we still go to a radiologist for an opinion 24 on what you've seen. 25 Q. One of the things you won't be aware of but we've been Page 20

1 looking in some of our sessions at some of the evidence 2 that existed around the way neurosurgical services were 3 delivered in the Tayside area and one thing that was 4 quite significant that happened in the period we were 5 looking at is effectively the service delivery moved 6 from one hospital to another. It was originally, from 7 the period we are looking at 1995 to 1998, delivered 8 from Dundee Royal Infirmary and effectively, all the 9 services were being moved out, it was an old hospital. 10 And in 1998 neurosurgery was one of the last services to 11 move to Ninewells, which was obviously a bigger teaching 12 hospital. And the arrangement of the services, although 13 they were formulated slightly differently, first before 14 the move and after the move, was that the clinical 15 groupings that existed together and moved together all 16 started with neuro. Is the purpose of the teams 17 sticking together is all of those teams needed to work 18 with each other? 19 A. It would be, yes. 20 Q. So effectively it was called the neurosciences 21 directorate. 22 A. Correct. 23 Q. They had various different neuro- and then some other 24 type of thing at the end of it. 25 A. Yes. Page 21	1 interpreting things and what one should do in certain 2 circumstances. Would that be the sort of thing, in 3 a meeting like this, that others would start to worry 4 about? 5 A. Yes, and raise concerns and write to their clinical 6 director. And if they weren't heard by their clinical 7 director, write to their divisional director. If they 8 weren't heard by the divisional director, write to their 9 medical director. Those would be the expectations, 10 those concerns would be reported outside of the MDT for 11 a rapid resolution. 12 Q. It sounds, from what you're saying, Dr Gilder, like it's 13 well-known in surgery that radiologist -- 14 A. (Overspeaking) Not just surgery, any multi-disciplinary 15 team environment is an environment where you can 16 experience conflict and if there is conflict in that 17 environment then the team needs to be brought together 18 and a series of processes to support them to function 19 well. 20 Q. Indeed, but just in the surgical context, you also 21 mentioned a moment ago that the radiology is 22 fundamental. 23 A. Yes. 24 Q. Therefore I wondered whether that is something people 25 would notice. If a surgeon, for example, was starting Page 23
1 Q. And when they moved, they all moved together. 2 A. Yes. 3 Q. I think I was taking from that the idea that that was 4 because the service that was delivered required all of 5 those people to work together to deliver a surgery, 6 effectively? 7 A. Correct. You can't have a neuroradiologist in one 8 hospital and a neurosurgeon in another hospital and then 9 have excellent communication. 10 Q. Indeed, yes. That would be theoretically possible -- 11 A. Be tricky. 12 Q. -- but the theory behind keeping them together is they 13 are going to have to work together regularly. 14 A. Well, that's the point and communication is enabled. 15 Q. Understood. Indeed, thank you. Another aspect of this 16 that I just wondered, just to talk about the radiology 17 aspect of a little more. You've said, Dr Gilder, that 18 radiologists, neuroradiologists are fundamental in this 19 situation, and to take it back to something 20 Professor Walshe was talking about earlier, the way in 21 which this may be an early warning sign. It might be 22 an early warning sign that would manifest itself in 23 a neurosurgical multi-disciplinary situation if there 24 started to be disagreements between the radiology side 25 and the neurosurgery side about how one should go about Page 22	1 not to listen to what the radiologist was saying, that 2 would tend to suggest that that surgeon had ceased to 3 think that the radiologist was fundamental? 4 A. Well, they might not -- or they were not interested in 5 the opinion -- I'm not sure they would think of it in 6 those terms, but, yes, they would be disregarding 7 deliberately the opinion of the neuroradiologist. 8 Q. Thank you. Would it also, in those contexts -- I'm just 9 trying to understand what happens when sitting in these 10 meetings -- you would ultimately be discussing the way 11 in which, for example, you would go about doing the 12 surgery because others may have a view on that. 13 An anaesthetist, for example, might have a view on 14 certain aspects of certain surgeries, at that stage 15 I would imagine, and you would certainly know about 16 that. 17 But I wondered whether the sort of thing that might 18 come up would be an ability to discuss the way in which 19 imaging is used during the course of the surgery because 20 we've heard something about the possibility that, in 21 order to try -- for example, our expert neurosurgeons 22 told us that one would tend to use imaging before, 23 during and after surgery in order to make sure that one 24 was operating a spinal decompression surgery at the 25 right site which can be something that can be tricky to Page 24

1 work out? 2 A. Yes, that's very current practice though, that wouldn't 3 have been expected practice in 1995. 4 Q. Well, that's not what the neurosurgeons told us. 5 A. Really? 6 Q. Yes, they told us that there was a more rudimentary form 7 of -- 8 A. (Overspeaking) well, because you had a mobile x-ray, 9 yes, I was thinking about some of the stereotactic 10 elements. 11 Q. No, they told us one would have a mobile x-ray, that 12 would be used. 13 A. Yes. 14 Q. But in terms of -- would a multi-disciplinary forum be 15 one in which that sort of thing might be discussed in 16 terms of what the planning was for how one was going to 17 approach surgery? 18 A. So this is definitely beyond my expertise, I would say. 19 Q. Thank you, I appreciate that. You go on to say, in this 20 passage at 14.8, if we can look at that. Again, I think 21 this is Professor Walshe telling us that: 22 "The key features of successful approaches that 23 support oversight of individual doctors' practice 24 include ... 25 "The use of MDTs: Their use is particularly Page 25	1 happen, is that right, in appropriate cases? 2 PROFESSOR WALSH: I think so. I actually think that bit 3 was drafted -- 4 DR GILDER: (Overspeaking) By me. Absolutely, certainly in 5 the teaching hospital in which I worked, it was quite 6 common where it would be a two-consultant procedure. 7 Q. For teaching purposes? 8 A. No. No, no, because of the complexity. When you're in 9 a small district general hospital that is less common 10 because the cases, well, you'd expect them to be less 11 complex. But it's just the practice of a consultant and 12 a consultant working together when the cases are 13 complex. And yes, you would expect that. And also 14 consultants asking other consultants for help when 15 things haven't gone as planned, but that's obviously not 16 a scheduled environment. 17 Q. Understood, and the reference to the teaching hospital 18 is because that's where you would tend to find the more 19 complex cases done? 20 A. Yes, so where I've come across it most is in 21 neurosurgery, in transplant surgery, in vascular 22 surgery. These are all highly complex, highly 23 technical, and many more surgical sub-specialties. 24 Q. Thank you. And the formal peer review and case note 25 audit, was that something you were contemplating would Page 27
1 important, particularly in the context of complex 2 pathologies (such as neuro-oncology, spinal or 3 neuro-vascular cases). Attendance and presentation of 4 cases that come within these areas at MDT meetings 5 should be a prerequisite for surgery, so that such cases 6 can be subject to peer challenge, and collective 7 sign-off at such meetings." 8 I think that's what we've been discussing, 9 Professor Walshe, up till now, and you go on to tell us 10 about some other ways in which this might be promoted: 11 "Dual-consultant operating for high-complexity index 12 cases: Structural scheduling policies should require two 13 fully qualified consultants for ultra-high-risk 14 interventions." 15 You then tell us about formal peer review and case 16 note audits: 17 "In cases where there are specific concerns, routine 18 auditing of a consultant's outpatient letters, operative 19 notes, and indications for surgery by an internal and 20 external peer group, is indicated to ensure ongoing 21 alignment with established practice guidelines." 22 In that regard -- I'm not going to ask you about the 23 dual consultant because that would probably get quite 24 specifically into what a high-risk case in neurosurgery 25 was, but you told us that that is something that might Page 26	1 happen in a particular situation where there were 2 concerns about the way a surgeon or doctor would -- 3 undertaking their practice, rather than it being 4 routine? 5 A. Yes, it's not routine at all, it's where there are 6 concerns and you need to seek evidence for harm or 7 a near miss. 8 Q. So this is more connected to the sort of clinical 9 supervision that we were contemplating, we asked the 10 question which is: if concerns are there, what various 11 options might -- 12 A. (Overspeaking) These are the opportunities to find them. 13 Q. Indeed, and I think you mentioned that there would be, 14 perhaps -- we talked about concerns and what that might 15 mean yesterday and you mentioned, Dr Gilder, I think 16 there might be various stages that one would escalate 17 things to. One would want to intervene early and one 18 can imagine if concerns were raised, this might be a way 19 of sorting things out. So others can get involved and 20 say: have you thought about doing it this way? And that 21 would correct the problem, is that -- 22 A. (Overspeaking) Yes, so it would be part of 23 an investigation and more common if you had repeated 24 concerns or more likely to happen if there were repeated 25 concerns. Page 28

7 (Pages 25 to 28)

1 Q. I see, but this is redolent of a culture, I think, where 2 consultants are happy for others to come in and offer 3 help and vice versa if needed, is that what we're aiming 4 towards? 5 A. Yes, although this 14.8.3 doesn't reflect that, that 6 would be part of a formal investigation. That wouldn't 7 be something you do as an informal, I wonder. You would 8 have to go through -- instigate a formal investigative 9 process to do that. 10 Q. I see, understood. And 14.8.4, something you've 11 mentioned already: 12 "Regular departmental and cross-departmental 13 mortality and morbidity ... meetings: [mortality and 14 morbidity] meetings are most effective when they include 15 the wider clinical team as well as being well structured 16 and led to support safe discussion of each case; to 17 ensure discussions are minuted; and that attendance is 18 mandated." 19 We've discussed that, I think, on a number of 20 different occasions, the principles I think being the 21 same but those sorts of meetings being for a slightly 22 different purpose. One of the aspects of that that 23 I just wanted to focus on is the importance of meetings 24 of that nature and perhaps also multi-disciplinary 25 meetings being minuted, is that important? Page 29	1 not minuted and again, that's down to local custom and 2 practice, down to resource, down to time, down to the 3 point that Professor Walshe made about the number of 4 individuals within that specialty and how difficult it 5 is to attend regularly. If there are just two of you, 6 one of you may be covering the ward and then there will 7 be an M&M meeting. So the M&M meetings are challenging 8 in environments in particular where there are fewer 9 individuals within that specialty. 10 But the approach to minuting is very variable. In 11 terms of the CQC and my experience is that they expect 12 to see them but it's actually very variable. So you 13 might get them -- the departmental secretary might hold 14 them commonly but each department will have their own 15 solution to that. 16 Q. But as far as you're concerned, and perhaps the CQC, 17 they should be minuted but you are telling me that 18 sometimes they're not? 19 A. (Overspeaking) They should be -- yes. 20 Q. Yes, okay, and you have explained why it's important 21 that they're minuted. When you talk there about the 22 departmental secretary, does that mean that there is, 23 somehow, a separate set of paperwork or computer files 24 which are kept within a department separate from the; 25 patients' medical records? Page 31
1 A. It is important. 2 Q. Why is it important? 3 A. Because you have documentary evidence of (a) the 4 attendance and (b) the discussion and also the actions 5 you would take as a consequence of the learning that 6 might have come out of it. 7 Q. Thank you. One aspect which we'll get on, I think, more 8 with Professor Farrell later relates to medical records 9 and documentation but just in relation to the meetings 10 that we've talked about, one aspect that may be 11 commonplace in hospitals or may be familiar to doctors 12 which seems slightly difficult for us to follow is the 13 places where records relating to patients, or more 14 broadly, are kept in hospitals, it seems to be 15 a difficult area. But we've encountered situations 16 which one has medical records related to an individual 17 patient but there are other places where records may be 18 kept which contain either information in relation to 19 that patient or a broader range of information relating 20 to a number of patients. 21 Where would you expect the minutes of 22 multi-disciplinary and morbidity and mortality meetings 23 to be kept in a hospital? 24 A. It's not standard, it's down to local custom and 25 practice and I could also say that many M&M meetings are Page 30	1 A. Yes. 2 Q. That would contain these sorts of minutes. What other 3 sorts of information -- 4 A. (Overspeaking) Minutes of an audit meeting, for example. 5 Those are minuted, they're kept in -- they may be -- and 6 again, these are all generalisations and every 7 department has a different solution, but these days you 8 would expect them to be a folder on a computer system 9 that's usually held under the departmental secretary, if 10 that administrative function still exists because there 11 is a move to remove as much administrative support as 12 can be possible at the moment. 13 THE CHAIR: If the minute covered a meeting in which 14 a particularly complex case involving a particular 15 patient, if it covered that sort of ground, would there 16 not be a basis for suggesting that the minute of that, 17 or at least the part of it that was relevant to that 18 part of the discussion, appeared in the patient's 19 records as well as the departmental records, and 20 indeed -- 21 DR GILDER: (Overspeaking) So I think there are two 22 different processes we are talking about here. One is 23 patient care, follow-up, response to complaints, 24 et cetera. One is the purpose of a morbidity and 25 mortality meeting which is fundamentally learning. And Page 32

1 so one would expect that the discussions, the debate, 2 the learning, the outcomes, in some way or other would 3 be reflected in the care that that patient had. One 4 would expect that if there was something within 5 a discussion where you would want to go back as 6 a clinician and say: I actually need now to do this on 7 the basis of that discussion, you would expect that in 8 the patient's notes. But the two processes are actually 9 separate. 10 THE CHAIR: Okay, all right. Thank you. 11 MR DAWSON: Thank you. One of the things that I set out at 12 the beginning that we were trying to do here -- it was 13 your phrase originally, Dr Gilder, was to try and work 14 out what "good" looks like, with regard to the way in 15 which medical records should be kept and stored, that's 16 what I'm interested in, in this area because you've told 17 us already that perhaps practice in this regard is 18 variable, but what I'm interested in finding out is what 19 should happen in this regard. So as far as the records 20 are concerned, you've told us that for these two types 21 of meetings, there should be minutes kept and that 22 although there would be local practices that would -- 23 presumably certain ones be within the bounds of what 24 "good" might look like, in these circumstances you would 25 expect those to be kept in some sort of departmental Page 33	1 A. Yes. 2 Q. Whether they're specific to the patient's care or at 3 a learning meeting afterwards; is that correct? 4 A. Yes, but again, I just want to make sure everyone 5 understands, there's the patient's healthcare record 6 which is about the care that you're giving the patient, 7 the discussions you have about the patients -- so the 8 MDT record, for example, would go into a patient's 9 medical record -- rather than environments where you're 10 discussing and having learning environments and learning 11 conversations, about the patient, because at that point, 12 the care -- you're reflecting, you're looking back on 13 care. 14 Q. Understood, and I think you mentioned that the other 15 sorts of records that might be kept within the 16 department office or something would be audit-related? 17 A. Yes. 18 Q. So just to be clear because sometimes I think I use 19 "audit" in a way slightly different from you, but what 20 do you mean by "audit"? 21 A. Right, so originally -- so audit meetings have been 22 renamed in most institutions, but not completely, as 23 clinical governance meetings. So audit was, if you 24 like, what we did before we took a much broader 25 approach and a more systematic basis to clinical Page 35
1 office or on a departmental filing system, on 2 a computer, is that right? 3 A. So I think I want to, again, distinguish between the 4 patient's medical record and aspects of their care, 5 decisions made by their care and how those records are 6 held. But to the meetings that I'm referring to, which 7 are departmental learning meetings, the meetings where 8 cases are raised, discussed, safe space and any learning 9 or action or for anything that might be relevant to that 10 individual patient, what you might want to do as 11 a consequence, and many of these actual conversations 12 are after the fact. 13 Q. Understood. 14 A. And should there be investigation into the care of 15 a particular patient, as discussed there, these records 16 would be pulled out and put as part of the 17 investigation. 18 Q. Yes. 19 A. They would not sit within the patient's medical care 20 record. 21 Q. Understood. Because these records might be important 22 for aspects of clinical governance? 23 A. Yes. 24 Q. Which is one of the reasons why there should be minutes 25 and there should be records of all of them? Page 34	1 governance. So an audit meeting would be the same, you 2 would discuss cases, you would -- of interest, you would 3 discuss cases where you'd learnt, you may look at 4 a paper, a medical research paper and discuss how we 5 might enact that within our own department. You might 6 bring a new piece of medical equipment in. Audit 7 meetings are really bringing the whole department 8 together to learn and there would be -- again, in many 9 institutions the agendas were not proscribed and that 10 came -- that was a sort -- that's evolved over time. So 11 it's -- I'm sorry, I'm giving you -- but it's exactly 12 the state of play for many teams over many years, is 13 that an audit meeting is where you bring various things 14 you want to discuss, to learn and improve your clinical 15 practice. 16 Q. Okay, thank you. Are there any other types of materials 17 that one would expect to find in that departmental 18 office that we've hypothesised? 19 A. Attendance records, divisional management meetings, so 20 any -- so we would normally minute business meetings, we 21 would minute -- we'd expect to minute an audit meeting, 22 which sort of transformed into the wider clinical 23 governance meeting. Morbidity and mortality, we'd 24 expect -- meetings and again, individual departments 25 could keep things differently. It may be that you don't Page 36

1 have administrative assistance and that the audit lead 2 might keep those minutes on the computer that they 3 access within the trust or hospital. I'm afraid it's 4 extremely variable. 5 Q. Okay, but there would be certain standards, minimum 6 standards I think, of the fact that you would 7 have minutes of these things kept somewhere within some 8 sort of department of that nature? 9 A. If minutes were taken and made, that's what absolutely 10 you'd expect. 11 Q. To be clear, would you expect minutes to be taken and 12 made of those meetings? 13 A. Best practice would be to minute those meetings. 14 Q. Yes, thank you. And when you talked a moment ago about 15 business meetings, would that be the sort of thing where 16 you're considering: should we be putting a case together 17 to get more equipment, or do we need new staff or 18 something like that? 19 A. Correct. 20 Q. Understood, thank you. So that discussion, is that 21 an internal discussion in the department before you take 22 your case to someone external? 23 A. Yes. 24 Q. Yes, understood. That's helpful. One aspect I wanted 25 to pick up, again, I think that this may be Page 37	1 about this when we were drafting the report and 2 struggled to find out online. This is the maintaining 3 high professional standards framework produced by the 4 Department of Health, which sets out the processes which 5 hospitals are meant to go through, or healthcare 6 providers, NHS healthcare providers are meant to go 7 through in dealing with concerns and in managing 8 suspensions. And it's very important to have strong HR 9 support throughout that process because, certainly in 10 the past where that process has not been properly 11 followed, clinicians who are subject to that process 12 have been able to challenge the way in which their 13 suspension has been enacted or indeed whether it was 14 fair. There was a recent case where that went to 15 judicial review, and the challenges have largely been 16 about adherence to process. 17 It sets out, for example, timescales in which any 18 suspension has to be reviewed. It's designed to make 19 sure that suspension is, as we said, a neutral act but 20 also that suspension balances the concerns for patient 21 safety and public protection against the legitimate 22 interests and concerns of the clinician. I think 23 Dr Gilder is probably better placed to talk about the 24 realities of this than I am. 25 DR GILDER: Fundamentally, human resources have the Page 39
1 Professor Walshe, we shall see. It's related to another 2 subject that we discussed yesterday which is suspension 3 and it's one particular aspect of it I wanted to pick up 4 because it resonates with some evidence we've heard. 5 14.9.2, please. You are talking there about suspension 6 and you're indicating that there are some important 7 aspects of the way in which one should go about 8 suspension and you mention, first of all: 9 "Separation of immediate suspension from 10 disciplinary action ..." 11 It's the second one I want to read. The third one 12 is: 13 "Immediate external regulatory notification ..." 14 We've touched on that to an extent already. The 15 second one is of interest to us, which is: 16 "Adherence to standardised national human resource 17 practices and frameworks ..." 18 Could you tell us why that is important and whether 19 that would mean that you would have to get human 20 resources, managers or individuals from that department, 21 involved at that stage? 22 PROFESSOR WALSH: So there is a national framework which 23 I think I'm right in saying applies in England, Wales 24 and Northern Ireland, but I'm not completely clear on 25 whether it applies in Scotland. We had some discussions Page 38	1 expertise, they are trained to do this properly and 2 that's a difference between -- yeah, that's the 3 importance of national human resource practices. These 4 are not common events and they need to be done properly 5 and I think we have talked about clinicians as managers. 6 Most clinician managers only have a proportion of their 7 whole time allocated to that role and clearly they're 8 managing an entire -- a huge environment. 9 So the importance of human resources that they have, 10 they need to be expert in this. 11 Q. Might it, in fact, be the case that, for all the reasons 12 that you've mentioned -- there are obviously legal 13 reasons, Professor Farrell, related to this as well -- 14 that it would be advisable, as we've said in other 15 circumstances where concerns are raised, to involve 16 human resources at an earlier stage rather than a later 17 stage. Because if you take a judgment where: I don't 18 need to get them involved until a certain point is 19 reached, you may already have caused a problem from 20 a judicial review point of view that you haven't 21 integrated fundamental aspects. And indeed, viewing it 22 from the doctor's perspective. You may not have done 23 things that they are entitled to in terms of their 24 employment relationship? 25 A. When there is a concern best practice is to immediately Page 40

1 talk to your HR, the person you liaise most closely 2 within human resources, early. 3 Q. Understood, thank you. 4 PROFESSOR WALSH: And in my experience as a non-executive 5 director, your HR team and the HR director will then 6 draw on employment law advice from pretty much every 7 trust has a set of legal advisers on hand who provide 8 them with employment law support and it's really 9 important to get that support, to make sure that you're 10 doing things by the book. 11 Q. Indeed, thank you. Can I take you to another part of 12 the statement. Again, I think we've touched on parts of 13 this but I just wanted to flesh it out a little bit 14 more. In more than one place, probably due to the 15 clumsiness of the questions drafted by me, but in more 16 than one place you tell us, I think quite helpfully for 17 our purposes, summarise a number of pitfalls or issues 18 that one might see and want to avoid in relation to 19 clinical governance systems. In particular, the first 20 iteration of this is at paragraph 13.3.1, which is one 21 that we've touched on before near the very beginning of 22 evidence but I just want to go back to try and flesh it 23 out a bit more. 13.3.1, please. 24 So Dr Gilder mentioned this at an early stage, the 25 tick-box aspect. You say: Page 41	1 authorities like regulators or government, there's 2 a risk that that performance management drives people 3 to, you know, "teach to the test", I think is the 4 expression. In other words to, you know, tick the 5 boxes, make sure they've done the things that need to be 6 done but not to enact it as policy intends which is, 7 I think as we've said, for it to be a proper engagement 8 in thinking about the quality of care. 9 Q. I think you mentioned, when we were talking about the 10 emergence of clinical governance we talked about there 11 being a resistance to the bureaucracy of it at a certain 12 time and we talked about the fact that there was 13 resistance perhaps amongst older professionals, but 14 there were newer professionals who saw this as the 15 future. And I had rather hoped that the position might 16 be that the newer professionals -- become the prevalent 17 attitude, but I think you identified that this was still 18 an issue in some places, as far as you were concerned? 19 A. I think we were talking particularly about appraisal and 20 if you read the literature around the time when 21 appraisal was introduced, there were lots of criticisms 22 in the medical journals from people who said -- and 23 I think I said this yesterday: this is a big 24 bureaucratic imposition, we're not being given time in 25 our job plan to do this properly. Dr Gilder referred to Page 43
1 "Tokenistic 'box-ticking' bureaucracy ..." 2 This is a pitfall within clinical governance 3 systems: 4 "The operational failure modes of clinical 5 governance systems frequently stem from administrative 6 gaps or organisational culture dysfunction: The most 7 common failure occurs when clinical governance becomes 8 a passive administrative paper-chase. If annual 9 appraisals, SOAR inputs, and job plans are completed 10 merely to satisfy a regulatory checklist without active, 11 qualitative cross-checking of the data, dangerous 12 variances in clinical capability can remain undetected 13 for years." 14 So, first of all, what you're talking about there is 15 the need for this not to be seen -- as I think maybe 16 Professor Walshe told us, some of this had been seen as 17 a sort of bureaucratic inconvenience, but actually 18 an extremely important part of the way that a healthcare 19 system should function? 20 PROFESSOR WALSH: Yes, I think this speaks to the risk that 21 it becomes a kind of performative exercise in which 22 people go through the rituals of checking rather than 23 taking it seriously and engaging in it as it is meant to 24 be. And in a way, you know, the performance management 25 of these systems within an organisation or by higher Page 42	1 the considerable amount of work needed to assemble your 2 supporting information and to have disappointing -- or 3 say, if somebody then had the experience of appraisal 4 being, you know, a pat on the back and: yes, fine, tick 5 to your supporting information and off you go. 6 I do think attitudes have changed as it has become 7 accepted. I don't think we have great evidence on that 8 but certainly that's my experience from talking to 9 doctors. But I think it's still regarded as, you know, 10 something of an inconvenience by plenty of people. And 11 it all depends, as you have said, therefore on the 12 quality of process. I mean, all of us you know find our 13 personal appraisals, as an academic or in -- you know 14 a bit of a combination of a carrot and a stick. You 15 know, we have to do it but if it's done well it is 16 actually quite a good experience. 17 Q. You then go on to tell us about the possible drawback or 18 pitfall of the clinical silo and professional 19 protectionism. You say: 20 "In complex, highly specialised areas like 21 neurosurgery, departments can develop insula 'silos', 22 leading to what has been described as a 'club culture'. 23 If non-specialist managers or general medical directors 24 defer entirely to a senior clinician's reputation 25 without independently reviewing raw outcome data, Page 44

1 mortality rates, relevant national audit results or 2 staff complaints, the governance system becomes blind to 3 localised patterns of malpractice." 4 I think, again, we touched on this I think yesterday 5 in a more general conversation but again, is this 6 a phenomenon that you think is an important thing to 7 avoid in a proper clinical governance system? 8 A. I think that paragraph is particularly making the point 9 that in complex areas where you have small 10 sub-specialties, a small number of clinicians, it's 11 possible for them to become something of a silo and that 12 other clinicians, other doctors in roles such as 13 clinical directors and divisional directors and medical 14 directors will not have the specialist knowledge to 15 really be able to judge the performance of those 16 clinicians, which is why the ability to bring somebody 17 in from outside, sometimes informally but often more 18 formally to do things like case note reviews, or 19 indeed -- and this is another formal stage down the 20 line -- to ask Royal Colleges to provide an invited 21 review team to come and do a review of a given area is 22 so important because the expertise is very particular. 23 Q. We've come across invited reviews in some of the 24 evidence that we've heard in particular from the Royal 25 College of Surgeons in England and they were clear that Page 45	1 suppress information regarding complications, alter 2 clinical charting, or conceal near-misses out of fear 3 for their employment, driving clinical risk underground. 4 This occurs where what might be called a 'fortress 5 culture' exists, where there is an unwillingness to 6 learn from elsewhere; there is a closed corporate and 7 professional mindset; there is overconfidence in the 8 organisation's reputation and standing; and there is 9 a tendency to place blame elsewhere. In this type of 10 working environment, staff often exhibit learned 11 helplessness, and there is normalisation of the abnormal 12 in early terms of behaviours or actions." 13 So again, I think this is to do with something 14 called the "just culture" and that being important. 15 I wondered whether it was important to realise that, to 16 put all these things together, that these three points 17 are not silos, in fact they interact to an extent. 18 Because could it be possible that phrases like "just 19 culture" might appear within institutions but they 20 become something of a sort of sticker or something like 21 that, you say: well, we have the just culture and so 22 that's fine. But they actually in fact need to exist 23 within the systems in order for them to work properly? 24 A. Yes, I mean I think this paragraph draws on research 25 I did quite some time ago which, when you review cases Page 47
1 they offer broadly two types. One was an individualised 2 review into an individual surgeon but they also 3 offered -- they called it a "service review", but 4 I suggested it was more of a systems review and the 5 individual, Professor Smith, agreed that that was what 6 we were talking about. Is that what you're talking 7 here, the possibility that someone might be brought in 8 from a more specialist area to say: this is not how 9 a surgical team should work, perhaps do it this way? 10 A. It will not normally be one person, it will be a team, 11 a small group and they will agree a terms of reference. 12 But I think all the Royal Colleges now have an invited 13 review process where they'll agree a remit, a team will 14 come in for a few days, they will interview people, they 15 will likely review sets of cases and then they'll 16 produce a report which is made available. And the 17 processes for sharing those reports perhaps vary a bit 18 but the purpose is to provide that external expertise. 19 Q. Indeed, thank you. Then the next thing, again, we've 20 touched on this, but I just wanted to give you the 21 opportunity to add to where you say: 22 "A punitive or 'blame' culture: If an institution 23 responds to adverse event reports with immediate 24 disciplinary action, finger-pointing, or public shaming, 25 the report system will fail. Staff will actively Page 46	1 of major service failure in healthcare organisations, 2 you find this consistent pattern of concerns being 3 sometimes raised but then suppressed or withheld, the 4 organisation or individuals or departments become 5 defensive about the issues and being unwilling to accept 6 external advice or support. Sometimes in organisations 7 there's a belief in their own excellence which isn't 8 always justified by their results but they've got 9 a belief that they're actually very good. And that 10 point about learned helplessness I think is important 11 because where there are major service failures in 12 healthcare organisations, you almost always find that 13 there are plenty of people there who knew there was 14 something wrong, some of whom had made efforts to raise 15 their concerns and been knocked back and then they kind 16 of held their hands up and said: well, that's just what 17 we'll have to put up with. And they'd kind of got used 18 to the way that organisation works. Its patterns of 19 practice became the way things are done around here. So 20 it's a concern that in organisations where things go 21 wrong, you find this kind of set of circumstances that 22 we described as a kind of fortress, defensive culture. 23 Q. Thank you. One aspect of this that may be of relevance 24 to us is how you deal with sort of bringing together 25 a just culture, trying to invite people, make the Page 48

1 systems accessible and things that people actually use 2 and invest in, in an appropriate way and the possibility 3 that there needs to be, alongside that, separately from 4 that, some sort of disciplinary regime. Because the two 5 must interact to some extent logically but I think the 6 idea of a just culture is that you try and keep these 7 things completely separate and people can invest in 8 a system where they are reporting things or raising 9 concerns in a way that will not lead to them getting in 10 trouble themselves. Is that the concept behind it? 11 A. Yeah, and I think colleagues might want to come into 12 this as well, but the ideas about a no-blame or a just 13 culture have evolved over time. And I think people -- 14 it began by trying to say that we ought to have 15 a no-blame culture, a culture in which we recognise that 16 most of the things that go wrong in healthcare 17 organisations derive not simply from the actions of one 18 individual but from a complex set of circumstances which 19 can be to do with resources or training or access to 20 equipment or other things. And I think that term 21 "no-blame culture" then raised concerns that that, in 22 some ways, wasn't compatible with a proper professional 23 accountability. So that idea of a just culture, I 24 think, is an attempt to find a third way, if you can use 25 that expression, between, on the one hand, a punitive Page 49	1 might lead to disciplinary action, their engagement in 2 the process? 3 PROFESSOR WALSH: So I sometimes tell people about 4 an organisation I came into contact with quite a few 5 years ago, an ambulance service where they'd introduced 6 a system for instant reporting and the staff had named 7 it "shop a mate". And that kind of encapsulates that 8 problem, that you need a culture in which people feel 9 they're able to raise their concerns but they're not 10 then going to be hit over the head with it. A few years 11 ago there were real concerns around one particular GMC 12 case that the content of discussions in an appraisal and 13 about somebody's professional development could then get 14 used in a regulatory disciplinary process. And there 15 was much debate about how to manage that because you 16 want someone in their appraisal to be able to be really 17 honest and to talk about their failings and to talk 18 about how they might not have done as well as they should. 19 At the same time, you need to find proper ways of 20 holding them to account. And so I think that is -- for 21 a medical director, or a clinical director that's 22 a lived tension that they have to navigate. On the one 23 hand trying to make sure people are able to be open and 24 honest and that problems are discussed constructively, 25 but on the other hand recognising that there is Page 51
1 culture that would treat every error as a potential 2 cause for discipline and there, but for the grace of 3 God, go all of us, as we all make mistakes. On the 4 other hand, a culture in which there wasn't 5 accountability for people behaving properly as trained 6 clinical professionals and that's the idea of a just 7 culture. And the reality, I think -- and Dr Gilder may 8 want to come in -- is that it's really hard to find that 9 third way in practice because you have to recognise 10 that, if you find significant malpractice, that you have 11 to deal with that properly through the appropriate 12 channels within the organisation or through the 13 professional regulator. 14 But on the other hand, we know that it's quite hard 15 to separate out individual accountability from the 16 system or service and often those two things are really 17 ennmeshed. 18 DR GILDER: I think the only thing I would add is a just 19 culture needs to be set by the executive team. It 20 starts at the top. 21 Q. In general terms, in order to understand the way these 22 systems have to co-exist but are separate, if 23 I'm getting it right, would it be a good idea to 24 advertise on the face of a system which seeks to engage 25 people and have them report issues or concerns, that it Page 50	1 a responsibility to hold people accountable for their 2 professional conduct. 3 Q. I suppose there might be a way of going about that where 4 those two things could be known to exist but that they 5 try to deal with things separately. So to put it into 6 your context, I suppose to ask my question in the 7 context you're talking about, would it be a good idea to 8 put on the appraisal form: careful what you say because 9 it might get you in trouble? 10 A. I think if we end up putting that on appraisal forms 11 then we're perhaps ruining the process of appraisal. 12 But certainly, trying to make sure that you construct 13 your records in a way that isn't a hostage to fortune. 14 DR GILDER: I wanted to add that the NHS actually describes 15 "just culture" as a framework and within that framework 16 it absolutely describes following the appropriate 17 disciplinary processes. And the just culture approach 18 is really asking questions to understand the system in 19 which this incident has occurred. So not just the 20 individual but the system and it asks questions about 21 best practice, protocols, health, looking for intention 22 for deliberate harm. 23 And then the other questions, as you go through 24 them, in terms of the structure, will may reveal 25 deficiencies in the systems or in the individual. And Page 52

1 then, when you then follow those lines of enquiries 2 down, take the appropriate action which may well be 3 disciplinary but more often than not, is looking at how 4 do we fix the system rather than the individual. And 5 the point of it is to and courage everyone to recognise 6 that oftentimes when bad things happen there are 7 a sequence of things which contribute to that outcome 8 and that all of them need to be addressed because some 9 of them will have led to the individual making the 10 mistake that they did. 11 PROFESSOR FARRELL: I just wanted to add, around no-blame 12 culture or even just culture, there's a need for 13 differentiation. We're talking about systems-based 14 processes and reflective learning, but it's often 15 expanded around the doctor-patient relationship and 16 perceptions that can result from patients pursuing 17 concerns. And that that may be, well, the system or 18 clinicians, or even a particular health board, that 19 there's a fear that they're being blamed and that maybe 20 those forms of grievance or redress are the problem as 21 well. 22 So it's fine, we're talking about systems here and 23 processes, and within particular health boards or 24 services, but there's another way in which it is also 25 used. And it's sort of elided in a range of, I would Page 53	1 there's a cultural issue which is part of that system, 2 in particular one that may involve deference to 3 seniority. 4 One aspect that we're interested in looking at is 5 the possibility that people might not engage in systems 6 for fear that there may be consequences, not through the 7 system itself with which they're engaging -- for fear 8 that that system may say: no, it's actually your fault 9 that this happened. But that it might have 10 ramifications elsewhere, for example the feeling that if 11 they've spoken up about an issue, they may be passed 12 over for a promotion or they may not get access to the 13 best surgeries or they may not get advantages because of 14 the fact that if you speak up, in particular, against 15 someone senior that that might have consequences for 16 you. That seems, to me, to involve an element of 17 cultural issue or systemic issue. And I wonder, as 18 you've mentioned this being an important feature to 19 avoid, what -- perhaps, Dr Gilder, what your experience 20 of that is, but also why it's important that that aspect 21 be eradicated from a good clinical governance system? 22 DR GILDER: The second part of your question is very much -- 23 is that if people fear for their own careers, they will 24 not speak up. And I have considerable experience of 25 this because there are pockets of it still and what Page 55
1 suggest, inquiries, et cetera, where the doctor-patient 2 relationship and what's happened in that context is 3 elided with systems processes. And they do interact but 4 they are different as well. 5 Q. Thank you, that's helpful. If I could just skip to 6 another page and bring, into this very conversation 7 another aspect, another pitfall you identify, because 8 this is definitely of interest to us. Page 63 of the 9 report, please. Again, this is part of your analysis 10 I think of pitfalls of the systems, features that do not 11 provoke successful outcomes. You repeat here some of 12 the aspects you've mentioned before, such as 13 box-ticking, but here, you say: 14 "The 'conspiracy of tolerance' and deference to 15 seniority: Elite clinical standing and institutional 16 hierarchy can obscure systemic or individual failures 17 with respect to quality and safety in healthcare 18 settings." 19 You were mentioning, a moment ago, the sort of 20 balance that might need to be struck in the systems we 21 were talking about would need to focus, I think, on the 22 fact that what one is looking for is a systemic problem 23 and that there may be systemic reasons why things are 24 going wrong. It may also be -- and this is a word 25 that's come up a couple of times yesterday -- that Page 54	1 leads to that is an environment where difficult 2 conversations aren't had early and tolerance of 3 behaviours are enabled. And I'll bring in the learned 4 helplessness because it's really important. When people 5 have raised a concern and they haven't been heard or 6 nothing has been done and for example the behaviour 7 continues, they will stop raising concerns. And to flip 8 that culture, you have to do a fairly major intervention 9 around, you know, what -- at a senior level, with the 10 team involved, saying what this organisation stands for, 11 what our values are and often bring in somebody external 12 to get -- to actually interview individuals in order to 13 get underneath what's going on and then act on the 14 information that you have. 15 Q. When you say "you have to do an early intervention", do 16 you mean someone on the executive side of a healthcare 17 organisation? 18 A. If the organisation isn't trained or the managers in 19 an organisation are not trained to have that -- what is 20 a very difficult conversation, to hold people to 21 account, and this is in particular with reference to 22 behaviour because what we're talking here about is 23 really the behaviour of an individual when a concern is 24 raised about them, but if organisations don't have that 25 skill -- and it is a skill, and it is difficult and Page 56

1 uncomfortable and Professor Walshe referred to the fact 2 that quite a lot of managers are clinicians, so there's 3 also the collegial relationship that gets in the way. 4 So: I'm your colleague but I'm also your manager, but 5 now I have to have a very difficult conversation with 6 you to hold you to -- those are very, very skilled, or 7 they require a lot of skill to have those conversations 8 and traditionally those skills aren't taught, they're 9 not built and they're not necessarily prioritised. 10 And when you don't -- and this is about the cup of 11 coffee conversation, nipping things in the bud. As soon 12 as you see poor behaviour you have documentation of that 13 behaviour, that's the conversation that needs to happen 14 in the hope that the behaviour will not repeat itself. 15 But when we get into situations of, you know, the 16 conspiracy of tolerance and deference to seniority, it's 17 generally because people have not had those 18 conversations, they have not held that individual to 19 account when the behaviour has first appeared. 20 Q. Understood and I think the culture that you've talked 21 about -- I think you used the phrase, Professor Walshe, 22 that can result in a "normalisation" of what, to anyone 23 external, would seem like an abnormal situation. And is 24 that the consequence of not dealing with things early 25 on, as Dr Gilder has suggested would be the best Page 57	1 staff, have been better at institutionalising what 2 broadly people call "safety science". And that safety 3 science has come somewhat late to healthcare 4 organisations but I think it's now really quite well 5 understood and expertise -- people often cite the 6 aviation industry or the nuclear industry or the oil 7 industry, and they're very different settings but some 8 of the common lessons and methods have certainly been 9 found to be really useful in healthcare. 10 Q. Thank you. And the last aspect, before the break, 11 I just wanted to raise with you from the same passage, 12 if we can scroll down a little bit in 15.1.4. Again, 13 this is another example of a feature of a clinical 14 governance system that you think should be excluded, or 15 would not be helpful, is: 16 "Fragmented data architecture ... Fragmentation of 17 complaints, audits, and clinical outcomes data across 18 separate administrative silos prevents early risk 19 identification." 20 I think that related to our conversation about 21 triangulation of data; is that what was meant there? 22 A. Yes, but also having people see the whole picture which 23 is partly about expertise and knowledge and 24 organisational arrangement, but it's also just about the 25 fundamentals of data systems and information. We talked Page 59
1 practice here? 2 PROFESSOR WALSH: Yes, and I think you'd not just see it in 3 clinical services but in most organisations, that, you 4 know, people get used to a culture even if it's quite 5 a toxic one because they recognise that's the way things 6 are around here. 7 Q. One matter that that touches upon that was of interest 8 to the Inquiry, in fact in putting this group together 9 at the beginning, was the question around whether the 10 medical profession and in particular healthcare 11 provision draws on examples and the way in which things 12 outwith the medical world work in order to try to 13 improve its practice. Professor Walshe, is that 14 something that you think happens, or does healthcare 15 view itself as something unique that has its own 16 systems, or does it draw on business or other forms of 17 doing things? 18 A. That's a very broad question. I would say, in the last 19 few decades, healthcare systems in the UK and elsewhere 20 have become more open to learning from other sectors, 21 both public and private. And that's particularly true 22 in the field of safety, where we've got better at 23 understanding that other organisations which are 24 high-risk organisations, where there's a risk of harm to 25 customers or service users, have been -- or indeed to Page 58	1 yesterday about the role of systems like Datix which 2 I can say actually began in the mid-1980s, it's been 3 around for quite a long time and is very widely used in 4 the NHS at trying to integrate that data and bring it 5 together, so there's a dashboard, if you like, of 6 performance for individuals but also for departments. 7 And if you sit on a board of an NHS organisation, your 8 board reports these days will contain a lot of 9 information, statistical information about performance, 10 about numbers of incidents, about levels of harm and so 11 on. I chaired the quality assurance committee for 12 an NHS Trust for eight years and our conversations 13 entirely resolved -- were very data-driven and I think 14 we, as a committee and as a board, had good assurance 15 that the organisation had very effective systems in 16 place for identifying and dealing with concerns and 17 dealing with incidents, particularly serious incidents. 18 And following those through into change. 19 Q. You may already have answered my final question, which 20 was: is there a risk here -- you talk about the 21 fragmented data architecture in particular, but you 22 talked about siloing as well, which I think are features 23 of the same sort of thing, but if one does have 24 different departments, different components, whose 25 responsibility in the organisation is it, to bring it Page 60

1 all together in that way? 2 A. I think it comes back to the board, to the executives, 3 particularly the chief nurse and the chief medical 4 officer and the chief executive. But also to other 5 executive board members and to the non-executives and 6 the chairs. I think the structure here of health boards 7 and NHS Trusts in England are different but the same 8 principle, that it's the board that is responsible for 9 clinical governance. 10 MR DAWSON: Thank you, sir. That would be a convenient 11 moment. 12 THE CHAIR: 15-minute break now. Thank you very much. 13 We'll start again at 11.35. 14 (11.20 am) 15 (A short break) 16 (11.36 am) 17 MR DAWSON: Thank you, sir. I'd like to return to a topic 18 that we did discuss largely with Professor Farrell 19 towards the beginning of yesterday's evidence and that's 20 complaints systems. We talked, in our discussion about 21 the evolving landscape with Professor Farrell, about the 22 emergence of a Scottish-identified healthcare system and 23 we looked at that in particular in the post-devolution 24 period and to a certain extent, we looked at complaints 25 through the prism of things like the 2011 Act, the Page 61	1 but in the UK system more generally. And it's moved 2 between various iterations of centralisation, 3 decentralisation, informal, formal, arrangements as well 4 as providing support services for patients and families 5 who have experienced grievances. 6 But at a broader level, there was quite a seminal 7 paper in the early 1990s not specifically dealing with 8 complaints processes but dealt with what happens when 9 patients and their families suffer from grievances or 10 concerns about medical treatment. And it was by 11 Charles Vincent and colleagues and it was: what do 12 patients want when things go wrong? 13 And it informed sort of later developments around 14 redress systems, but I think the principles are 15 instructive in terms of what might work for a complaints 16 system. And they want ongoing communication with their 17 treating doctors to find out what happened. Now, that 18 may be through informal processes, through follow-up 19 discussions with them, or through informal or formal 20 investigations down the track. They want an explanation 21 as to what happened. If appropriate, an apology. And 22 apology not as an admission of liability but as 23 an expression of regret. And importantly, 24 accountability. And they really wanted to ensure that 25 what happened to them, for example, or their concerns or Page 63
1 charter in 2012, focusing on that aspect of things. 2 What I'd like to talk about a little bit more is to 3 expand upon -- which I think may be Dr Gilder and 4 Professor Farrell have talked about this in different 5 places -- is that in the same way as we looked at this 6 for clinical governance, what good features and bad 7 features of a complaints and feedback system are. 8 One aspect of this that I'd like to touch on is the 9 importance of having different features of a complaint 10 system and not just relying on a formal complaints 11 system, that our own Terms of Reference use various 12 different phrases that may be relevant in a situation 13 where a patient might have an issue with their treatment 14 that relates -- that the words "issues", "feedback" and 15 "complaints", all feature. 16 So first of all, if I could just address, as 17 a question of what does a good complaints system look 18 like, is it important that the system is able to 19 accommodate issues being raised, concerns being raised, 20 feedback being proposed, short of a formal complaint 21 system that may involve filling out forms and that sort 22 of thing? 23 PROFESSOR FARRELL: Yes. The NHS, over many decades, has 24 struggled -- not struggled, but sought to adjust its 25 complaints systems. That's not just only in Scotland Page 62	1 if they did suffer particular harm, does not happen to 2 other patients. 3 Sometimes that's -- I did raise it before the break, 4 maybe interpreted as a blame culture on the part of 5 patients but actually the empirical research is quite 6 clear that the emphasis is on accountability in that 7 regard. 8 So, depending on where you are in the system, you 9 may have a different aspect on what complaints are 10 about. But the broader principles have been fairly 11 consistent in that regard, and the different mechanisms 12 and support structures in place have varied over time to 13 deliver that. 14 Q. And does the research perhaps -- or your own views on 15 it, does it tend -- does the research tend to suggest 16 that, given that we're dealing with a situation where 17 something bad has happened already or at least a patient 18 perceives something bad has happened, does the failure 19 of a system adequately or properly, to deal with all of 20 the things that you've mentioned, create in that 21 inevitable context the possibility of outcomes being 22 significantly worsened by the system not handling 23 a complaint or an issue or a feedback properly? 24 A. When you say "outcomes", could you define what you mean 25 by that? Page 64

1 Q. Well, the overall experience for the patient. So, for 2 example, let's say a hypothesised example where 3 a patient has had an operation where the consultant 4 wasn't very nice to them and they didn't get the result 5 they wanted in terms treatment working. That's a bad 6 context, but if the hospital or the authorities are not 7 accountable and they don't deal with things in a way 8 that's fair and clear and the various principles you've 9 set out in the statement, then does it have the 10 possibility of making what's an existing harm 11 disappointment, possibly physical harm, possibly mental 12 harm and to compound that significantly by way of 13 overall outcome? 14 A. Certainly the empirical research supports that. Even 15 the empirical research that I pointed to yesterday that 16 was done as part of the no-fault compensation review in 17 the relevant period and talking to patients and their 18 families about complaints systems, a lot of it was a mix 19 of grievances and concerns. One of the major issues 20 was, as you identify, miscommunication, or a failure, in 21 the context of that doctor-patient relationship -- 22 I appreciate multi-disciplinary teams are involved, but 23 in terms of professional obligations that relationship 24 is very important. But from the patient perspective, 25 when that is not fruitful, when they don't feel that Page 65	1 who they have their relationships with and that, more 2 often than not, are their treating doctors and supported 3 by other healthcare professionals. Once you more 4 formally engage with complaints systems, then it can 5 extend to the systems and the actual sort of service as 6 well. Sometimes it is intertwined, but the notion of 7 how people are treated, whether they're treated with 8 dignity and respect -- we spoke about that yesterday in 9 relation to the charter -- are very important and 10 particularly you feel -- not feel, you may feel 11 aggrieved or concerned, but if you've suffered harm, 12 say, particularly if a family member has passed away, 13 there's a need to deal with and manage expectations, but 14 the emotions of that situation -- and as Dr Gilder said, 15 it's a skilled art in terms of dealing with adverse 16 events, whether you're dealing with treating doctors, as 17 well as patients as well. So in the complaints system 18 more generally, there's various systems that have been 19 set up to act as, you know, independent advocate or to 20 provide that sort of support. 21 But again, the empirical research that I have been 22 involved in myself also points to external people, 23 friends and family, particularly those who have medical 24 backgrounds, often people from nursing backgrounds 25 strangely enough, who -- not strangely enough, but who Page 67
1 their concerns or potentially their grievances are 2 addressed, then that can snowball, most definitely. 3 And I think for -- and again, there's research on 4 this, lawyers who may become involved down the track, 5 a lot of what they have to do in terms of initial 6 screening is to work out, for example, is there any 7 potential legal liability. But more often than not, it 8 results from a breakdown in that relationship that leads 9 to a range of, shall we say, adverse outcomes in terms 10 of progression of grievances and concerns. So that 11 relationship between that doctor and patient is vital. 12 Q. Well, that's an interesting aspect, if we build this 13 into some of the evidence given by others this morning. 14 I think Dr Gilder -- and perhaps at that stage you 15 probably all said this -- that when things go wrong it 16 can often be the case that it's multi-factorial and 17 there's a systems element, but perhaps an individual or 18 more than one individual involved as well and perhaps 19 the individuals' conduct or performance has been 20 affected by a system and it's complex. 21 To what extent then, if that is the case, and often 22 when things go wrong or there are disappointing outcomes 23 it can be multi-factorial, who are patients looking to 24 be accountable? 25 A. The empirical research says it's the people initially Page 66	1 have some contact with health services are very useful 2 for people who have had poor experiences in healthcare. 3 Q. Could I just reiterate, because we were discussing 4 yesterday complaints as a feature of a potential source 5 of information for triangulation -- 6 A. Yes. 7 Q. -- I think it was Dr Gilder with whom I was discussing 8 this yesterday describes it as complaints as an early 9 warning diagnostic tool. So we've discussed complaints 10 in that context but what I'm addressing with you, 11 Professor Farrell, is more that patient-facing complaint 12 aspect, rather than what the organisation can learn from 13 it. But, as I think it's important to recognise, there 14 are those two components to complaints. There's dealing 15 with patients in a compassionate, constructive, clear 16 way, communication being very important in that, as 17 you've said, but also the institution taking learning 18 and taking information from that, in the way that it 19 might inform what it wants to do next about various 20 different things. 21 But to focus on the patient aspect of the 22 relationship, there are various things that you set out 23 for us helpfully in the statement. We've gone through, 24 to a certain extent, I think, as part of our general 25 analysis of this building of a Scottish healthcare Page 68

1 approach in the devolution period. I think you also 2 tell us that, even before that, there were early NHS 3 complaints-related documents in Scotland which I think 4 were very early in the UK context, but that they were 5 built on particularly through the devolution period; is 6 that broadly correct? 7 A. Yes, I think you can notice a much more systematic 8 approach to complaints processes, post-political 9 devolution in Scotland. 10 Q. Yes, and I think you tell us -- there are a couple of 11 specific things I wanted to raise with you that you've 12 helpfully told us about. One is at paragraph 19.3. 13 This is where you're telling us about the NHS complaints 14 procedure, I think as it exists now. Could we have that 15 up, please, thank you very much. And you're telling us 16 here about various components of this, the breadth of 17 the expression, any expression of dissatisfaction as to 18 what can trigger the use of this service and also, in 19 various places, you mention the importance of the 20 advocacy services that are available and there's 21 an acronym called PASS, a patient advocacy service in 22 Scotland that can be used. One aspect that I just 23 wanted to raise with you is you tell us, in about the 24 middle of this paragraph, just towards the bottom on the 25 screen, where it says: Page 69	1 to -- certainly for people responding to these sorts of 2 things, to know: yes, we need to be timely in our 3 response. And that's important to injured patients and 4 families. 5 But as you identify, there could be a number of 6 reasons why a patient's experience or if somebody has 7 passed away, either you can't identify the connection 8 between what the outcome is and the series of events 9 that led to that, sometimes in law we might call a range 10 of things "latent injuries" that only become apparent 11 much beyond these sorts of time limits. 12 So there's a knowledge gap, there may be, for 13 patients that can take some time, that don't neatly fit 14 into administrative processes. So you would hope 15 a compassionate complaint service would have 16 opportunities for that and that administrative barriers 17 like sticking to time limits would not be adhered to and 18 not too many processes have to be gone through where 19 there are legitimate concerns because that's got to be 20 the ultimate focus, isn't it, to address those concerns 21 in a timely and empathetic manner? 22 Q. Thank you. This passage is slightly reminiscent of what 23 you will be aware of as a highly contentious area of 24 when time limits start running in law for various 25 things -- Page 71
1 "The complaint should ..." 2 At the end. Do you have that? About halfway down 3 the page, towards the right-hand side, it's about ten 4 lines down: 5 "The complaint should ordinarily be submitted within 6 6 months of the specified event, or when the patient 7 finds out they have a reason to complain, but no longer 8 than 12 months after the event itself (this can be 9 subject to review by the Scottish Public Services 10 Ombudsman ...)." 11 Then you explain the process. Just in terms of time 12 limits, I think this can sometimes be an issue for 13 patients in the sense that there can be good reasons why 14 patients don't raise things in the immediate aftermath, 15 for example, of a family member dying. Is there 16 rationale for why these time limits exist in the way 17 that they do? Obviously for administrative purposes, 18 one might think it's a good idea to have time limits but 19 are these time limits ones which appear to have 20 a broader rationale? 21 A. Well, you know, in terms of good process or due process, 22 you want to be seen to be responsive as soon as 23 possible, to any grievance or concern or 24 dissatisfaction. So again, as you highlighted from 25 an administrative point of view, it can be very helpful Page 70	1 A. (Overspeaking) Yeah, limitation of actions, yes. 2 Q. -- be a lot of time and argument being taken up. But 3 one would like to think that, putting aside the legal 4 rules of what one thinks about that, in these sorts of 5 situations, it would seem that the word you've used, 6 "compassion", should be at the forefront; would that be 7 your opinion, if you like? 8 A. Yes, and particularly if people have suffered 9 life-altering injuries or somebody has passed away, 10 there of course is a mixture of emotions, they don't fit 11 to a particular timetable. So of course, even in 12 a professional capacity, there needs to be a degree of 13 empathy in responding to a complaint. If the ultimate 14 outcome is to identify -- to be responsive to those 15 concerns, but equally, to, as early -- as a warning 16 system within, you know, the system or the service that, 17 you know, may be something has gone wrong and it's worth 18 investigating as well. So it's dual purposes but 19 I would suggest that adherence to strict time limits 20 has -- there is a rationale for it, but from the 21 patient's perspective empathy and compassion is 22 required. 23 Q. I think that's resonant, to an extent, in a different 24 context of evidence that Dr Gilder gave yesterday about 25 the importance of involving patients in expressing their Page 72

1 views and their treatment decisions. In many ways, 2 I think she said if you didn't involve patients then 3 effectively there was no point in it at all, but the 4 same might be said of this process because, of course, 5 one wants the patient to have a satisfactory outcome but 6 equally, in terms of the learning that one might get 7 from the process, which is another component part of 8 a complaints process, as we identified yesterday, is it 9 not important that patients are properly engaged and 10 being able to do so at the right time so that the 11 process can be as likely to be successful for them but 12 also for the institutional learning? 13 A. Absolutely, but as we've observed, there has been 14 an evolution in thinking around this during the relevant 15 period. Having said that, as we did highlight in Good 16 Medical Practice, that need to be open and honest with 17 patients on the part of registered doctors, for example, 18 the GMC has emphasised that from even before the start 19 of the relevant period. So that obviously manifests 20 itself in different ways in different health services 21 and cultures but those professional obligations, I would 22 suggest, have long been in place. 23 Q. Yes, indeed. We heard some evidence to that effect from 24 the ethics group about if one is open and honest during 25 the various stages of treatment, if things do go wrong Page 73	1 A. Yes, well, I'm quoting from particular research in this 2 context. I should just preface it by saying there is 3 quite a substantial literature around apologies and 4 regret in the relevant literatures -- academic 5 literatures, both I suppose, in broader terms as well as 6 empirical research. But this emergence during the 7 relevant period of importance of apologies and the 8 extent to which it can be interpreted as an omission of 9 liability as opposed to a broader remit of expressing 10 regret for unintended consequences, for example. 11 So the faux apology was noted in empirical research 12 as representing, from -- well, I suppose, the academic 13 researchers but also the people they interviewed about 14 it -- as a non-apology or a false apology: I am sorry 15 you feel that something has gone wrong here. Which 16 imputes the cause of distress to the subjective and 17 possibly misguided impressions of patient complainants. 18 Q. Do apologies like that have the significant possibility 19 of making things considerably worse? 20 A. Again, I have not conducted the research myself but in 21 my previous life as a lawyer representing injured 22 patients and families, yes. 23 Q. Yes, and as far as the sort of components that would 24 make apologies a good thing, because presumably research 25 says that apologies can be very important and helpful, Page 75
1 for some reason, it tends to be easier to deal with that 2 because there has been a good relationship built up 3 throughout and I think that might be what you're saying? 4 A. And just to emphasise, again, we have discussed this 5 already, but that relationship is very much valued by 6 patients, a good relationship with -- they're vulnerable 7 you know and -- capable but vulnerable and that they 8 very much -- and all the research points to that, very 9 much value a good relationship with their treating 10 doctors and other health professionals. 11 Q. Would you go further than saying it's just valued as 12 a fact, that it's essential? 13 A. Absolutely and I would say not only in terms of a good 14 relationship but also in terms of all sorts of outcomes 15 as well. And it adheres to our obligations as -- both 16 ethical and legal. 17 Q. Thank you. In 19.4, over the page, please, can we 18 scroll down a bit, please. This is where -- you already 19 mentioned apologies; this is something, again, of 20 interest to us. You've given us a very helpful 21 research-based analysis of the importance of apologies 22 here. In particular, you mention something called the 23 "fauxpology", which is a word I hadn't come across 24 before but it's very useful. Could you explain to us 25 what that is? Page 74	1 if made correctly? 2 A. Absolutely. 3 Q. What are the sorts of features then, in this research 4 that you've helpfully summarised for us in this passage, 5 that would be the components of a good apology or one 6 that would actually have the chance of improving the 7 outcome? 8 A. Well, again, there's a range of different approaches to 9 it. In fact, it became so vexing in Australia, they 10 passed legislation about it to confirm exactly -- sort 11 of delineating between admissions of liability and 12 apologies. I think being open about -- it sort of links 13 into explanations as well, and there's forms of words 14 that are, say, for example, published by the body we 15 spoke about yesterday, NHS Resolution, sort of talking 16 about a lot about how we do apologies. But being open 17 about what happened, it's not to be seen as an admission 18 of liability but explaining to patients what happened, 19 unintended consequences, and proceeding in an open and 20 honest manner. 21 Q. So encompassed within that, probably a number of 22 concepts I think, whether there should be 23 comprehensiveness to the apology? 24 A. Yes. 25 Q. There should be clarity in the apology? Page 76

1 A. Yes. 2 Q. There should be openness about the apology? 3 A. Yes. 4 Q. There should be honesty in the apology? 5 A. Absolutely. 6 Q. And "honesty" means that the apology is actually meant? 7 A. Exactly and again, the research points to this but also 8 my own personal experience is, again, the value in that 9 relationship between the doctors and patients, that 10 sense of repairing that relationship perhaps after 11 things have gone wrong, that sense of being open and 12 honest is very keenly felt by patients and their 13 families. 14 Q. Well, I was going to ask you about that, linking it 15 about a can into the questions I asked you towards the 16 beginning of this section, was you told me about the 17 importance of the relationship between the patient and 18 the individual doctor who had been in charge of their 19 care but also that there could be a multifaceted aspect 20 to the way things have gone wrong and led to 21 a complaint. In that context, is it important from whom 22 the apology comes? 23 A. That's interesting. I think, in terms of personal 24 relationships and also from a legal perspective, it 25 often is that main treating doctor. And there's often Page 77	1 organisation that -- that's the perception on the 2 part -- so it's being responsive to the grievance or 3 concern or the dissatisfaction expressed by patient 4 and/or their families and they're very, very varied. 5 But often there will be particular individuals that they 6 identify with as aligned with that organisation, but it 7 can be both. 8 Q. And so, in the same way as we had this in treatment, as 9 far as complaints and resolution when things go wrong 10 and apologies, there's a need for an individualisation 11 of the approach depending on what it is that the patient 12 is concern about? 13 A. Yes, but within the context of a broad approach to 14 dealing with complaints. 15 Q. Understood. 16 A. So as we have we're looking at 19.4, there is a process 17 by which it is hoped that that individualisation occurs. 18 Q. Okay, thank you. There are various aspects, as we've 19 seen in other parts of the report, you've helpfully set 20 out for us some of the successful high-performing 21 hospital-based complaints system and the sort of 22 components one might see in those. If we look at 23 19.6.1. Some of these we've touched on already and some 24 are sort of novel and we might explore them. The first 25 is there should be a: Page 79
1 been criticisms about that because it's 2 multi-disciplinary teams and a range of people involved 3 in the treatment of a patient, but certainly the 4 importance of that relationship, that patients and their 5 families attached to that treating doctor is seen as 6 very important. 7 Q. Should apologies be formulated by reference to wider 8 organisational goals or should they be focused on the 9 patient or patients to whom they are directed? 10 A. Well, in terms of professional obligations for the 11 doctor, that relationship with the patient -- those 12 obligations require a response to that patient directly, 13 but obviously, you know, the doctor operates in a wider 14 environment but ultimately, there are professional 15 obligations that that treating doctor has to that 16 patient in terms of being open and honest. 17 Q. Okay, what about apologies that it might be appropriate 18 to be issued on behalf of an organisation, maybe as well 19 as a doctor, but or a doctor -- 20 A. (Overspeaking) And certainly the complaints procedure 21 facilitates that as well and it may be appropriate that 22 that is done and it is offered and it should be offered, 23 but as you see in the policy, if appropriate and wanted 24 by the patient. It depends, the nature of complaints 25 are very varied and it may turn, you know, on the actual Page 78	1 "Streamlined resolution pathway: In alignment with 2 modern public service/ombudsman models, complaints are 3 routed through a strict and staged framework." 4 You recognise that the framework is important, but 5 is it important that the framework be clearly set out 6 from the start? 7 A. Yes, and -- but again, that has evolved over time and 8 it's also reflecting that shift towards, over time, 9 a more centralised or localised approach, but that 10 staged framework, over time, seems to be the best 11 practice approach as well. I suppose the question 12 always comes in terms of lived experience of patients 13 who do have grievances, concerns, have been harmed, as 14 to whether they operate smoothly, whether they feel 15 they're responsive to them. And going through those 16 stages, there's an amount of time and effort and energy 17 that may be involved in that and so whether that 18 actually works in practice, it requires ongoing 19 evaluation. 20 Q. Again, I think the next point that you make, again, has 21 resonance in some of the things we were talking about 22 this morning as features of a good clinical governance 23 system. You say, just on the next page, at 19.6.2: 24 "Centralised data aggregation and coding: All 25 incoming patient feedback, written complaints, and Page 80

1 verbal concerns are expected to be registered in 2 a single centralised digital architecture (such as Datix 3 or InPhase) and complaints are expected to be 4 cross-coded by the clinician's name, the specific 5 procedure type (where relevant), and the clinical 6 sub-directorate to enable automated trend analysis." 7 So therefore, there's two aspects to this, one 8 resonant of something we discussed this morning about 9 clinical governance, that one has to have a system where 10 all of the relevant documentation is kept and processed 11 efficiently but also I think you say that all incoming 12 patient feedback, written complaints and verbal concerns 13 should all be in that system, is that right? 14 A. I say this in general terms and I was also in 15 consultation with Dr Gilder about this, given her role 16 and experience. So I'd just like to turn to her in case 17 she would like to add anything? 18 DR GILDER: No, I think there is nothing to add. The answer 19 is "yes". 20 Q. So I mentioned earlier the possibility that there may be 21 something that was a formal complaint within a system 22 but there were other concerns, feedback. And our terms 23 of reference requires us to consider all of these things 24 because issues can be raised in many different ways 25 based on the individual or the circumstances, but your Page 81	1 that you've mentioned as we've gone along but I have not 2 touched on and I'm not going to touch on with you is the 3 duty of candour. You've mentioned it a few times and 4 we've talked about that. The reason I'm not raising 5 that specifically is that that was an area we covered 6 quite a lot with the medical ethics group already. But 7 I just wanted to make it clear to you -- I think it's 8 you who provided the written evidence on that and that's 9 been a very helpful supplement to what we've already 10 heard from our other group, which is perhaps inevitable 11 given your interest in the same sort of areas as them. 12 But I didn't want to go past that without acknowledging 13 the fact that that's been very helpful, but I'm not 14 going to dwell on it as I'd like to -- 15 A. (Overspeaking) That's absolutely fine. 16 Q. The documentation -- I find myself probably falling into 17 this trap but sometimes I think, as I come to this as 18 the last major topic, documentation can kind of be seen 19 as a bit of an afterthought. And indeed, even in our 20 own terms of reference, it comes as the last term of 21 reference, term of reference 14. We've heard, however, 22 in our sessions, evidence about the importance of 23 documentation, the importance of documentation to 24 patients, but also the importance of documentation to 25 proper healthcare management, both at the time that Page 83
1 view -- your experience and opinion is that all of these 2 should be put into a single system? 3 A. Yes. 4 Q. I think that has a dual function of, as we've been 5 discussing with Professor Farrell, first of all, 6 maximising the chance that the individual complaint is 7 dealt with efficiently and in accordance with good 8 administration, but being able to centralise all of the 9 information which then becomes intelligence that could 10 be used by the institution in bettering its systems? 11 A. Yes. 12 Q. Because if, for example, you have feedback and 13 complaints all over the place in the hospital, it's very 14 difficult -- first of all, it might mean that the 15 complaints are being dealt with in inefficient ways in 16 places for the individual patient but secondly, it would 17 be very hard to aggregate that information to be able to 18 draw any firm conclusions about whether a hospital is 19 functioning well or not? 20 A. That is correct. 21 Q. Thank you. One other area that I'd like to speak about, 22 it seems like a large area to embark upon but it's the 23 large major area -- again, I think it's an area for you, 24 Professor Farrell, that you covered -- it's the area of 25 documentation in healthcare. One aspect I should say Page 82	1 patients are receiving care and afterwards. We heard 2 evidence -- to give some context to the questions 3 I'm going to ask you -- with our very first witness was 4 from a campaigning Member of the Scottish Parliament, 5 who talked about her evolving understanding of issues 6 that patients were raising with constituents of hers. 7 And she explained not only that she had been shocked to 8 learn about the particular circumstances and indeed the 9 consequences for the individual patients, which had 10 obviously attracted her concern and involvement, but 11 that as time went along what she had tried to do was to 12 turn to the health board and try to find answers, as one 13 might expect an elected representative would try to do. 14 But that on many occasions she found that the 15 answers were not available and that the answer that she 16 was given was that there was no paperwork to answer the 17 questions. And in those circumstances, that, on her 18 part and on the part of the patients whom she 19 represented, had given rise to significant suspicions as 20 to why the paperwork did not exist when, in her 21 independent representative capacity, she thought that 22 the paperwork should. And I think she had rather 23 undertaken to the patients she would get the paperwork 24 and therefore be able to provide the answers. 25 And so, that, as a context to these questions, Page 84

1 I hope tries to explain to you, because you've probably 2 not heard that evidence, how important that this is to 3 patients and really, frankly why we're standing here 4 having this conversation. 5 So, what I have tried to do here -- because this is 6 a complex area, is it not, Professor Farrell? 7 PROFESSOR FARRELL: I would agree. 8 Q. And you have very helpfully, certainly very helpfully to 9 me, tried to help us navigate a number of the 10 difficulties that exist in the area of document 11 management. And I'd like to address, at a relatively 12 high level with you today so that we get 13 an understanding of the complexities but the importance 14 of the different areas, what those various different 15 components might be. 16 A. I think in the report what we were trying to do and what 17 I was trying to do was to provide an outline for you of 18 the various elements. Obviously, you'll need to drill 19 down into it but it is a complex area, but, as you have 20 correctly identified, vital. 21 Q. Yes, thank you. And I think one of the ways in which 22 we've certainly tried to approach this in the questions 23 we've asked you and have asked others, is try to 24 differentiate between systems that might exist relating 25 to -- well, what we would call medical records, but Page 85	1 information -- source of ethical obligation, which are 2 important in different areas. So when asking the 3 question, for example, as one might ask: what are the 4 obligations with regard to the retention of medical 5 records or health records? There may be a number of 6 different places one would have to look. If you want to 7 ask yourself the question, as this Inquiry has to do: 8 where would one find what one needs to do in order to 9 maintain high quality, accurate medical records? Again, 10 there are various places where one would have to look, 11 I think. So it's trying to navigate some of that, as 12 part of our introductory sessions, that I'd like to do 13 today. I fear there's a danger, if we try to delve too 14 deep into this that we will get into the weeds and 15 complexity, which for present purposes, I think, as your 16 report makes very clear, you have understood, 17 Professor Farrell, and you've helped us with 18 understanding these various different areas. So 19 I'd like to try and look at some of those things today. 20 First of all, I think you have identified for us 21 that there are, perhaps as regards how one defines 22 records, different terminology that might be used and 23 different definitions that existed over the period. In 24 particular -- I'm going to try and help you where 25 I found the passages in the statement and we can perhaps Page 87
1 I think are called health records in the legislation -- 2 and then, on the other hand, other types of material 3 that might be relevant to matters that we are looking 4 at, or indeed important to patients. This was the 5 reason why I was asking Dr Gilder some of the questions 6 earlier about where these things might be found in 7 a hospital because it's not immediately easy or obvious 8 to be able to find where these things would normally be 9 held. And I think there are also issues here of 10 terminology, so when someone talks about "medical 11 records", that might mean one thing to one person and 12 something else to someone else. And there are, as 13 you've helpfully identified, places where you identify 14 that terminology may have changed over the years, and 15 that there is some statutory terminology that may not 16 match up with the terminology that might be used in 17 day-to-day discussion -- 18 A. That is very true. 19 Q. Yes, and indeed -- so that's one complexity, we'll talk 20 about that in a second. But another complexity which 21 exists here is that the legal framework here is complex, 22 would that be fair? 23 A. That would be fair. 24 Q. Yes, and there are a number of intertwining, different 25 sources of legal information and indeed, ethical Page 86	1 use that to orientate ourselves -- in the context of 2 a question about the rights of patients to be able to 3 seek amendment or correction of their records, you set 4 out a kind of introductory passage, saying: well, it 5 kind of depends on what you mean by "records" to start 6 with -- 7 A. Yes, sorry. 8 Q. No, it's very helpful. Paragraph 28.2, you tell us: 9 "What constitutes patients' health records could 10 also be said to have changed over time in Scotland, in 11 terms of their nature and scope. In 1993, 'health 12 records' were defined as those which relate to patients' 13 physical or mental health 'which have been made by or on 14 the advice of a health professional in connection with 15 the care and treatment of that person or in connection 16 with the organisation including microfilm, computer 17 files, slides and specimens'. In 2024, 'health records' 18 were defined as consisting of 'information and data 19 relating to the physical or mental or condition of an 20 individual which have been made by or on behalf of a 21 health professional in connection with the care of that 22 individual'. Nowadays, patients' health records are 23 expected to be 'clear, accurate and legible' and should 24 be made at the same time as the events occur, or as soon 25 as possible afterwards. They should include relevant Page 88

1 clinical findings, drugs investigations or treatments 2 proposed, provided or prescribed, investigations or 3 treatments proposed, information shared with patients, 4 concerns or preferences expressed by patients concerning 5 their ongoing care and communication support 6 preferences. Such records can comprise handwritten 7 notes; computerised records; correspondence between 8 [healthcare providers]; laboratory reports; imaging 9 records, including x-rays; photographs; video and other 10 recordings; and printouts from monitoring equipment." 11 So, that passage, I think, identifies a lot of 12 important information about how all this works, 13 including things like what you might describe as 14 documents or information and there are different 15 terminology used in lots of different enactments and 16 documents can comprise lots of different things. It 17 could be notes, it could be a computer file, it could be 18 an x-ray. All of these things are comprised within 19 "health records", broadly, is that right? 20 A. That's correct. 21 Q. And as far as the definitions are concerned, although 22 you've helpfully pointed out that the precise 23 definitions are different at different times, which is 24 right, I think it's correct to say -- and please correct 25 me if I have got this wrong -- that in terms of the way Page 89	1 relating to someone's care and the other sorts of things 2 we've just been talking about, for example, Dr Gilder 3 mentioned earlier there may be importance attached to 4 the retention of mortality and morbidity meetings -- 5 A. Yes, precisely. 6 Q. -- which would be a non-health record that would be 7 stored in the medical department but there may be 8 certain rules about that we may come across, but there 9 are different rules, different sets of rules? 10 A. That's correct. 11 Q. So if we could start off, first of all, please, with -- 12 this is going through the various different components 13 and stages of -- from there being no record, to that 14 record not existing anymore, the various different 15 things that might happen to them over that period -- to 16 try to understand the various different aspects of what 17 might apply to those records. 18 So first of all, there's a question about the 19 creation, the generation of a record. So that might be, 20 for example, somebody sending an email or somebody 21 writing a medical record after a consultation, or 22 somebody drafting a letter reflecting what had happened 23 at consultation to a general practitioner or something 24 like that. So there are, in relation to the compilation 25 of such records, a number of different rules and Page 91
1 that the legislative and regulatory framework works, 2 there are differences, in certain places certainly, 3 between what one would describe as "health records" in 4 terms of the legislation, what one might call "medical 5 records" in normal parlance and other records that might 6 exist within a hospital, is that right? 7 A. That's correct and in the report I sought to 8 differentiate that by talking about 9 "non-clinical/administrative records", that may form 10 a very important part of clinical governance and overall 11 information governance in a given health board, for 12 example, versus what is we colloquially call "patient 13 records", "medical" and "health records". And it was 14 interesting hearing Dr Gilder this morning talk about 15 audits, for example, and reflective learning, not 16 technically patient records but very germane to both 17 health and reflective learning and I would suggest 18 corporate governance processes. 19 Q. Yes. So if we could start, then, to try to look at the 20 various different component parts of the legal and 21 regulatory framework around what it is one needs to do 22 with both these types of documents -- and we'll try and 23 differentiate because there are certain aspects that 24 refer to "medical records" or "health records" -- which 25 are effectively documents made by a health professional Page 90	1 regulations that would relate, effectively, to trying to 2 maintain the quality of those records. Is that right? 3 A. That's correct. 4 Q. So what we might mean by the "quality" of the records 5 could include a number of different components. It 6 could include, for example, the accuracy of the records, 7 is that right? 8 A. Yes. 9 Q. It could include their legibility? 10 A. Yes. 11 Q. It's been something of an issue of discussion amongst 12 doctors in this Inquiry already, that legibility might 13 be an issue. 14 A. An ongoing, long-standing issue for anybody who has 15 reviewed medical records. 16 Q. Yes, indeed. And beyond that, there may be issues about 17 the comprehensiveness of medical records, which may 18 touch upon accuracy as well, is that right? 19 A. Yes, that is correct. 20 Q. So there are various different considerations with 21 regard to that. It might also be that there are rules 22 or considerations relating to the way in which records 23 are taken, so for example, whether they're taken at 24 exactly the same time as the events are happening or 25 that they are written down later? Page 92

1 A. Yes, I was about to mention that, whether they're 2 contemporaneous or not is important to know. 3 Q. Yes, absolutely. There might be questions as to who had 4 actually written the thing down, whether it, for 5 example, was a senior doctor who had done an operation, 6 or a more junior doctor who had assisted, or a nurse who 7 was standing in the room, or someone who wasn't there at 8 all; all of these things might affect the quality of the 9 record, is that right? 10 A. That's correct, as to whether they're well documented or 11 not, yes, the quality. 12 Q. Yes, and all of these things are to do with the 13 creation, generation of the record in the first place? 14 A. Not quite sure what you mean by that, to do with "in the 15 first place". You're saying the quality? 16 Q. So going from there being no information -- 17 A. Absolutely, yes. 18 Q. -- to there being some sort of written record? 19 A. Yes. 20 Q. As opposed to what one might do with that record 21 thereafter, which we'll come on to. So in this regard, 22 there are a number of things, I think, that are 23 potentially relevant. You've told us about all of these 24 but I just want to touch on them so you can tell us 25 a bit about them if you feel you can add something to Page 93	1 at times, makes it more specific to surgery. That's 2 broadly what it appears to -- 3 A. (Overspeaking) I think Dr Gilder is saying -- 4 DR GILDER: (Overspeaking) You are correct. 5 Q. Thank you. So there have always been then, over the 6 relevant period, ethical requirements that all of the 7 various different components that I have mentioned be 8 properly attended to by medical professionals, is that 9 right? 10 PROFESSOR FARRELL: Yes. I would say, though, over time, 11 that has become much more detailed. It just goes more 12 broadly to being open and honest and that would involve 13 recording your interactions with those you treat, for 14 example. There are ways you can convey that verbally to 15 the patient, but you also document it in the records. 16 Q. So, from what you're saying -- the question I had about 17 this was in relation to the obligations in the Good 18 Medical Practice, Good Surgical Practice, I think 19 broadly refer to "medical records" particularly, which 20 I think, in this context, is what you call, under the 21 statute, "health records". There are, however, as 22 you've helpfully identified, other principles that might 23 be applied to the generation of other records, such as, 24 for example, records of departmental meetings, mortality 25 and morbidity meetings, that sort of thing, that are Page 95
1 it. 2 It seems, first of all, that, in relation to health 3 and medical records certainly, there are ethical rules 4 that exist about all of the things that we've just 5 discussed, so -- 6 A. (Overspeaking) Yes, and I do mention that in the report, 7 yes, absolutely, and they relate to professional 8 obligations and how that's recorded, if you are 9 a healthcare professional. 10 Q. Absolutely. That's a very important component of this, 11 I think. 12 A. Absolutely. 13 Q. And so, we've already seen that in a publication we've 14 talked about, Good Medical Practice, there are rules 15 about this; is that right? 16 A. Yes, that is correct. 17 Q. And indeed, you don't mention it, I don't think, but we 18 have seen, more specifically, there are references to 19 this in the document called Good Surgical Practice, from 20 2002 I think, was the first publication. Very similar 21 types of things. 22 A. Yes, it would be a broad principle that would apply 23 across registered doctors, for example. 24 Q. Yes, precisely. I think broadly, Good Surgical Practice 25 imports a lot of stuff from Good Medical Practice, but Page 94	1 not, strictly speaking, health records but to which 2 similar standards might be applied. Do you agree with 3 that or not? 4 A. Yes, I have to say as a result of doing research in this 5 area, it presented as more of a grey area that moved 6 between -- not strictly speaking, as you have 7 identified, health and medical records, but they could 8 be interpreted, by those engaged in document retention 9 and recording, as more relating broadly to governance, 10 non-clinical and administrative records. The reason 11 it's important is because, as we see at the turn of the 12 millennium, that sort of shift towards clinical 13 governance means all these sorts of documents may be 14 relevant to clinical governance processes. 15 Q. Absolutely. Or indeed, be relevant to aspects of 16 a doctor's relationship with their patients, for 17 example? 18 A. Yes, so it's multi-layered but sometimes they're not 19 intersecting legally, shall we say. But ethically, is 20 a way of drawing it together, yes, more broadly. 21 Q. That's very helpful. So when you say there's more of 22 a grey area in that regard -- 23 A. Probably law wise, I'm saying. 24 Q. -- yes, is it correct to say -- so, my interpretation 25 would be that one looks at the ethical guidance which is Page 96

1 quite specific as to what has to happen when it's health 2 records -- 3 A. Yes. 4 Q. -- but beyond that, the proposition I'll put to you -- 5 please tell me if you disagree with this -- is that the 6 same obligations would apply in the compilation of other 7 records but the rules are not specific. But if one 8 applies various different principles, then that is the 9 sum total of the way in which those should be approached 10 as well? 11 A. It is very general, what you're saying. I appreciate 12 the intent behind it. Document retention, say, outside 13 the strict sort of clinical space would be outside my 14 expertise, but you would -- and I would even turn to 15 Professor Walshe about good governance in terms of 16 document retention, if you are -- 17 Q. (Overspeaking) I'm going to take this step-wise because 18 otherwise it's complicated. If we just stick, at the 19 moment, still talking about quality, accuracy, 20 legibility of the records and we're still just talking 21 about doctors -- 22 A. (Overspeaking) Then of course you would want a clear, 23 accurate and legible documentation. 24 Q. Yes, whether that's health records or any other type of 25 records? Page 97	1 A. Yes, and it's sort of, over time, really being 2 recognised more broadly. I would say in the early part 3 of the relevant period -- you know, and that's prior to 4 a lot of the data protection laws coming into being -- 5 it's much more explicit nowadays. 6 Q. Yes. One of the aspects of this that makes it slightly 7 more complicated is, although we have in a lot of the 8 evidence so far focused on the relevant period, this is 9 a part of the evidence where, in fact, we're interested 10 in aspects of the relevant period, so obviously we're 11 interested in the relevant period with regard to the 12 quality of records because that's when records we're 13 interested in were created, but as far as other 14 principles, for example retention are concerned, we're 15 interested in everything up to today obviously because 16 it wouldn't help as much if the records had to be 17 retained in the relevant period, but they didn't have to 18 be retained and we wouldn't have access to them now. So 19 again, that's another unfortunate complexity of what 20 I have tried to put to you. 21 A. No, I understand. 22 Q. So, the data protection rules. There are also -- you've 23 helpfully directed us to the Public Records (Scotland) 24 Act 2011 and I think the basic reason for that Act being 25 in existence is that it imposes obligations on public Page 99
1 A. As a matter of general principle, yes, without drilling 2 down into the specifics. 3 Q. But beyond that, again, just in relation to these 4 components, accuracy, legibility, et cetera, I think 5 there are other legal rules that apply more widely 6 beyond doctors. So, for example, you've helped with us 7 the way in which the data protection legislation has 8 evolved over time, the latest iteration of that is 9 reflected basically through the GDPR, the general data 10 protection regulation and the most recent legislation 11 relating to data protection. One of the principles -- 12 the way that legislation works, as I understand it, is 13 effectively there are a number of important principles 14 set down and organisations, public organisations, 15 require to do things that show that they are adhering to 16 those principles, is that right? 17 A. That's correct. 18 Q. And one of those principles is that documentation 19 requires to be accurate? 20 A. Yes. 21 Q. So therefore, what that legislation is doing is imposing 22 an organisational requirement that organisations, like 23 hospitals or health boards, do things to make sure, to 24 maximise documents that are being processed within their 25 organisations being accurate, is that right? Page 98	1 bodies to provide, to government, things called "records 2 management plans". And I think records management plans 3 are a statutory requirement for organisations like 4 hospitals, health boards, to tell the government what it 5 is that they are doing to adhere to all of the various 6 document and information-related obligations that they 7 have; is that right? 8 A. I would need to check the legislation. 9 Q. I think this is emanating from aspects of the narrative 10 that you've given me. 11 A. Yes. 12 Q. So therefore, there are obligations on organisations. 13 I think also there are, both in relation to doctors and 14 organisations -- this is the bit that I said I was going 15 to skip over, but we're going to come back to -- there 16 are aspects of the duty of candour that apply to the way 17 in which documents are created because it's part of 18 candour that documents are clear, legible, accurate, of 19 a sufficient quality; is that correct? 20 A. Yes and Scotland's been particularly focused on that in 21 recent times. 22 Q. Absolutely and again, you've helped us with the aspects 23 of that in the report. I said we wouldn't get into 24 this, but there are differences in the way in which 25 duties of candour work. There is an organisational duty Page 100

25 (Pages 97 to 100)

1 of candour which is imposed on the likes of health 2 boards and hospitals by statute, is that right? 3 A. Yes, that is correct. 4 Q. And there are ethical duties of candour imposed on 5 individual doctors, for example? 6 A. Yes. 7 Q. And this is where it might get a bit complex, the two 8 interact to an extent because of the fact that doctors, 9 because they are the agents of bodies that have 10 statutory duty of candour, they require to have regard 11 to that statutory duty in the way in which they act in 12 their duties on behalf of a hospital or a health board, 13 is that right? 14 A. I mean, it's complex for doctors, healthcare 15 professionals, and I'm sure that was pointed out, 16 because there may be different triggering of thresholds 17 for the professional that may be different to the 18 triggering points for the organisation. 19 Q. Yes, and in fact there are different trigger -- 20 A. (Overspeaking) Indeed, there are. And I think it's very 21 instructive to have a look at the latest advice issued 22 by the Scottish Government in March 2025, reflecting on 23 the introduction of the duty of candour in Scotland 24 in 2018 to -- they've really reflected on these sorts of 25 areas and tried to provide further guidance. Page 101	1 "transparency", which is related to candour and which 2 requires people exercising public functions to do things 3 in a certain way that may also impinge upon the accuracy 4 and quality of the way that things are written down? 5 A. That's correct and interestingly, there is a bill going 6 through the UK parliament at the time arising out of the 7 Hillsborough disaster talking about candour in public 8 office, shall we say, and it refers to the 9 Nolan Principles specifically. 10 Q. Yes, indeed. We're familiar with that because of the 11 fact that it creates certain obligations with regard to 12 public inquiries, I think? 13 A. Yes. 14 Q. Thank you, and I don't think you mention this but there 15 is another act of the Scottish Parliament which is 16 called the "Ethical Standards in Public Life etc. 17 (Scotland) Act 2000", which is effectively the means by 18 which the Nolan Principles are enacted into legal 19 obligation. You'll be aware of it probably, generally, 20 I think; yes? 21 A. In general. 22 Q. Yes, and there are various bodies whose responsibility 23 it is to police a number of these things. So for 24 example, the last one I mentioned, the Ethical Standards 25 in Public Life is something called the Standards Page 103
1 Q. Because you might ask yourself -- and I did say we 2 wouldn't do this -- but if you might ask yourself as 3 a doctor: well, what exactly do I need to do here, 4 because I have ethical duties that apply in certain 5 circumstances, you're telling me I have a duty to carry 6 out my organisation's duty of candour and others; how 7 does it all work? And I think what that guidance is 8 attempting to do is to try to bring some clarity to that 9 difficult -- 10 A. (Overspeaking) Yes, it is difficult in practice but 11 again, as many professionals face who have ethical 12 obligations -- and in this case that goes to your 13 registration as a doctor -- obviously, you would hope 14 you would receive support and advice in the context of 15 your organisation, or you would seek external advice in 16 that regard. But certainly, the latest advice from the 17 Scottish Government seeks to provide greater clarity, as 18 you identify, and provides some useful scenarios that 19 have, no doubt, come from practice. 20 Q. Thank you. One might also, in this first area of the 21 various different ways that the obligations that exist 22 in relation to the way that documents are created, so 23 the legibility, the accuracy, there are also the 24 Nolan Principles which relate to the way in which people 25 exercise their duties in public life, one of which is Page 102	1 Commission for Scotland, is that right? Do you 2 understand that to be right? 3 A. Well, I would have to trust you in that regard. It's 4 not something I think I strayed into in the report. 5 Q. Thank you. I just wanted to point out as well that 6 there are also other obligations. So for example, as 7 far as data protection is concerned, there are other 8 means by which data protection obligations can be 9 enforced? 10 A. Absolutely, yes. 11 Q. And there are also, as we have discussed already, the 12 ethical obligations can be enforced through the likes of 13 the GMC, for example? 14 A. That's right, yes. 15 Q. And also in this field, there are employment-related 16 obligations as between, say a health board and a doctor, 17 that could be enforced in that relationship that would 18 also require documents to be kept to a high standard? 19 A. Again, I'm not an expert in employment law so that would 20 be outside my area of expertise. 21 Q. Okay. So if we then move beyond the way in which 22 documents are created and their quality, to the way in 23 which documents are used and stored, again, there are 24 different rules relating to that. So I'm not talking 25 now about them being put into some sort of catalogue or Page 104

1 something, but in the way they're actually being used in 2 hospital. So for example, if a patient has come in and 3 they've had a pre-operative consultation, there's a note 4 there, that note will need to be available when the 5 patient comes in for the next consultation or for the 6 operation and different people will need to consult it. 7 I'm talking about that phase. Again, there are rules 8 within the data protection legislation relating to the 9 way in which documents are processed. Processing, 10 I think, is a broad term -- 11 A. It is, yes. 12 Q. -- that really applies to doing anything with 13 information? 14 A. It's very widely drawn. I would just preface that by 15 saying I am not a data protection legal specialist but 16 just reading it, it is very broadly described. 17 Q. Yes, so therefore, the data protection principles would 18 apply to that as well that we mentioned accuracy but 19 there are other principles involved, such as the data 20 minimisation principle, which means that -- 21 A. Yes. 22 Q. -- the least number of people that have a legitimate 23 reason to see the information, see the information, 24 broadly. Is that your understanding? 25 A. That's correct, yes. Page 105	1 records, 1990? 2 Q. 1990. 3 A. That is 28.6, yes. 4 Q. Thank you very much. And that Act lays down rules, 5 I think, relating to the rights to patients to access 6 medical records; is that correct, broadly? 7 A. That's correct and obviously it pre-dates a lot of the 8 data protection. 9 Q. Exactly. I'll get on to that in a minute. My 10 understanding that Act is still extant in relation to 11 certain types of records -- 12 A. That's correct. 13 Q. -- records of people who are deceased, I think, that's 14 still governed by that legislation, is that right? 15 A. Yes. 16 Q. However, access to records of living people are dealt 17 with under the data protection legislation? 18 A. That's correct. 19 Q. And there's something under the data protection 20 legislation called a "subject access request", 21 I think -- 22 A. Yes. 23 Q. -- where people can access personal data relating to 24 themselves, is that right? 25 A. That's correct. Page 107
1 Q. I'm not an expert either so I won't get into anything 2 beyond the principles in this conversation, just to 3 reassure you. 4 A. And I just want to check that Dr Gilder may have 5 something to say? No, you do not. 6 Q. Thank you. I think also that the records management 7 plan that I mentioned under the Public Records 8 (Scotland) Act 2011, impinges upon this area which is 9 how documents are used within an organisation; is that 10 broadly correct? 11 A. Broadly. As you're correctly identifying, there are 12 a range of intersecting principles and laws that pertain 13 to different sorts of records and how they're handled, 14 retained and the extent to which you collect them, there 15 must be that sort of minimisation and "only where 16 necessary" sort of approach. 17 Q. Absolutely. Thank you, that's helpful. As far as 18 access to records are concerned, in particular for 19 patients, there is a whole other set of rules, I think? 20 A. There is. 21 Q. There's something called the "Access to Health Records 22 Act 1990", that you mentioned? 23 A. Is it access to medical records, or is it? 24 Q. It may be medical records. 25 A. I'm just trying to find the -- access to medical Page 106	1 Q. One aspect I wanted to ask you -- this may be 2 a difficult question to come up with the answer to 3 on the spot -- is the extent to which -- we 4 differentiated earlier, when we were talking about the 5 quality of the records, between professional rules 6 relating to medical or health records and other records 7 that one might be creating. In this space, I wonder 8 what the rules are relating to, first of all, access to 9 information that's held about you, which is not 10 contained in medical records. So, for example, we 11 talked earlier about multi-disciplinary team meeting. 12 Now, a multi-disciplinary team meeting, it might or 13 might not -- it was Dr Gilder's view that that was 14 something, I think, that should be in the medical 15 records because it relates to the patient. It might or 16 might not be viewed as a medical record but it is 17 something that has information about you. Equally, 18 something that probably wouldn't be in the medical 19 records, if there was a discussion on a board of an NHS 20 body about a particular patient who had written in and 21 complained or wanted some redress about something, there 22 might be a discussion in the board but that discussion 23 wouldn't be part of someone's medical records 24 ordinarily, would that be right? 25 DR GILDER: That would be correct. Page 108

1 Q. So, we'll get on to the freedom of information 2 legislation in a moment but are you aware of there 3 being -- other than the freedom of information 4 legislation which enables people to get access to all 5 sorts of information, not just stuff relating to them -- 6 whether there is a legislative means by which you can 7 get access to information about you that is not in 8 a medical record? 9 PROFESSOR FARRELL: Again, that really is straying outside 10 my expertise but what I would say is, in terms of my 11 legal career, that many clients would come to see me in 12 terms of wanting to find out what had happened to them 13 and through various opportunities, through the legal 14 process, you would obtain that through a process that we 15 call in some jurisdictions "discovery". 16 Q. In the context of a legal action? 17 A. Yes. 18 Q. Yes, but I'm talking here -- 19 A. (Overspeaking) But in the context, even before that, 20 basically you would only get access to health or medical 21 records. 22 Q. Yes, indeed. So it may well be that one requires to 23 rely on the more general freedom of information 24 legislation -- 25 A. (Overspeaking) Yes, you would try various -- Page 109	1 PROFESSOR WALSH: There will always be people who deal with 2 GDPR and data protection and subject access requests and 3 so on. I would guess that they do have the opportunity 4 to consult the lawyers the trust will have on 5 a retainer, but I think it's a little outside my sphere 6 of understanding. 7 Q. Thank you. 8 PROFESSOR FARRELL: If I could just add, I mean broadly, you 9 would put it under, nowadays -- I'm sure in terms of -- 10 I could be corrected by Professor Walshe, but it's 11 a question of broader information governance at the 12 board. And that may take different forms, for example, 13 but I mention in the report, the position of the 14 Caldicott guardian and it's a different, you know, 15 naming process in Scotland but the principles apply. So 16 there's different aspects of data management and 17 information governance and it's become much more 18 complex, of which, data protection is an element. 19 Q. Well, you've touched on exactly an aspect I was going to 20 ask you about there, which is helpful. Information 21 governance, I think you've attached as being something 22 that the board is responsible for, would that be right? 23 So for example, setting policies about how you're going 24 to go about managing documentation? 25 A. I would see it as a form of, you know, certainly the Page 111
1 Q. (Overspeaking) I think that was my feel for it as well, 2 but in case you were aware of something -- 3 A. (Overspeaking) No, that would -- in a range of 4 jurisdictions, but again, you would -- given the current 5 legal landscape and the complexities of data protection 6 and SARS and the way in which that's interpreted -- and 7 I have, you know, personal experience of that in 8 a complex environment, which is a university, it really 9 requires specialist expertise and people who have a good 10 deal of experience in interpreting the legislation and 11 consulting with those involved in releasing that 12 information before it takes place. So, in that 13 environment, it may be used, for example, useful to talk 14 to people who have specific experience of SARS. 15 Q. Yes, earlier on, Professor Walshe, you mentioned that in 16 different contexts, one might wish to take advice -- we 17 talked about HR professionals and them possibly taking 18 advice from people within a health board or a health 19 trust about aspects relating to employment. We were 20 talking about supervision or suspension. Would it be 21 normal for there to be people who are embedded within 22 a health board, health trust, to have knowledge of this 23 sort of complex and, as Professor Farrell has pointed 24 out, as I'm probably demonstrating, a very specialist area 25 of the law? Page 110	1 principles, because there's so many different aspects of 2 it. But, again, I would just double-check with 3 Professor Walshe, in terms of sitting on boards 4 yourself. 5 PROFESSOR WALSH: I think it's a big part of what boards 6 spend their time in. And whether they would actually 7 set the policies or expect their executives to create 8 and set those policies and to be assured that they are 9 in place and that the organisation conforms with the 10 requirements, particularly of law around data 11 protection. 12 Q. Well, that was precisely the question I was going to get 13 to, which is, in addition to there being those policies, 14 which as you set out Professor Farrell in certain areas 15 actually derive either from the law or from government, 16 is it necessary for a hospital, for example, to have in 17 place systems that ensure they are complied with? 18 A. Yes, and I think those systems get tested when there are 19 requests. So it's not unusual, I think, for a trust or 20 a board to get subject access requests in relation to 21 employment disputes. And there's a pretty established 22 process, a laborious one, for then, for example, 23 searching a wide range of records, including emails, HR 24 records and other sources in order to respond within the 25 law to that subject access request and to take account, Page 112

1 for example, of the need for appropriate redaction and 2 so on. But that comes back to HR advice as well. There 3 will always be HR advice on those. 4 Q. You mention there, though, that that might be 5 a situation in which a request would be made but the 6 robustness of the systems might be tested and that's to 7 do with trying to work out whether you're able to access 8 the information that someone is legally entitled to 9 having, is that right? 10 A. Yes, and that gets you then into these days policies 11 around the retention and deletion of email records and 12 other forms of electronic records. 13 Q. But it might get you into other areas as well, such as 14 the quality of the records that were there in the first 15 place? 16 A. Yes, and your ability to actually search them and 17 retrieve material. 18 Q. To find them indeed. That could be lots of -- 19 A. Back to your point about those records being distributed 20 and held on/in departmental records rather than in some 21 central repository. 22 Q. Thank you. 23 PROFESSOR FARRELL: I just wanted to add, it was 24 a particular feature as I was doing an historical deep 25 dive into document retention and access to medical Page 113	1 broadly right, Professor Farrell? 2 A. I do refer to it. Here we are, 27.4. So provision for 3 the disclosure of information held by Scottish public 4 authorities or by persons providing services for them or 5 for connected purposes. So fairly -- so NHS 6 organisations are public authorities under that Act. 7 And "record" means anything in which information is 8 recorded in any form. 9 Q. So this is moving beyond the legislation and rules 10 relating to accessing information about yourself, 11 personal data? 12 A. It's much broader. 13 Q. It's much broader. So if you wanted to know what was 14 the policy that governed information governance in this 15 year, you could use -- you could have an FOI request and 16 try and find that out? 17 A. And in different jurisdictions that's the preferred way 18 forward. Say outside European Union, for example, if 19 there's freedom of information laws, you would pursue 20 a search for information through via that legislation. 21 Q. And the rules under freedom of information legislation 22 are enforced by the Scottish Information Commissioner; 23 is that right? 24 A. Yes, so again that would be an ideal person to talk 25 about a lot of the interlocking regimes that you're Page 115
1 records. In Scotland you notice pre-devolution the 2 circulars that were published, sort of advice saying: if 3 it's at all possible to grant informal access to 4 documentation for patients. And that being -- so in 5 a sort of pre-data protection era but still upon for the 6 relevant period, and particularly the start of it, 7 having access to records, even on an informal basis, was 8 something that was provided for in that not legally 9 binding guidance but certainly followed in that regard. 10 Q. So even before the statutory regime from the 1990 Act, 11 or around about then, it was trying to promote the 12 concept -- 13 A. Yes, and into the '90s, really up until political 14 devolution there are circulars. 15 Q. So the thrust of that, if you like, is to try to allow 16 patients access to records, even if it's an informal 17 mechanism? 18 A. Exactly. 19 Q. Thank you, that's helpful. So just to finish off my 20 tour of the various different pieces of legislation. 21 I mentioned the freedom of information, which is the 22 Freedom of Information (Scotland) Act 2002. That 23 I think allows people to access information in a general 24 sense held by public authorities, which is subject to 25 certain statutory restrictions and exception, is that Page 114	1 speaking about. 2 Q. I'm sure that's right, yes. The final area I just want 3 to talk about was the retention of records which we've 4 mentioned already. Again, there are data protection 5 implications of retention of records because one of 6 their principles relates to not keeping records for 7 longer than is necessary? 8 A. That's correct, yes. 9 Q. Then beyond that I think you've helpfully, very 10 specifically actually in places, set out for us that 11 there are, in this area, there's a lot of government 12 regulation about standard retention periods in relation 13 to documents? 14 A. Yes. 15 Q. I think it's the case that -- and you go right back into 16 the history; you tell us about 1993 guidance and things 17 in this regard -- that in all of the iterations of the 18 government guidance, or there are things called code of 19 conduct -- as to exactly how prescriptive that is, one 20 could have an argument -- but what are generally set are 21 minimum retention periods. I think that's correct? 22 A. That is correct. 23 Q. And I think there's a recognition in those documents 24 that perhaps inherent in the concept of having a minimum 25 period, that there should then be on the ground Page 116

1 operational decisions as to whether that is the period 2 that should be applied and the documents should be 3 destroyed, or whether particular considerations apply to 4 documents that mean they should be retained for longer? 5 A. Yes, and so what I was trying to highlight, as you 6 correctly identify, is the bare minimum, in terms of 7 retention records, but there may be intervening 8 circumstances. And given our current set of or context 9 circumstances, if there is anticipated legal action or 10 tribunal or inquiries, then further considerations need 11 to come into play, both in terms of procedure but also 12 by virtue of legislation. 13 Q. And what are the sort of circumstances -- you may or may 14 not be able to answer this -- in which it would be 15 appropriate for documents to be held for longer than 16 their retention period? I think the test is whether 17 it's necessary to do so but that could apply in lots of 18 different circumstances? 19 A. I think I tried -- well, I did my best to highlight it 20 in paragraph 27.11. I used the example of the Inquiries 21 Act 2005 and the Rules from 2007. So the health boards 22 must put in place appropriate measures to ensure as far 23 as reasonably possible that information and records are 24 prevented from alteration or deletion and are easily 25 retrievable should they be requested, for example, by Page 117	1 A. And that was recognised in the documentation of 2 NHS Tayside. 3 Q. Indeed, which, perhaps above and beyond what we asked 4 you, you managed to find presumably publicly available 5 documents? 6 A. Yes. 7 Q. So beyond even the NHS code that's issued by government, 8 you did actually manage to find some of the retention 9 processes from Tayside itself? 10 A. Yes, and NHS Tayside had very detailed procedures. 11 Q. So what that creates, I think, that minimum retention 12 period rule, is that there needs to be effectively for 13 documents or classes of documents a bespoke 14 decision-making process about whether they are likely to 15 be necessary for any purpose going forward. It would be 16 wrong I think therefore to interpret those rules as 17 meaning that there should just be a blanket destruction 18 after a certain number of years? 19 A. Yes, but it involves broader governance procedures in 20 a health board, doesn't it, that sort of who is involved 21 in document retention links in with other parts of the 22 hospital governance process to make those broader 23 decisions. 24 Q. One other aspect of this that is really to do more with 25 the processing, use of the documents within health Page 119
1 a tribunal or inquiry, and that health boards need to 2 consider what information may be relevant, based on 3 Terms of Reference for the Inquiry. 4 I think underlying it though, and some of the 5 research and reviews that I did, did highlight 6 an anticipatory approach as well, given particular 7 events that may be occurring in a health board. 8 Q. Absolutely, because it would be the same, as we've 9 mentioned in other areas, if you destroy the documents, 10 they're destroyed. So you need to think, well are there 11 situations in which these might be necessary and apply 12 quite a low threshold. Is that correct, is that what 13 you mean by anticipatory? 14 A. Exactly, yes. 15 Q. I think you also actually expand on this slightly later 16 in the statement, I think. If you look at 27.8, and 17 27.9 -- 27.9 you say, for example: 18 "If a record due for destruction is known to be the 19 subject of a request for information, or potential legal 20 action, destruction should be delayed until disclosure 21 has taken place or, if NHS Tayside has decided not to 22 disclose the information, until the complaint and appeal 23 provisions of the Freedom of Information (Scotland) 24 Act 2002 have been exhausted or the legal process 25 completed." Page 118	1 boards -- it might be something that Dr Gilder will have 2 some experience of or perspective on as well -- there 3 are certain expectations, understandable expectations on 4 the part of patients, that information about them will 5 not be used other than for circumstances that are 6 legitimate, their medical care. I think there's 7 an expression that one sees in some places which is, 8 "Nothing about us without us". So effectively people 9 should know if their medical records are being used for 10 any purpose. 11 Whether that is -- I don't think that's a formal 12 rule, but in circumstances where medical information 13 about an individual is being accessed for any purpose, 14 so for example other than their treatment and care -- so 15 for example, again, hypothetically, if a patient had 16 made a complaint or a patient had complained to a board 17 about something happening, would it be important or 18 would it be required that that patient should be aware 19 if anyone within the board is accessing their medical 20 records? 21 A. I think you'd have to check with the specific health 22 board and I'd have to check that myself actually. It 23 would make sense in terms of professional obligations, 24 ethically speaking, that that -- you know, being open 25 and honest about what's going on -- that that would be Page 120

1 disclosed, but you would need to look at specific laws 2 and the reasons why that was happening. 3 Q. Yes, Dr Gilder? 4 DR GILDER: And the Caldicott principles are very clear. 5 There are eight principles -- I cannot recite them off 6 the top of my head -- there are eight principles that 7 make it very clear about how and why we should be and 8 when we should be accessing patients' records. So that 9 members of the board would need to meet one of the 10 requirements of the eight Caldicott principles, 11 otherwise they would be accessing medical records 12 inappropriately. 13 Q. And I think Professor Farrell told us already, the 14 Caldicott principles exist in order to try to regulate 15 how people are accessing private confidential 16 information including within health boards, and that 17 there is, I think -- you may, in fact, have held this 18 position Dr Gilder at one stage -- 19 A. I did. 20 Q. -- it's called different things in different places but 21 Caldicott guardian is a phrase that's used -- 22 A. Yes. 23 Q. -- which is someone who is required to exist within 24 an organisation, like a hospital or health board, to 25 make sure those principles are being adhered to? Page 121	1 go along the line and start with you Professor Walshe? 2 PROFESSOR WALSH: Nothing to add. 3 Q. Professor Farrell? 4 PROFESSOR FARRELL: Nothing to add. 5 Q. Dr Gilder? 6 DR GILDER: Nothing to add. 7 MR DAWSON: Thank you very much, sir. 8 THE CHAIR: Now Mr Dawson, it is 12.50. We obviously would 9 normally break for lunch we would also at this stage in 10 the procedure have a short break because it is possible 11 some other questions may be put by counsel at the 12 incidence of participants to the Inquiry. I'm quite 13 flexible about whether we do that now, or simply take 14 our lunch break first? 15 MR DAWSON: Well, sir, it really depends on the views of the 16 panel. It might be best to take the lunch break now, 17 allow core participants the opportunity to ask 18 questions, and then ask them after lunch, as long as the 19 panel -- 20 THE CHAIR: If you're content with that? (Agreed) 21 All right, let's break for lunch and meet again in 22 one hour from now. 23 (12.51 pm) 24 (The short adjournment) 25 (2.02 pm) Page 123
1 A. That is correct. 2 Q. We heard some evidence from the medical director of 3 NHS Tayside and I think he held that position within 4 NHS Tayside just now. But that is an important 5 principle because there being unregulated use of 6 people's medical records is a significant undermining, 7 is it not, of the trust that patients put in hospitals 8 and health boards? 9 A. Yes, it also needs to be reported to the data 10 information officer. 11 Q. Indeed. 12 A. So it is what you have described should not happen. 13 PROFESSOR FARRELL: And just to note, of course, and it is 14 in the report, that the whole development of the 15 Caldicott guardians took place in the late 1990s so it's 16 very relevant to the period under consideration. 17 Q. Absolutely. It's not a very modern innovation, it's 18 been around for a large part of the period that we're 19 most interested in. 20 A. That's correct. 21 Q. Thank you that's very helpful. Sir, I'm sure the panel 22 will be pleased to hear I have no further questions. At 23 this stage I offer all witnesses the opportunity to add 24 or say anything they wish to do so, in order to 25 supplement the evidence they've already given. So I'll Page 122	1 THE CHAIR: Good afternoon. Mr Dawson. 2 MR DAWSON: Sir, there are no further questions for the 3 group. Thank you very much indeed. 4 THE CHAIR: Thank you. Well, no sooner have I said "good 5 afternoon", than I am now in a position to set you free 6 from your session and indeed, all three of the sessions 7 which you have contributed to. Please don't go without 8 me taking the opportunity of thanking all three of you 9 for sharing your insights and reflections, both 10 cumulatively and individually, on what has been a very 11 broad range of matters to do with healthcare 12 administration and I'm very grateful for all of that. 13 I also recognise the effort that has clearly gone 14 into composing the report, and populating it with 15 a range of documentary materials which we will continue 16 to study with interest as we progress forwards. But in 17 extending the Inquiry's thanks and my personal thanks 18 for that too, I can tell you now you're all free to go. 19 Thank you. 20 DR GILDER: Thank you. 21 PROFESSOR FARRELL: Thank you, sir. 22 (The witnesses withdrew) 23 THE CHAIR: Yes. 24 MR DAWSON: Sir, the next witness is Sandra MacLeod. 25 I think, as we found before, it might be useful to have Page 124

1 a very short break. 2 THE CHAIR: Yes. 3 (2.04 pm) 4 (A short break) 5 (2.13 pm) 6 Housekeeping 7 MR DAWSON: Sir, there are a couple of matters relating to 8 the ambit of the evidence that's spoken to by this 9 witness that I want to raise, similar to some 10 information I imparted to you and those who are 11 interested and listening in advance of Ms Dunning's 12 evidence last week. 13 As you know, sir, the NHS Tayside statement in 14 response to the Rule 8 request was answered by a number 15 of different individuals. With Ms MacLeod's evidence 16 this afternoon, we'll have heard from all of them during 17 the course of the last few weeks. 18 It is the case that in certain areas, it was 19 difficult to understand why certain people with certain 20 responsibilities had answered certain questions, but as 21 I've informed you last week, one piece of information 22 that had been drawn to our attention was that certain 23 questions that had been listed under Ms Dunning's name 24 had, in fact, been answered by other people and those 25 questions were questions 102 to 105 within the Page 125	1 morning we have, for the purposes we've addressed to 2 factual witnesses from NHS Tayside and others such as 3 the healthcare administration group, divided our 4 questions into two different types for reasons, I think, 5 that became apparent in the evidence this morning, that 6 the legislative and professional frameworks relating to 7 what are called "health records" -- we might call them 8 "medical records" -- are different from those that 9 relate to other records. 10 So it would appear there are limitations on what 11 Mrs MacLeod can, in fact, answer questions about. We're 12 told that those she's able to answer questions in 13 relation to health records, but that any data protection 14 or freedom of information aspect of the response would 15 fall under information governance which, at the relevant 16 time, would have fallen under Margaret Dunning. 17 Now, that's difficult to understand in the context 18 of having been told that Ms Dunning did not, in fact, 19 answer certain questions last week. For example, 20 question 104 which is to do with the accuracy of medical 21 records, which we were told that she did not speak to. 22 And of course, accuracy of medical records is 23 a fundamental data protection principle. 24 So I think the position at the moment, sir, is that 25 we will still hear evidence from Mrs MacLeod, I will Page 127
1 statement. They were all questions which related, in 2 different ways, to different types of records held 3 within NHS Tayside. 4 I have informed you at that time that we were told 5 that the questions had been effectively reallocated to 6 others for the purposes of the hearings, in that 7 question 102 had been allocated to Dr Cotton and 8 questions 103, 104, and 105 had been allocated to 9 Mrs MacLeod. Fortunately, I was able to tell you at 10 that time although people may have been expecting 11 Ms Dunning to answer certain questions about certain 12 matters and that it would not be possible to ask her 13 those questions last Friday, that because we were still 14 to hear from Dr Cotton and Mrs MacLeod, we would be able 15 to redirect those questions as appropriate elsewhere. 16 We were informed yesterday evening, effectively, as 17 I understand it -- well, it is not at all easy to 18 understand, if I'm honest with you, sir, exactly what 19 has happened because the information that we now have is 20 that certain of those questions, it would appear, should 21 have been posed to Margaret Dunning when she gave 22 evidence last week, in particular questions 103 to 105. 23 We're told that Mrs MacLeod can answer those questions 24 now, insofar as they relate to health records. But, as 25 you may have picked up, sir, in the evidence this Page 126	1 have to put to her, at the beginning of her evidence, 2 what she can and cannot speak to. 3 Sir, when I tried to explain my understanding of the 4 position last week, it was done in order to reassure 5 individuals who have questions relating to what, I think 6 the evidence has now shown, is an important area of your 7 investigation, namely document management. I am aware 8 and I have received questions from core participants, 9 some on behalf of patients in particular relating to 10 these matters and what I intended to do last week was to 11 clarify although some of those matters would not be 12 dealt with, with Ms Dunning last Friday, the intention 13 had been that they would be dealt with today with 14 Mrs MacLeod. 15 The recent change to the position, I think it would 16 be fair to say, makes it clear that there may be matters 17 which Mrs MacLeod, in fact, cannot answer questions 18 about. Insofar as there are such limitations, I think 19 it would be fair to say that in the written evidence 20 provided by Mrs MacLeod, there is very little evidence 21 provided about the matters which she originally 22 purported to speak to, and I think it will be necessary, 23 in any event, for further investigations and further 24 evidence to be procured about this important area, in 25 any event. Page 128

1 Therefore, what I can say, although there is 2 a degree of confusion, I think, amongst the Inquiry team 3 as to exactly where we now stand with this witness -- 4 which has been unfortunately intimated to us very much 5 at the eleventh hour -- however, what I can say, by way, 6 hopefully, of reassurance to those who take an interest 7 in these matters, is that the Inquiry will be making 8 further investigations in addition to whatever evidence 9 we hear today from Mrs MacLeod. That may now cover 10 areas that we had intended to cover that we have not 11 been able to do with Ms Dunning or others. I think, in 12 any event, it would have been necessary for certain 13 matters to be pursued because of the lack of apparent 14 explanations provided in the written statement. 15 I should say, for the sake of fairness, that 16 contrasts significantly with some of the other 17 NHS Tayside witnesses, for example, Mrs Watson and 18 Ms Smith, who have provided very full explanations of 19 the questions that they answered and indeed, have 20 provided very full oral evidence in my submission. 21 THE CHAIR: That was certainly my recollection and you spent 22 a lot of time with the people you have mentioned, going 23 through, in great detail, matters that it turns out, 24 they were able to assist us with. 25 MR DAWSON: Indeed, sir, and I think there will still be Page 129	1 THE CHAIR: All of that is noted. Thank you very much. 2 Could we have the witness, please. 3 MRS SANDRA MACLEOD (affirmed) 4 Questions by COUNSEL TO THE INQUIRY 5 Q. You are Sandra MacLeod? 6 A. I am. 7 Q. Did you contribute to a statement which was written on 8 behalf of NHS Tayside in response to a Rule 8 request 9 received from this Inquiry? 10 A. I did. 11 Q. Could we look, please, at NHST-04944. Is this the first 12 page of the statement to which you contributed? 13 A. Yes. 14 Q. Can we go to the final page, please, which is 273. And 15 do you understand that on that last page, the statement 16 has been signed by Dr James Cotton, the executive 17 medical director of NHS Tayside? 18 A. Yes, I do. 19 Q. And the statement is dated 8 June 2026? 20 A. Yes. 21 Q. As far as you're concerned, in particular with regard to 22 the matters on which you made a contribution, is it the 23 case that you believe that the facts you have stated to 24 be true? 25 A. Yes. Page 131
1 benefit to hearing from Mrs MacLeod this afternoon, but 2 I want to make it clear that there may well be 3 limitations to what she feels she can responsibly speak 4 to. But to reassure those who take an interest in these 5 matters, as I know many people do, that the Inquiry will 6 not leave it at that and we will continue to investigate 7 these matters thoroughly. 8 THE CHAIR: Well, all of that is noted, Mr Dawson. It will 9 be understood, of course, that while it might have been 10 preferable to be able to exhaust all of these issues 11 within this session, it has been introductory in nature 12 and people will be aware of the programme that we have 13 before us and the opportunities that arise, inevitably, 14 to reconsider and reassess and indeed, revisit matters 15 that we've covered over the last four weeks. 16 MR DAWSON: Indeed, sir, and in that regard, if we think 17 right back to the beginning of this session which seems 18 like some time ago now, I did set out the beginning sort 19 of pathway for where we go with this evidence after this 20 which, of course, also included an opportunity being 21 afforded to core participants to make submissions about 22 where, as far as they're concerned, we find ourselves 23 with the evidence and what proposals they would make for 24 the next steps, which is something we're going to look 25 at after our section 2 hearings in December. Page 130	1 Q. Thank you. I understand, Mrs MacLeod, that you were 2 formerly the interim deputy chief executive of 3 NHS Tayside; is that correct? 4 A. That's correct. 5 Q. And I understand that, in fact, that position was one 6 that you held between February 2024 and February 2026, 7 is that right? 8 A. That's correct. 9 Q. I think it was a seconded position, is that right? 10 A. Yes. 11 Q. And so you worked somewhere else in the NHS in terms of 12 your formal, main position, is that right? 13 A. I was employed by -- as part of -- as chief officer in 14 Aberdeen City Social Healthcare Partnership and my 15 employment there was through NHS Grampian. 16 Q. I see, so you were working there and then you went on 17 secondment to NHS Tayside in February 2024? 18 A. Yes. 19 Q. I think that the position, as interim deputy chief 20 executive, came to an end in February 2026, is that 21 right? 22 A. I gave notice -- I retired in February 2026. 23 Q. Okay and so that was retiring from your main, 24 substantive post, I suppose? 25 A. Yes. Page 132

1 Q. But I think you did, in fact, carry on working for 2 NHS Tayside for a period after that? 3 A. From March 2026 until today. 4 Q. Today, and that role actually ends today, does it? 5 A. It does. 6 Q. Okay, and what has that role been? 7 A. It's been executive lead for facilities. 8 Q. And what sorts of things does that cover? 9 A. Facilities covers soft facilities, so that's domestics, 10 portering, catering, all the service components of 11 staff, as well as the property and maintenance and 12 compliance issues. 13 Q. Understood. So, in both the roles, the interim and the 14 one you've held over the last few months, are those 15 roles which form part of something that we've heard of 16 called the chief executive's executive team? 17 A. Yes. 18 Q. Yes. So we've heard from various other people who are 19 part of that team. I think everybody else who we've 20 heard from is part of that team, is that right? 21 A. Yes. 22 Q. And so your roles have been to report, effectively, to 23 the chief executive on certain matters. In the interim 24 role, you cover certain matters and subsequently, the 25 ones you've just told us about? Page 133	1 Q. Right, so does that role involve clinical matters at 2 all? 3 A. It involves the collation of, say, waiting time targets, 4 complaints -- so, the overall board report is split into 5 different areas. So there'll be the acute services, 6 there will be facilities, there will be mental health, 7 all of those areas and it's all collated and pooled into 8 one and sent on to the board. 9 Q. So presumably, the process would be that those who are 10 responsible, let's say for acute services, they would 11 have to compile -- or they would have to be producing 12 a report that would be going back to the board every so 13 often, but your role was to pull all that together into 14 a form that would be presented to the board, is that 15 right? 16 A. So I was executive lead. There was an associate 17 director of -- who was responsible, operationally, for 18 pulling all that information together. 19 Q. I see, but you took a lead role overseeing that, is 20 that -- 21 A. (Overspeaking) Executive lead role, for governance and 22 assurance. 23 Q. Understood. Thank you very much. Why was it necessary, 24 in February 2024, for there to be an interim deputy 25 chief executive? Page 135
1 A. That's correct. 2 Q. What are the matters you were responsible for when you were 3 in the interim role? 4 A. In the interim role when I started in February 2024, 5 I was initially responsible for adult board retained 6 mental health and learning disability services. Then 7 within May, I was asked to take on the digital 8 directorship of which health records forms part of that 9 directorship, and that was in May 2024. Then in 10 June 2024, business activity and performance was added 11 to my portfolio and then in October 2025, facilities was 12 added to my portfolio. 13 Q. When you say "performance and activity" what sorts of 14 things does that cover? 15 A. Business performance and activity is effectively 16 looking -- it's the collation of all the performance 17 targets for -- in presenting through the chief executive 18 team and onwards, to board. 19 Q. Right, performance targets for what sorts of 20 departments? 21 A. For all areas across the organisation. It was a monthly 22 report that was prepared, board retained services, board 23 clinical reports. I was executive lead, so not involved 24 in the day-to-day operation of that, but just related to 25 executive lead. Page 134	1 A. I was asked for -- I came down with the previous chief 2 executive who had come down in an interim role and I was 3 asked to come down and support her within that role in 4 NHS. 5 Q. I see. So the previous chief executive had been there 6 over what period? 7 A. She commenced, I think, December, if I recall correctly. 8 Q. Of? 9 A. Of 2023 and she was there until the current chief 10 executive took over. 11 Q. Understood. I should have reminded you of this. When 12 you're speaking, could you try to speak as best you can 13 into the microphones. The reason for that is that, 14 although I can hear you fine, your voice needs to be 15 picked up in our systems so others can. It's slightly 16 artificial, but if you could try to do that it would be 17 much appreciated. 18 A. Thank you. 19 Q. So when you say you "came down", did the chief executive 20 who we were just talking who came in, did he or she come 21 for an interim period as well? 22 A. Yes, she was initially for an interim period. 23 Q. And had that been from Grampian as well? 24 A. Yes. 25 Q. Right, understood. In relation to the matters that you Page 136

1 can help us with today, my understanding is that there's 2 been some level of lack of clarity around which areas 3 you speak to and which you don't. I think, broadly, my 4 understanding is that there may be two other people that 5 speak to some areas we thought maybe you did speak to. 6 I want to understand which areas you speak to and which 7 you don't. 8 So one person who perhaps speaks to some of the 9 questions that we understood that you were dealing with 10 is Dr Cotton. And I think, broadly speaking, we asked 11 some questions around what systems existed for making 12 sure that there were certain aspects of quality in the 13 creation of medical and other records and that what we 14 now understand the position to be is that, in fact, that 15 would be a matter for the medical director to speak to 16 because effectively what that involves is matters of 17 professional responsibility, is that right? 18 A. That's correct. 19 Q. So insofar as we may have asked questions about what 20 systems were in place to try to achieve accuracy in 21 medical records, that would be for him? 22 A. Yes. 23 Q. Insofar as the accuracy were emanating from doctors or 24 nurses, is that right? 25 A. Yes, that would be my understanding. Page 137	1 a number of aspects that related to that area including 2 the board's obligations under data protection law, is 3 that right? 4 A. Yes. 5 Q. And I think also containing the board's obligations 6 relating to freedom of information law? 7 A. That's correct. 8 Q. Now, as it happens, we've heard some evidence about 9 those areas from other witnesses this morning. My 10 understanding when I took the evidence from Ms Dunning 11 was that effectively, because of the fact that she is 12 a board secretary and dealt largely with corporate 13 matters, as I understood it, her responsibilities with 14 regard to information governance extended as far as the 15 setting of policies in that regard, and the statement 16 tells us quite a lot about different policies, either 17 external to NHS Tayside or internal to NHS Tayside. And 18 my understanding certainly was that she was responsible 19 for those but the position was, insofar as the operation 20 of the policies was concerned, that that was something 21 that was dealt with by other people and our 22 understanding was that , relating to any records 23 held within NHS Tayside, would be something spoken to by 24 you. 25 I think that's wrong, isn't that right? Page 139
1 Q. And we've also asked other questions about accessibility 2 of records and understandability of records and that 3 sort of thing, all broadly to do with their quality with 4 a focus on their availability and usability by patients. 5 But if the questions pertain to the role of doctors or 6 nurses in that, that would be for Dr Cotton, is that 7 right? 8 A. That's correct. 9 Q. Or perhaps, if it were nurses, for Mr Dunn? 10 A. Yes, that's right. 11 Q. Beyond that, we heard some evidence last week from 12 Ms Dunning, who is the board secretary. It was 13 a confusing picture because I think, as I understand it, 14 there have recently been some changes in the executive 15 responsibilities which seem to have resulted in a number 16 of responsibilities previously held by Ms Dunning in 17 particular being distributed amongst other executives, 18 is that broadly correct? 19 A. That's my understanding. 20 Q. And I think my understanding was that, first of all, one 21 of the areas for which she had, until quite recently had 22 responsibility, was something called "information 23 governance", is that right? 24 A. Yes. 25 Q. And I think information governance contained within it Page 138	1 A. My understanding and the role that I had was executive 2 lead for health records. So -- and that's within the 3 health records department and what was maintained there. 4 So you're correct in stating -- 5 Q. (Overspeaking) Yes, Indeed. That's what I understand 6 now to be what it was about Ms Dunning's position that 7 wasn't clear last week. Ie, we asked a number -- as you 8 know, because you answered some of these questions, we 9 tried to divide the questions into questions that 10 related either to what I think are called, technically, 11 "health records", people sometimes call them "medical 12 records" and then other types of records. 13 The reason that we did that was because of the fact 14 that the regulatory and legislative landscape that 15 relates to health or medical records is different from 16 other records. Was that at least understood? 17 A. Yes. 18 Q. And so I think what you're telling me is that you could 19 help us with questions that we have about health 20 records, so people's medical records, is that right? 21 A. I will try, yes. 22 Q. Yes, as best you can? 23 A. As best I can. 24 Q. But beyond that, if I had any questions about other 25 types of records, then that's not something you can help Page 140

1 us with? 2 A. Outwith a broad sense of policy, that's not my area. 3 Q. Yes, because, of course there are, in answering 4 questions about, for example, policies to do with 5 medical records, you would probably, perhaps 6 inadvertently, be answering questions about other 7 records because some of the policies apply to all 8 records? 9 A. That's correct. 10 Q. But some of the policies, in the same way as some of the 11 legislation, only apply to health records, I think? 12 A. Yes. 13 Q. So if you're answering a question about a general policy 14 you might actually, perhaps inadvertently, be talking 15 about other records. But in effect, what you feel you 16 can come and help us with today are questions we've 17 asked about health records? 18 A. Yes. I was just keen to be as open and honest and try 19 to help the Inquiry and in raising that, that's really 20 how the evidence has been prepared. I've had 21 responsibility for health records, but it's not my -- 22 I'm not subject matter expert. So therefore, I wanted 23 to be very clear about the remit of my knowledge. 24 Q. I see. So even within the field of health records, you 25 have made a contribution -- we've been told by others Page 141	1 you're not a "subject matter expert", what do you mean 2 by that? 3 A. So as part of the process in gathering the information 4 for the Inquiry, there was some responsible owners were 5 allocated to assist with the gathering of information. 6 There was a -- the responsible owners were subject matter 7 experts. The responsible owner was the head of health 8 records, who largely contributed to the searches, the 9 pulling together of documents. And then my role in that 10 was -- as accountable executive, was in signing off that 11 from an executive perspective. But the detail and the 12 knowledge was assisted and pulled together by the 13 responsible owner, which was part of the process. 14 Q. You say that was the head of health records? 15 A. Yes. 16 Q. Who is that? 17 A. Heather Anderson. 18 Q. I mean, ironically in this area, it might actually be 19 because of the fact that if someone is gathering the 20 records, the subject matter is gathering records about 21 gathering records, in a way. So it might -- do you 22 think it's possible that Heather Anderson might be 23 someone who would be able to tell us more about some of 24 the questions that we've asked? I don't want to ask you 25 any questions that would be unfair or beyond what you Page 143
1 that there was a sort of decision-making around 2 different parts being split and allocated to other 3 people and of course, some of the witnesses we've heard 4 from were, if I can put it this way, they were around at 5 the time so they were able to tell us things from their 6 direct experience, for example Lynn Smith was one who 7 could do that. 8 A. Yes. 9 Q. And Ms Dunning herself as well had contemporary 10 experience, but others had only arrived -- like 11 Dr Cotton, Mr Dunn, they had only arrived more recently, 12 Ms Connor. And so what they were trying to do was 13 a different sort of exercise, was to identify what, for 14 example, documents existed and help us with 15 understanding what looks like happened at an earlier 16 stage. Mrs Watson was another one who did that, who 17 arrived more recently at the board but was able to 18 undertake an analysis of what was there before and add 19 her views and opinions, based on the role she had had. 20 So your position is that you're in that latter 21 category. You certainly weren't there at the time -- 22 A. Yes. 23 Q. -- but you were asked to look at some questions relating 24 to health records, in particular, and so you've tried to 25 collate for us information about that. But when you say Page 142	1 feel comfortable doing, that's why I'm trying to clarify 2 that. 3 A. Yeah, I have worked with Heather. I'll be able to -- 4 Heather definitely is a subject matter expert, there is 5 no denying that. Today, I have prepared to the best of 6 my ability to give you answers that I can. 7 Q. Understood, thank you. Because one of the major sort of 8 issues, if I can put it that way, with the answers to 9 the questions that I do understand you can answer within 10 the parameters we've discussed, about things that fall 11 within what was Ms Dunning's responsibility and things 12 that fall within the more clinical area of Dr Cotton and 13 possibly Mr Dunn, is that where you have answered 14 questions relating to just the health records side, we 15 have asked for information about systems broadly, 16 because that's broadly what this Inquiry is interested 17 in. So, as we have done in other areas, we've asked: 18 what was the system for recruiting consultants? Or: 19 what was the system for organising neurosurgical job 20 plans? 21 So we've asked questions, and others have asked me 22 to ask questions on their behalf about systems. Now, 23 what you have broadly done, as I understand it, is you 24 have largely provided to us a number of documents which 25 relate to the management of documents, health records in Page 144

1 particular, but as I've said, to an extent more broadly, 2 which are effectively policies but they do not tell us 3 about systems, in the sense of how those policies were 4 implemented. 5 So, if I might give you an example. A policy might 6 say that you have to be very careful about who you give 7 medical records to because there are confidentiality 8 implications and there are data protection rules arising 9 from something called the data minimisation principle 10 that means you have to be very careful. 11 What an operational policy might do would say, in 12 light of that policy, if someone phones up the medical 13 records department and says, "I would like to see 14 Mr Smith's medical records", then it might set out: you 15 can show those to Mr Smith, you can show those to 16 Mr Smith's nominated consultant, you can show it to all 17 these other people, but you cannot show it to this 18 person without a certain form being filled out, or you 19 could never show it to this sort of person. That would 20 be a sort of operational policy which might give us some 21 insight into at least how the systems were meant to work 22 and then beyond that, what we're interested in trying to 23 find out is how they actually worked. 24 Now, I understand the limitation on your ability to 25 be there because you have only been there for Page 145	1 indeed, even if you feel you can answer them, whether 2 they might be better addressed to someone else. 3 There's often little point, if there's another 4 individual who can give us more reliable answers, based 5 on having been there longer, actually undertaking some 6 of these tasks, being there perhaps at the time periods 7 we're interested in, it would be better to speak to them 8 more directly. Are you saying that you're effectively 9 just reporting to me what somebody else has told you 10 anyway? 11 A. My evidence will be based on a review and the 12 information that's been provided and by discussing with 13 colleagues how the systems were operating. So my 14 knowledge is based on reading the evidence, looking at 15 what's available. 16 Q. Understood, and is this an area -- I mean, it's not 17 information governance, I know. I'm not quite sure what 18 you call this area, is it "document management", or 19 something like that? 20 A. Health records is the area whereby -- so, what is held, 21 we have the libraries of all the paper documents. They 22 are responsible for holding all of the patient records, 23 if you like, the hard-copy ones. They will give advice, 24 they have the tracking system from -- effectively, from 25 creation, through storage, through retention and Page 147
1 a relatively short period of time. Some of your 2 colleagues answered those questions by going to speak to 3 people who perhaps were there at the time or had more 4 knowledge. Now, you've spoken to Heather Anderson 5 obviously. Would it be likely that Heather Anderson has 6 more information about the operational systems, if you 7 understand the way I'm using the term, and how those 8 operational systems actually worked in practice? 9 A. Yeah, Heather would and I have discussed the -- I think 10 what you're talking about is the standard operating 11 procedures and they, I think, do form part of the 12 submission which describes how processes -- how policy 13 was implemented into day-to-day practice, which I think 14 is what you're describing. 15 Q. That may be the case, but we may go through the 16 documents and you can tell me more about what they 17 actually are. I mean, in essence, question 100 is 18 basically just a list of documents that emanate from 19 various different sources. The list doesn't even work 20 in chronological order, it doesn't give any explanation 21 as to what any of the documents are there for, how they 22 were used, how they interacted with other documents. 23 These are the sorts of things that we received from 24 other people in other areas and I'm just trying to 25 understand whether I can asking those question or Page 146	1 onwards, through to either archiving or disposal. 2 Q. Okay, so is that called "health records" then? 3 A. Yes. 4 Q. Okay, understood. I call it "document management", it's 5 called "health records", understood. 6 A. It's the health record component of that. There will be 7 other -- the document management policy will affect 8 all -- it's an organisational-wide policy, health 9 records. 10 Q. Understood, but is there something called the "health 11 records department" then? 12 A. Yes. 13 Q. And you mentioned there something you probably can help 14 us with which is -- you mentioned the libraries, that's 15 something that comes up in the questions you answer. So 16 that's often used in the plural, rather than being one 17 library. Do I take it that these are some sorts of 18 places where documents are stored? 19 A. That's correct, yes. 20 Q. So where health records are stored? 21 A. That's correct. 22 Q. How many are they and how do they work? 23 A. So from an acute perspective, there are libraries at 24 Stracathro, at PRI; those are acute. As well as 25 Claverhouse and Ninewells. There's additional libraries Page 148

1 that hold mental health records which are separate as 2 well, and community records. 3 THE CHAIR: I'm not sure that we've come across Claverhouse 4 before. Where is Claverhouse? 5 A. Claverhouse is just an NHS Tayside building within 6 Dundee. 7 THE CHAIR: Thank you. 8 MR DAWSON: And "PRI", Perth Royal Infirmary? 9 A. Sorry, Perth Royal Infirmary. Apologies. 10 Q. Not at all. So effectively, we should look at these as 11 health records repositories for each of these hospitals, 12 is that right? 13 A. That's correct. 14 Q. Excellent. So there's one in Ninewells where the health 15 records for patients in Ninewells are kept? 16 A. So the one with the Ninewells, because of the volume of 17 patients that go through Ninewells, generally health 18 records stored within Ninewells if they're active within 19 a two-year period. After that, they will be moved to 20 Claverhouse which is where longer-term records are held, 21 either to be go back into Ninewells or whether they're 22 required to be archived or disposed of. 23 Q. Yes, and you've told us a bit about how that works in 24 the statement. 25 A. Yes. Page 149	1 things might be in the paper file? 2 A. In the timeframe now, we're moving to electronic patient 3 records, so the majority of things will be held now on 4 electronic files. 5 Q. Right, so that would mean -- 6 A. Test results, x-rays, consultant notes, contemporaneous 7 notes. 8 Q. Yes, so would all of those things be created directly 9 into an electronic medium? 10 A. Yes, is my understanding, yes. 11 Q. So that would mean notes of a clinic would be typed up 12 into the system, rather than written on a piece of 13 paper? 14 A. That is my understanding, yes. 15 Q. Correspondence wouldn't be printed out in a letter and 16 sent in -- it would go in an email or something, yes? 17 A. Yes. More likely, yes. 18 Q. Attachment to an email or something, or it might even 19 just be an email? Okay, so historically then, there was 20 a period where there were paper records used for this 21 sort of scenario and you say that, even now, I would 22 have a paper record but you're trying to move towards 23 electronic. So that would tend to suggest that not 24 everything works electronically now. So what would 25 remain in paper form? Page 151
1 Q. So, are we still talking about physical, paper records 2 then? 3 A. So, health records, if they are asked to do -- I don't 4 want to stray into -- so, for example, a subject access 5 request, the subject access request would go through 6 health records and it would be both the physical and the 7 digital records -- digital records are held on our 8 electronic systems. 9 Q. So, you do tell us a little bit about this in the 10 statement so I think you might be able to help us with 11 this, which is if I were a patient getting treatment at 12 Ninewells Hospital, I would have a set of paper records, 13 would I? 14 A. You would have probably a mixture of electronic and 15 a paper record. 16 Q. Yes, but I would have a paper record in the first 17 instance, yes? 18 A. Yes. 19 Q. And then there might -- I think the case is there might 20 be some electronic records as well? 21 A. Yes. 22 Q. And can you tell me what sorts of things -- imagine if 23 I was being treated in the orthopaedic department or 24 something like within Ninewells Hospital, what sorts of 25 things might be in the electronic form and what sorts of Page 150	1 A. It -- I suppose, it would depend. I can't give you 2 a clear example in that. Apologies. 3 Q. Right, so there's a sort of hybrid system maybe, is that 4 how it works? 5 A. There's is. It's progressing towards that as we move 6 towards electronic records, yes. 7 Q. Right, and how long has that hybrid system been in 8 place? 9 A. Do you mind if I refer to -- it's been progressing 10 probably through from my understanding 2012 onwards, 11 through TrakCare patient administration and it's 12 gradually progressing forward. Apologies if I don't 13 know the exact data. 14 Q. Right, so when you say "progressing", so in 2012, there 15 was an attempt to try to have more stuff done 16 electronically than in paper form? 17 A. There's a move to have electronic paper records across 18 the whole of Tayside, yes. 19 Q. Because there's a difference between things being 20 created originally in an electronic form or things that 21 were in paper before, being put on it a computer, if you 22 like, scanning it in? 23 A. Yes, that's correct. 24 Q. So can you help us with understanding -- because if 25 I imagine today, when we're talking about today you're Page 152

1 saying there's a move towards trying to put things -- 2 things would be typed into a consultation record, would 3 be typed into a box, presumably in a form or something 4 like that, whereas before it would be written in a sort 5 of lined piece of paper. 6 Was there a point where people started typing things 7 in, or was there a period where the computerisation 8 meant writing things on a piece of paper and then 9 uploading them onto an electronic system? 10 A. I'm not exactly sure of the time process for that. 11 Q. Okay, but before 2012, as you said, that was the start 12 of the system, everything would have been done on paper? 13 A. The majority. There would have been electronic tracing 14 of records, I think as far as -- from -- so there was 15 a system called Fountain information system -- 16 apologies, I'm just checking, it's one of the -- it's 17 appendix 7, 04945. And the Fountain information system 18 provided access to central repository of patient 19 information including lab reports and radiology reports. 20 That was the start. That's a graph that shows as each 21 system came on and when that started to go live and when 22 it -- 23 Q. (Overspeaking) It might be worth looking at this, if 24 this is of assistance to you. So if we could have up, 25 please, NHST-04945 at page 54, please. This is in one Page 153	1 A. That's my understanding, yes. 2 Q. And then, as we go through, one can see that there are 3 different systems in existence at different times and 4 there are systems that -- this is not a sort of linear 5 list, there are different systems doing different 6 things. But whereas, for the Fountain system and 7 indeed, for Fountain Odyssey, which I think was the 8 replacement of the original Fountain system, you tell us 9 what it is that the system contained. Some of them are 10 just things like patient administration system. So 11 that's, no doubt, right because they're all patient 12 administration systems but it doesn't tell us what sort 13 of information was kept, for example, in Compas between 14 1995 and 2004. You may not know the answer to that, 15 Mrs MacLeod, but presumably somebody does? 16 A. Yes, somebody will. I could certainly ask for that 17 information to be shared with the Inquiry, if that's 18 helpful. 19 Q. So this gives us a list of all the systems and, to 20 an extent, tells us what they were for. But beyond 21 that, we might then need to ask somebody else: so this 22 Compas system, which existed between 1995 to 2004, you 23 tell us was a patient administration system, what sorts 24 of things would we find in that? And somebody might be 25 able to find that out, but you can't tell us that, no? Page 155
1 of the -- this is an appendix which is attached to the 2 statement which is referred to in one of the questions 3 that you answered, I think, isn't that right? 4 A. That's correct. 5 Q. So what it does is it tells us about various different 6 systems that were used for holding information, back 7 to 1995. And so, for example, if we look at the 8 Fountain information system in 1995, it tells us that 9 that was: 10 "A system that provided access to [a] central 11 repository of patient information including laboratory 12 results and radiology reports." 13 So would I be correct in taking that to mean that 14 between 1995 and 1999 there was an electronic system 15 which housed people's laboratory results and radiology 16 reports? 17 A. That's correct, that's my understanding. 18 Q. Yes, but other than that, people's medical records were 19 kept in a paper file? 20 A. Yes. 21 Q. So your correspondence and the details of your 22 attendance at clinics and your surgery notes would be in 23 a paper file, but your scans and your blood tests and 24 things like that would be on the electronic system, is 25 that right? Page 154	1 A. No, I can't. 2 Q. Understood. And indeed, some of the other answers give 3 us information about laboratory results, things like 4 repository of information being shared between 5 NHS Scotland health board. So that might, for example, 6 be patients that are receiving treatment in different 7 areas for different reasons, would that be right? 8 A. That's right. 9 Q. And then there's another one which is called a portal 10 used to access a variety of systems used for primary and 11 secondary care, which may give us some insight into what 12 is contained. But it sounds like we're going to have to 13 find out more information about the specifics of these 14 systems. 15 A. Okay. 16 Q. Is it correct to say that, beyond what's listed here and 17 what we'll be able to work out in due course was 18 contained in these systems, things would be held in 19 paper records, is that right? 20 A. Yes, that would be my understanding. 21 Q. Within the broad ambit of health records, which is what 22 we're talking about. 23 A. Yes. 24 Q. Okay thank you. And you have also told us, in your 25 response, a number of things about, as I said earlier, Page 156

1 the high level, if you like, policy documents that 2 existed relating to document management over time. If 3 we could look, please, at paragraph 100.2 of the report. 4 Just before we look at that one aspect I meant to ask 5 you about, Mrs MacLeod, that you mentioned in your 6 evidence, I think you were keen not to stray into this 7 area too far but you mentioned subject access requests. 8 A. Yes. 9 Q. I think you did that in order simply to illustrate, if 10 a subject access request came in, this is how it would 11 be processed in relation to the matters we were 12 discussing, was that right? 13 A. Yes, I'm aware of how that's -- yes. 14 Q. You sort of stopped yourself as if you didn't want to go 15 into it too far. Is that because subject access 16 requests is something you can tell us about in terms of 17 how that works or -- because what you've told us in the 18 statement about subject access requests -- well, let's 19 just go to that. It's appendix 8. NHST-04945, page 55, 20 please. And again, much like you'd done before, this 21 was a question, I think, was directed at you, in which 22 we were looking for information specifically about 23 subject access requests that had been dealt with by the 24 health board relating to former patients -- made by or 25 on behalf of former patients of Mr Eljamel; is that Page 157	1 broad process. I could give you a high level of the 2 process. There are 30 days, the time limits and what's 3 collected in that -- 4 Q. Well, if you could, it would be useful to know. 5 Obviously we're confined to health records, it's not 6 anything else, so it's not freedom of information or 7 it's not any other request for any other type of 8 information. It's a subject access request under the 9 data protection legislation, relating to someone trying 10 to access their own medical records or medical records 11 of someone on whose behalf, if they're a solicitor or 12 relative or something, how does that work? 13 A. Are you okay if I refer to my notes? 14 Q. Yes. 15 A. A subject access request is -- as you state, is about 16 an individual's access to their own notes and there 17 is ... 18 I'd just like to tell you what I have. 19 Q. Yes, please. 20 A. Subject access requests are a process -- it's 21 an individual's right, as you've said, to access 22 their -- 23 THE CHAIR: Sorry, would you mind slowing down a bit? 24 A. Sorry. 25 THE CHAIR: Just take your time. Page 159
1 correct? 2 A. Yes. 3 Q. And what you provided us with was a table, if you look 4 over the page, it goes to 18 different requests, with 5 some information about who made the request -- it was 6 always a patient apart from on one occasion when it was 7 a solicitor. The date of the request, the date of the 8 response and what I might broadly call the outcome, 9 which usually involved saying either: we handed over the 10 data or we didn't, and when you didn't, you sometimes 11 give a data protection type reason why you didn't. For 12 example, legal privilege or something like that. Is 13 that what you've told us? 14 A. Yes. 15 Q. Is that the extent of what you can tell us about subject 16 access requests? What I mean is, there will be a whole 17 system, one imagines, around how subject access requests 18 work, there will be systems relating to what people are 19 told about when you should respond to them, who should 20 respond to them, how quickly you need to respond to 21 them, when you should never respond to them, what the 22 rules are, what you should hand over, what you should 23 not. Are you able to tell us about those systems or are 24 those dealt with by someone else? 25 A. Those are dealt with by health records and I know the Page 158	1 A. Okay. To access their own information and the process 2 should take 30 days. We have a system for acute, which 3 covers Ninewells, PRI -- Perth Royal Infirmary and 4 Stracathro, we also have a separate team which operates 5 on mental health and learning disabilities and dental. 6 The process is laid out as day 0 to 3. When the request 7 comes in, they would check the information, and it would 8 be added to a spreadsheet so that it could then be 9 logged, create a checklist and send an acknowledgement 10 letter to the individual. So we're checking that 11 they've got the relevant authority to request that 12 information, if you like the consent. 13 Day 4 to 8, we obtain the paper records and also 14 review all the electronic records. So that would be -- 15 a subject access -- they would search the electronic 16 records, go through there and pull everything together. 17 There would also be areas -- there are about six to 18 eight separate areas that hold separate documents. They 19 would go out to them and ask also if they held -- if it 20 was likely that they held any of those information. 21 Q. Just to pause there, are those separate areas the 22 separate libraries that we talked about earlier? 23 A. No, those are separate such as there will be things 24 like -- if it was relevant, there would be physios, 25 there's different areas that hold their own. Oncology Page 160

40 (Pages 157 to 160)

1 hold their own individual notes and they're held at that 2 repository as opposed to being in the health records. 3 Q. So for example, if oncology is one, are the records 4 relating to someone's -- because this is all to do with 5 someone's own treatment, it's their own information. 6 A. Yes. 7 Q. Someone's treatment in oncology, does that not find 8 itself, then, in one of the libraries? 9 A. They hold -- if they were documents that were being 10 actively used, they would be held in oncology is my 11 understanding. 12 Q. I see. So the fundamental position is that someone's 13 medical records are held within a library, but of 14 course, doctors need to have access to the records to be 15 able to treat the patients. And is that what you mean 16 by "in use"? So if someone is having, in oncology, 17 chemotherapy or something like that, the records might 18 in fact be in the oncology department so that they can 19 be updated and people can see the medical history and 20 all that sort of thing? 21 A. Some areas hold separate records outwith their main 22 health records. So health records understand who holds those 23 separate records and will ask them if that -- 24 Q. (Overspeaking) Understood. So there are some records 25 that might come -- for an individual, let's say someone Page 161	1 Q. Does neurosurgery hold its own record? 2 A. No. 3 Q. So the neurosurgery records, other than when they're in 4 use, live in the library? 5 A. That's correct. 6 Q. Okay, thank you. Please carry on with your analysis. 7 A. So as I've said, that's day 4 to 8, that's planned for 8 that and there's minimal delays in there. Day 9 9 to day 24 is request and receive permissions from 10 professionals. So that's -- there has to be 11 an authorisation given by the clinician or the 12 professional whose notes they are and there's certain 13 criteria that they would seek, that's making sure that 14 the person has capacity, previous wishes of anybody who 15 is deceased and if there's any third party been 16 impacted. Day 25 to 29, they copy the records, and 17 day 30, final check and then they're sent out. 18 Q. Does that mean that the quickest someone could get it is 19 30 days? 20 A. That's correct. 21 Q. Because it has to go through the various steps and 22 something happens on the 30th day? 23 A. Yes. 24 Q. I think that would be consistent with our understanding 25 of how long these took because some of these took Page 163
1 who is treated in lots of different places, to try and 2 cover as many possibilities as possible, if somebody was 3 trying to get hold of their medical records, you would 4 look at the library and then there would be two reasons, 5 is that right, why records might be held -- broad 6 reasons why records might be elsewhere? They might be 7 in use so they had been taken out for treatment to be 8 administered -- 9 A. That's correct. 10 Q. -- or for a doctor to check a letter or something. And 11 then there would be other departments that hold their 12 own records. So they don't live in the library, they 13 live in the department. And the medical library knows 14 which departments hold their own records? 15 A. Yes. 16 Q. And so, why do some departments hold their own records 17 and some do not? 18 A. I'm unsure. 19 Q. That's just the system? 20 A. It's the system. 21 Q. Okay. 22 A. They're still subject to the same processes and 23 procedures, safety, security, access, that sits 24 alongside that. But, yes, some areas hold their own 25 records. Page 162	1 considerably longer than that. One aspect I just wanted 2 to raise with you is there was one case where you told 3 us that the time period was 120 days, it's number 14. 4 But you say there "extended due to complexity". Is 5 there a system -- presumably, there's some sort of legal 6 or regulatory requirement to do it in 30 days, is that 7 right? 8 A. That's -- our process is to ensure that we do do that 9 within 30 days. And you're absolutely right about 10 complexity. There's currently -- so when I said about 11 professionals having to sign that off, so if -- my 12 understanding is that there could be six different 13 professionals who all need to give their permission for 14 that record to be released. So that's what can then 15 take the time, for each person to be given their 16 permission to do that and for queries. 17 Q. Understood. And if that happens, how does that work 18 within the process? Because obviously, on a normal case 19 of a patient applying for them, they would presumably 20 expect it to be done in 30 days. Would they be notified 21 that there are reasons why this is taking longer? 22 A. Yes, that's my understanding. It is noted as well that 23 we've had -- I think in the last six months, there's 24 been quite a significant increase in subject access 25 requests and that has been escalated through the -- from Page 164

1 the head of health records, I understand, to the 2 director of digital, and then onwards through the 3 information governance committee, to raise the 4 issue that there are delays caused just by volume and 5 process -- and a process and an actual plan are in place 6 to help improve that. 7 Q. But these are situations in which patients have a right 8 to access their records, so -- 9 A. Yeah, absolutely. Absolutely. 10 Q. So the answer to that might not be to raise the issue, 11 but to have more people dealing with them, for example? 12 A. Yes, it's a volume and a capacity issue as well as some 13 of the processes being looked at. 14 Q. Might that be part of what the escalation is about 15 because if it goes to a higher level and someone at 16 a higher level who deals with budgets and things like 17 that has to think: maybe we should be allocating more to 18 that because it looks like it's busier than we thought 19 it was going to be. Is that -- 20 A. That's part of the reason for the escalation, is to look 21 at capacity, volume and -- 22 Q. Understood and just as far as the question is concerned 23 of what the sorts of complexities might be, without 24 going into details. Is it because there are some 25 records -- you mentioned about professionals needing to Page 165	1 I think you mentioned a moment ago, you speak in 2 a number of places about trackers to do with records. 3 Does this information that's gone into this 4 table emanate from a tracker or does it emanate from the 5 underlying documentation itself as to what was happening 6 at what stage and what the outcome was? 7 A. My understanding, when a subject access request comes 8 in, that that's then put onto a spreadsheet and it will 9 be held from there, so what information was requested. 10 So that's where that would have come from, the 11 spreadsheets. 12 Q. Okay, because for example, if you look at number 1, the 13 response was on 17 January 2018. So it's rather mixing 14 up different aspects of health records management, but 15 is it possible that the documentation related to that 16 has been destroyed because it was quite a while ago, or 17 does it still exist? 18 A. I'm unsure. 19 Q. Because, you see, this might just be basic information 20 that's retained but the underlying information has been 21 destroyed. It's possible? 22 A. It is possible, unless it's had a do not -- a retain. 23 Q. Do you know -- we've heard some evidence from other 24 colleagues about the history of the way that the 25 neurosurgical service was delivered in Tayside and Page 167
1 sign it off. Is that because of particular sensitivity 2 of what the records contain or something? 3 A. My understanding, from the documents I have reviewed and 4 from discussion with Heather, is that there are key 5 permissions on them to determine whether the person has 6 capacity, also whether there is third party. And 7 sometimes there can be a dispute as to whether is that 8 information -- just possibly a knowledge base. So there 9 will be some discussion and debate as to how it would 10 progress, so they would seek advice. 11 Q. Understood. So there are effectively a number of steps 12 that have to be satisfied, in your 1 to 30 days. One is 13 assuring that the person has capacity to be able to be 14 given the records and that might be a matter of some 15 medical complexity so that's a reason why it might take 16 longer? 17 A. Yes. 18 Q. Understood. Thank you. You've provided with us a very 19 high-level overview as to what's happened with these 20 cases, but presumably it would be possible for us to 21 access the information as to, you know, more detail 22 effectively as to what these applications were about? 23 The records exist of these applications, is that right? 24 A. That would be my understanding. 25 Q. Because one of the things I wondered about with this was Page 166	1 indeed, the slightly complex corporate structures that 2 sit behind them. Ms Dunning, in particular, told us 3 about the fact that in the period we're interested in, 4 which starts 1995 to 1999, there was a certain trust, 5 Dundee Teaching Hospitals NHS Trust, which effectively 6 controlled the operation of neurosurgery. From 1999 to 7 pretty much 2004, there was another body called Tayside 8 University Hospitals NHS Trust that performed that 9 function and thereafter, although there had always been 10 the health board before that, that Tayside Health Board 11 basically controlled the operation. 12 And so we also heard that, as far as neurosurgery 13 was concerned, there was a significant development in 14 the way that the service was offered in 1998 because it 15 had previously been offered -- or conducted through 16 Dundee Royal Infirmary and in 1998, because I think that 17 hospital was closing down, the service moved over to 18 Ninewells. Is there information about -- well, first of 19 all, do any records still exist from that period and 20 also, is there information about the systems that 21 operated in that period? 22 A. Sorry, I'm not quite sure I follow. So, for example, 23 their are operating systems, how the hospital was 24 operating? 25 Q. We're interested broadly in understanding how health Page 168

1 records, which is the area that you're talking about, 2 were generated, were stored, were processed, were used. 3 And is it the case that because of the fact those were 4 different hospitals, different trusts, we don't know 5 anything about that? Or is it the case that you still 6 have records about how people did things with records? 7 A. I'm unsure. Apologies, I can't answer that. I have -- 8 just digress, sorry. 9 MR DAWSON: Sir, that would be a convenient moment for 10 a break. 11 THE CHAIR: Yes, surely. 15 minutes, please. We'll take 12 a short break and resume again shortly, thank you. 13 (3.08 pm) 14 (A short break) 15 (3.24 pm) 16 THE CHAIR: Thank you. We're ready to resume. Mr Dawson. 17 MR DAWSON: Thank you. Mrs MacLeod, we looked at the 18 appendix at the electronic systems, some of which you'd 19 been able to identify what sorts of documents they 20 contain, some of which we're probably going to look into 21 with you or your colleagues in due course. 22 Some of the repositories that you identified 23 contained radiology. Is it the case that there are 24 systems which effectively go beyond the boundaries of 25 Tayside, so for example, ones that are accessible across Page 169	1 information. This framework was established to advise 2 Scottish Ministers, NHS Scotland, clinicians, and the 3 public on the confidentiality and security of 4 patient-related information. Furthermore, it was formed 5 in response to rapidly evolving legal, technical, and 6 ethical contexts (... Data Protection Act 1998, Human 7 Rights Act 1998, growth of electronic information 8 systems). 9 "A major component of the CSAGS framework was 10 establishing conditions for when consent is required. 11 Its work represented Scotland's first coherent, national 12 information-governance framework, bridging the gap 13 between emerging legislation and modern digital 14 healthcare. It directly shaped both the 2003 15 NHS Scotland Code of Practice on Protecting Patient 16 Confidentiality, and the later Caldicott, IG, SIRO and 17 data-governance systems that followed." 18 So, I think you wanted to draw our attention, in 19 particular, to this paper, the framework and guidance 20 because it was a significant moment in the period that 21 we were looking at. What aspects of this were -- why 22 was it that you wanted to draw our attention to this, in 23 particular? 24 A. So my understanding, from reviewing the information, was 25 just a more that this was -- this formed a key document Page 171
1 Scotland? 2 A. As in radiology? 3 Q. Anything, but perhaps radiology, yes. 4 A. I'm sorry, I don't know the information. 5 Q. Okay. Could we have a look, please, at the statement at 6 paragraph 100.2. We asked you here what the systems of 7 document management were and we split that effectively 8 into two separate questions: one during the period when 9 Mr Eljamel worked there between 1995 and 2014. And 10 because, of course, we're interested in what's been done 11 with documents since then, in the period since then up 12 to the current day, that was a later question. But in 13 relation to this, this is what I was meaning earlier 14 when I said we had asked about systems and you had told 15 us about effectively a number of places where one finds 16 where the rules are written down, but we may get onto 17 some of the more detailed documents in due course. So, 18 you told us in particular at paragraph 100.2, that: 19 "The Scottish Executive Health Department 20 established The Confidentiality & Security Advisory 21 Group for Scotland (CSAGS) Framework ... in 22 September 2000 ..." 23 And you provide us with a copy: 24 "... to provide authoritative, system-wide guidance 25 on the confidentiality and security of health-related Page 170	1 that was put forward in identifying its core principles. 2 Sorry, if I could just start again. I understood that 3 this was a key document which influenced subsequent, as 4 you've said, confidentiality, information governance 5 arrangements across Scotland, so it was a key document 6 there. It had key themes which refer to patient 7 information which is confidential, patients should understand 8 how their information is stored, and boards must have 9 a governance system in place. So it was just really to 10 highlight that that document then led on -- was 11 a seminal document. 12 Q. Right, did you read that one of the notes that you'd 13 made? 14 A. Yes, I did, sorry. Apologies for that. 15 Q. You told me before these were notes you made by yourself 16 did someone tell you to write that down? 17 A. No, they didn't. These are my own notes. 18 Q. It's possible that they're your own notes in the sense 19 you made the notes, but did someone tell you write down 20 that information? It might have been, for example, 21 Heather Anderson who told you that? 22 A. No. 23 Q. So where did the information come from that you just 24 told me about? 25 A. Sorry, I understand what you're saying now. So, yes, in Page 172

1 reviewing the documents here, to ask why is that 2 document in there. Yes, that's my understanding is that 3 these are key documents that were put into to give that 4 information. Apologies, I picked you up incorrectly. 5 Q. So did you choose to tell us about the framework and 6 highlight its significance in paragraphs 100.2 and 7 100.3? 8 A. No, as I said earlier, my role was -- as with executive 9 oversight, this was pulled together from the subject 10 matter experts who felt that those were the relevant 11 documents. 12 Q. So in essence, were these answers written by someone 13 else? 14 A. These answers -- yes, that's what I said earlier to you, 15 yes. 16 Q. So all of the answers that you gave are written by 17 someone else? 18 A. Apart from I had to -- in my executive role, with 19 an executive oversight, I had to sign them off, yes. 20 Q. Right, so when you signed them off -- 21 A. They were written by someone else, yes. The responsible 22 owners, which was the process, as I described earlier. 23 Q. Understood. What I'd understood that to mean was that 24 they provided you with the information and you wrote the 25 text, but no, they wrote the text? Page 173	1 example, the evidence of Lynn Smith who told us, in 2 places in the statement, that she had asked other people 3 about this information, so she had made that clear. And 4 in one place, I think she actually names a person and 5 then she clarified in her evidence when I asked her 6 about this that she had had spoken to some nurses. And 7 indeed, different from you, she actually had some of her 8 own knowledge from the time. So she'd set all of that 9 out. Again, it does seem like a slightly odd way of 10 going about it, that it would be someone coming along to 11 give evidence to the Inquiry who hasn't written these 12 answers. 13 A. I understand that. 14 Q. And did you make the decision that that's the way that 15 this would be approached, or did somebody else tell you 16 to do that? 17 A. As in? 18 Q. Did somebody else set up this system of you taking the 19 executive lead and your subject matter experts assisting 20 you, or did they go: right, you're getting these 21 questions, and you decide to approach it that way? 22 A. No, there was a huddle, is my understanding, that was 23 set up. There was also a co-ordination group that 24 helped and then an oversight group that were pulled 25 together to help to pull together the evidence. Page 175
1 A. Yes. 2 Q. So, they made the choice to highlight this particular 3 document? 4 A. Yes. 5 Q. So the reason you've written down what you've written 6 down is presumably you thought you might be asked 7 questions about it -- 8 A. Yes. 9 Q. -- and you wanted to, if you were asked questions about 10 it, give us more information. But that information also 11 emanated from other people? 12 A. Yes, and from reading the documents. 13 Q. I see. Was that the way in which others compiled their 14 contributions to the statement? 15 A. I'm unsure how others contributed, how they compiled 16 theirs. That was definitely the way that I compiled -- 17 there were responsible owners allocated to help support 18 everyone. There was a lot of information that was 19 pulled together. 20 Q. So in all the other areas, there were responsible 21 officers who helped the executive who took charge of the 22 particular questions, is that right? 23 A. That would be my understanding. To what degree they 24 pulled that information together, I'm unsure. 25 Q. I think what you're describing, I can think of, for Page 174	1 Q. Right, so who made the decision that these questions 2 would be allocated to you, and that the way in which 3 they would be answered would be somebody else writing 4 the answers and you say: yeah, that's fine? 5 A. So my understanding, the reason that these were 6 allocated to me was because of my executive lead role 7 for health records. 8 Q. That wasn't the question. I asked you who made that 9 decision? 10 A. It would be have been through either the co-ordination 11 group or the oversight group. 12 Q. And you weren't part of those groups? 13 A. No, I wasn't. Apologies, sorry, I was asked to go on to 14 the oversight group from November 2025. 15 Q. Right, but the decisions had already been made by that 16 stage as to who would be allocated the questions, is 17 that right? 18 A. Yes. 19 Q. And how did the group work, in terms of who was making 20 the decisions? Who else was on that group? 21 A. On the oversight group? 22 Q. Yes. 23 A. Or the co-ordination group. The oversight group that 24 was led by -- some of the executive team were on there 25 as well as -- Heather was on -- from my perspective, on Page 176

1 the co-ordination group as well as on the huddles. 2 Q. Right. 3 A. And then, in November, when I was asked to go on to the 4 oversight group, bearing in mind I was on my notice to 5 retire, I asked Heather to attend on there. 6 Q. I see. And within that group, because I think at least 7 on one of the groups you had some experience, how did 8 decision-making work? 9 A. For? 10 Q. The group that you attended. 11 A. I didn't attend any of the groups. 12 Q. I thought you said you joined one of them in 2025? 13 A. No, I was invited to attend one in November 2025, but 14 I was working towards my retirement, my future 15 retirement, and thought, given the importance of the 16 Inquiry, I'd asked Heather, the head of health records, 17 could go on in my stead. 18 Q. Understood. So is it the case that you don't know who 19 made decisions about allocation -- 20 A. (Overspeaking) That's correct. 21 Q. Just let me finish the question. You don't know who 22 made decisions about how the questions were allocated, 23 or the decisions around when -- sorry, how the questions 24 will be done, in terms of someone taking the lead and 25 others providing subject expertise? You don't know the Page 177	1 lead for NHS Tayside in relation to these matters? 2 A. I assume, if that's the information that's been 3 provided, that would be correct. 4 Q. But you don't know? 5 A. My understanding is that Dr Cotton is the lead for the 6 oversight. 7 Q. So can we deduce from that, that it appears that it was 8 Dr Cotton, along with the other people on the committee, 9 who took the decision that it would be best, not the 10 person who answered these questions but for someone who 11 didn't answer these questions, to come before the 12 Inquiry about these important matters today? 13 A. That would be a reasonable assumption which -- I don't 14 have the facts in front of me, so I can't -- 15 Q. But we could check it in the minutes? 16 A. You could, yes. 17 Q. That's helpful. Okay, so in relation to what you've 18 provided -- well, someone has provided, at 19 paragraph 100.4, a list of a whole load of documents 20 that relate to the way in which health records -- and 21 I think some of these are wider, that they apply to 22 other records -- were managed over the period that we're 23 looking at. This was the list I was referring to 24 earlier, which doesn't really attempt to do very much by 25 way of explaining to us what any of these documents Page 179
1 answer to that? 2 A. No, I don't. 3 Q. Are there records kept of these meetings? 4 A. Yes, there are. 5 Q. Okay, and are decisions of that nature taken by one 6 group or the other, is it the oversight group or the 7 other one? 8 A. I would have to check back the records to understand 9 that. 10 Q. Right, and as far as the oversight group is concerned, 11 you've mentioned that there are executives who sit on 12 it. Can you tell me the actual people, tell me their 13 names, please? 14 A. My understanding, or my recall, without having the 15 minutes in front of me or the attendance in front of me, 16 is that would be Margaret Dunning, I believe, was on 17 that, Jane Duncan, James Cotton. I'm unsure if there 18 were others. 19 Q. Okay. I mean, for example, I think Dr Cotton has told 20 us already that he was on a group like that and also 21 Ms Connor told us that Dr Cotton had taken a lead in 22 relation to the response to the Inquiry and that was the 23 reason why she had deferred answering a number of 24 questions I put to her to Dr Cotton. So could I take 25 from that that Dr Cotton is the person who is taking the Page 178	1 actually do. A number of them are pieces of legislation 2 which I think you can take as read we've already seen. 3 But they also contain a number of Scottish Government 4 records management documents, including an NHS code of 5 practice, and certain other documents, including the 6 Scottish Hospital Service Destruction of Records 7 Memorandum from 1995. Would you be able to help us with 8 understanding what any of these actually are, or would 9 it be better that we address those questions to someone 10 else? 11 A. I would have -- I have notes on a broad understanding of 12 some of the documents, but possibly they would be better 13 directed at somebody with more information. 14 Q. Okay. So, for example, in bullet point three under 15 100.4, it says: 16 "The Code of Practice on the Confidential of 17 Personal Health Information, issued in Scotland in 1990 18 (NHS Tayside does not have a copy of this document, 19 however we do have a copy of the 2003 version ...)." 20 And you see there's a number there which means 21 you've produced that and we've given it a number. 22 This is meant to be UK Government, Scottish 23 Government, NHS Scotland legislation. Do you know which 24 organisation that emanates from, the 2003 version that 25 you've produced? Page 180

1 A. No. Apologies, I don't. 2 Q. As far as the NHS Tayside policy and guidance documents 3 are concerned, which are at 100.5, if you just scroll 4 through a little bit, please. Broadly here, there are 5 a number of documents, some are policies and there's 6 a mention of a handbook which I think may have been 7 updated. Can you tell us broadly what the policies are 8 there for and what the handbook was there for? 9 A. The policies are there just to highlight the policies 10 that are in place for the creation, the storage, 11 retention and management and disposal of records. The 12 handbook was a document that brought together all of the 13 relevant -- if you like, the relevant policies for that 14 with -- not just including health records, but also 15 other policies as well and gave guidance for staff. 16 Q. Okay, are these documents, at 100.4, and 100.5, 17 a comprehensive list of all of the relevant documents 18 that governed in this area? 19 A. My understanding is that these were pulled together as 20 the relevant periods covering the period, in response to 21 the question. 22 Q. So you don't have any more? 23 A. Not -- my understanding is this would be the documents 24 that have been provided. 25 Q. Well, presumably whoever did the search was trying to Page 181	1 to document management beyond this list that you haven't 2 told us about? 3 A. Not as far as I'm aware. 4 Q. Okay, I think you mentioned earlier -- if we go to the 5 end of 100.5, which is just at the top of the page, the 6 very end of 100.5. There, you say: 7 "The Health Records Operational Guidance and Service 8 Operating Procedures ..." 9 Was this the document you referred to earlier, or 10 is the series of documents you referred to earlier? 11 A. Yes. 12 Q. Because remember, I said to you that all of the 13 documents appear to be some high-level policies, but 14 what we'd actually asked about were systems and you 15 said there might be SOPs? 16 A. Yes. 17 Q. So these documents -- there are a number of these and 18 you can see that's why they have a number of different 19 numbers. And I think they start in 2011, is that right? 20 A. And work their way through, yes; they're different 21 version of the same document. 22 Q. Yes, as they will be updated -- 23 A. (Overspeaking) Updated. 24 Q. Yes, and I think what you were telling us earlier, these 25 are different from the other ones. They're not Page 183
1 give us everything you had? 2 A. It appears so. 3 Q. Because this wasn't actually in response to a Rule 8 4 request, it was in response to a section 21 notice which 5 is the means by which the Inquiry compels people to 6 produce things. So presumably, when whoever it was that 7 did this exercise was trying to get the documents, they 8 were trying to give us everything that you had, is that 9 fair? 10 A. It appears so. 11 Q. Appears so. I mean, presumably the answer to that is 12 "yes"? 13 A. Yes. 14 Q. And also, there are some documents, including the one 15 I just referred to a moment ago from 100.4, that is 16 referred to but not produced. And can we take it then 17 that, if the documents are referred to but not produced, 18 that's because you don't have a copy but you have tried 19 to provide us with a list of all of the relevant 20 documents that might have existed in this area? So 21 again, this is a comprehensive list of everything 22 relevant to document management, but some of them you 23 just don't have a copy of? 24 A. That's correct. 25 Q. So again, there are no other documents that are relevant Page 182	1 policies, they're not handbooks. They are operational 2 guidance and service operating procedures. Can you tell 3 us what sort of information those sorts of documents 4 would be designed to contain? 5 A. I think they were -- I think it states that they were 6 together, then they were separated out into the strategy 7 and management and separated out into the health records 8 operational guidance and service operating procedures. 9 Service operating procedures are how you would, if you 10 like, implement policy on a day-to-day basis, what the 11 practice is for people. 12 Q. I see. So these would be trying to take the higher 13 level policy and provide a kind of guidance as to what 14 it is people need to do every day to make sure that 15 policy is complied with, is that right? 16 A. That's correct. 17 Q. So this is why you identified this earlier as being the 18 sort of document that might help us with the systems we 19 talked about? 20 A. Yes. 21 Q. Yes, thank you. We then asked you a question, 101 was 22 specifically about medical records. So we asked you 23 about how documents were organised, generated, stored 24 and processed in the field of medical records. And you 25 told us about various aspects of paper-based or digital Page 184

1 records and then, in 100.2, if we could scroll to that, 2 please, thank you, you said: 3 "During the relevant period of 1995-2015, patients 4 had a paper acute medical records. Acute medical records 5 contained documentation from care or treatment on 6 a secondary care hospital site. If patients received 7 care or treatment on multiple hospital sites, they would 8 have a paper acute medical record created in each of the 9 locality areas (e.g. Perth & Kinross, Dundee, [or] 10 Angus." 11 So I'll just stop there. Again, if we hypothesise 12 someone who, for some reason, had to have treatment in 13 a number of different places, you're telling us, I think 14 there, that there would be a new paper record not 15 created, I think, hospital-by-hospital, but 16 area-by-area, is that right? 17 A. Those are from the acute medical -- so when it is saying 18 "Perth & Kinross", that would be at PRI and Dundee would 19 probably have been DRI, I would assume, and Angus would 20 be Stracathro. 21 Q. And Dundee would become Ninewells for neurosurgery at 22 a later stage? 23 A. Yes. 24 Q. I see. So they do relate to the hospitals rather than 25 the area, if you like? Page 185	1 in some way, migrate back to the neurosurgical base, if 2 I can put it that way? 3 A. I'm unsure about that. What I would say, if the record 4 did follow him from Ninewells, there's tracer cards and 5 I think there is -- it's described how records were 6 followed. There was a tracer card put on. That's where 7 they would go and then they would come back, but 8 effectively, I'm unsure. Apologies. 9 Q. So the tracer cards, I think, are about trying -- if you 10 have the record, say in the library, and the record goes 11 somewhere, for example if there's a request by a doctor 12 to see it for a meeting with patient or a clinic or 13 something like that, you keep a record there of where 14 it's gone, is that right? 15 A. Yes, that's correct. 16 Q. But in the scenario I was talking about it's slightly 17 different from that because there's a possibility 18 a record could be generated in another hospital. That 19 wouldn't have gone anywhere, it's the fact that it might 20 have originated there. But you can't help me with that? 21 A. Apologies, no. 22 Q. You tell us, at 101.4 that, as you've mentioned already, 23 that medical records, of course, have a life-cycle, from 24 creation through, various different usage, and then 25 retention, and then possible disposal, or permanent Page 187
1 A. Yeah, I think it's stated the locality areas, but that's 2 generally where they -- particularly from acute. 3 Q. Okay, that's fine. So that ties in with what you told 4 us earlier about the repositories being sort of 5 hospital-based, if you like, although Ninewells, not all 6 of it is actually is held at Ninewells, you told us? 7 A. Yeah, and I suppose mindful that when it's stating the 8 locality areas, that would have been -- for example 9 Stracathro and PRI would have been much more active 10 acute sites at that stage than what they are further 11 down the line. 12 Q. We heard some evidence, which we've explored with a few 13 people actually, about the possibility that although 14 neurosurgical services were delivered from DRI 15 originally and then Ninewells, that there was evidence 16 which one of your colleagues had provided that 17 Mr Eljamel had, in fact, worked to some extent at Perth 18 Royal Infirmary. And I think we clarified with others 19 that that would not be a sort of normal neurosurgical 20 function, but that it might be that he had to visit that 21 for a particular reason to do with a particular patient 22 or something and so that's why we've been told he worked 23 there, not a lot but sometimes. 24 And if that happened, then would the record be held 25 within the Perth Royal Infirmary records, or would it, Page 186	1 preservation in an archival facility. And you tell us 2 that the retention and disposal schedules have been set 3 out for the relevant codes of practice. I'm not sure 4 the codes of practice actually cover that whole period, 5 but insofar as you've been able to give them to us. You 6 say: 7 "Health Record employees are responsible for making 8 sure that all records are periodically and routinely 9 reviewed to determine what can be disposed of or 10 destroyed in light of local and national guidance. At 11 the end of the relevant minimum retention period, one or 12 more of the following listed actions applied in the 13 period 1995-2015 and continues to apply ..." 14 So what you're telling us here is the rules lay down 15 various minimum retention periods, is that right? 16 A. That's right. 17 Q. I think you tell us at one point that for neurosurgical 18 health records the period is six years, is that right? 19 A. Six years from last consult or three years post. 20 Q. Indeed, so I was interested in the context of it being 21 six years from last consult. So you talked earlier 22 about someone having an entire bundle of medical 23 records, if you like. So let's say someone is a patient 24 at Ninewells, they may go to various different 25 departments but all the records would be kept in one Page 188

1 bundle, apart from the ones that happened to be kept on 2 an electronic system which would be part of the 3 patient's bundle, but actually radiology or something 4 might be kept somewhere else, is that right? 5 A. Yes. 6 Q. So as far as the last consult is concerned, imagine -- 7 it's entirely possible and probably happens in lots of 8 cases -- that people attend a hospital for different 9 reasons. They might fall off their bike and go to A&E 10 or they might have an injury to their leg and go to 11 orthopaedics, or they might have to go to neurosurgery. 12 So people attend hospitals at lots of different times. 13 So as far as the retention and the last interaction is 14 concerned, how does that work? Because I might need 15 neurosurgical treatment and I have the treatment and 16 I go along and that comes to an end, but I come back at 17 a later time for my broken leg. When does the six-year 18 period start and stop? 19 A. So I asked that question in part of my preparation. My 20 understanding is that that would start -- that's 21 a new -- it's from the last -- there's no active file 22 from six years, if you like. So say you went to 23 neurosurgery, then you went to orthopaedics, then that 24 file is still classed as active from that last time 25 you're seen. Page 189	1 anything -- presumably then it would go back to the 2 department for decision-making as to whether the 3 six-year period should be used or, in fact, in the 4 circumstances of a hip replacement: no, no, we need to 5 keep those because for these types of patients they're 6 probably going to need to come back in and we are going 7 to need to look at the records of what happened in the 8 operation, possibly, if they come back; is that right? 9 A. My understanding is that the disposal of records is 10 against the retention periods that are set out in the 11 policy. There is a process that's in there, so no, they 12 don't go back unless they're into the area. 13 Q. Sorry, they don't go back, unless? 14 A. If there was -- so there's certain local areas. So for 15 example, if they had a cardiac surgery, if there was 16 a cancer, if there was a lifetime -- if there are 17 certain -- if they had a retention request date for 18 a clinical trial or anything, or if there had been 19 a request to hold that file, they would be on there. 20 But other than that, then they go through the process 21 of -- there is a set process against the policy, against 22 the retention schedules that are held. So they wouldn't 23 go back then, is my understanding. They wouldn't go 24 back to the consultant to check that, no. 25 Q. So the process basically is if the files are held in the Page 191
1 Q. Right, so as long as I return for my broken leg for 2 six years, then the record would still be there and then 3 the clock would start again, would it? 4 A. That's my understanding, yes. 5 Q. Because it would seem that might be quite a short period 6 of time for people that might need to come back and have 7 their treatment reviewed at a later date. So for 8 example, if someone had a hip replacement or something 9 like that, the likelihood is that they would need to 10 come back, depending on the timing and the nature of the 11 hip replacement and their age, 10 years later, 15 years 12 later, or something like that, maybe a long time later, 13 when they'd have to look at: well, do you need revision 14 surgery or something like that. But it's possible, in 15 that scenario, that the records might have been 16 destroyed in that period if the person hadn't attended 17 in a six-year period after the hip operation was done? 18 A. It's possible, unless there was a retention request. 19 Q. Yes, and so in those circumstances, imagine my 20 hypothetical hip replacement surgery, someone has the 21 surgery, then what would happen, I think you're telling 22 me is that in six years after that, if I had fortunately 23 not had to go back to the hospital for anything else, 24 that would then be flagged up in the medical records 25 department as: okay, that's a six-year, nobody has been Page 190	1 medical records library, the central one, so not held in 2 oncology, you mentioned as a department that holds its 3 own records, then what would happen is after six years, 4 they'd be destroyed? 5 A. If there had hadn't been any activity, yes. Which 6 is in line with the retention schedules. 7 Q. But it's not because what the policy and the 8 requirements lay down is that that's a minimum period of 9 retention, it's not: that is the period of retention. 10 So that's not in accordance with the policies. 11 A. Okay. 12 Q. We'd probably better be clear on this because I don't 13 think that's right. A minimum period of retention means 14 you have to keep it for at least six years, do you 15 understand that? 16 A. Yes, I understand that. 17 Q. But what you're telling me is that NHS Tayside, as far 18 as the records in the central repository were concerned, 19 the library, they didn't approach it in that way. They 20 approached it in the way that, in fact, the government 21 was telling them that they should destroy the records 22 after six years, if there had been no activity on the 23 file? 24 A. That's my understanding, according to the policies that 25 are laid out within NHS Tayside. Page 192

1 Q. Okay. 2 THE CHAIR: But that is against the data protection 3 statutory background that was described before the 4 break, I think -- 5 A. for keeping things for a minimum period. 6 THE CHAIR: -- requires that personal data not be kept any 7 longer than is considered to be necessary. That's at 8 least the statutory context? 9 A. That's my understanding, yes. 10 MR DAWSON: But there's no consideration after six years, if 11 there's been any activity on the file as to whether it's 12 considered necessary; it's automatically destroyed? 13 A. Yes, in line with the retention policies. 14 Q. Okay. You talk about archiving records. Just broadly, 15 what sort of records does that relate to? 16 A. Archives records before 1948 and anything of 17 historical significance. There's also, if there's 18 unusual cases or things that would be viewed to have 19 historical significance. 20 Q. Can you give any definition to the phrase you use in the 21 statement is "long-term historical value"? 22 A. In exploring this, in preparation, my understanding is 23 that it would be things that maybe rare conditions, rare 24 genetic conditions, things like that. They would 25 generally consult the archivist, to see whether they Page 193	1 patients or their representatives through the 2 application of the relevant provision under the Data 3 Protection Acts of ['84] ... and ['98] ... and the 4 Freedom of Information (Scotland) Act 2002 ... Patients 5 also had the right to have the information in their 6 medical records explained to them by a clinician." 7 Then it says: 8 "Records were understandable to patients or their 9 representatives through the application of [the] Data 10 Protection Acts ..." 11 Now, what I think you mean there -- you don't know 12 whether records were accessible or understandable, do 13 you? 14 A. My understanding from accessibility is through a subject 15 access request and through that legislation, through the 16 data protection legislation. 17 Q. No, no. We're at cross-purposes. I think you assert 18 there that records were accessible and records were 19 understandable. You don't know that, do you? 20 A. No. 21 Q. Yes. What you mean here, I think, is that there were 22 provisions which required them to be accessible and 23 understandable, is that right? 24 A. That's correct. 25 Q. But as to whether they were or not, as you assert here, Page 195
1 were viewed to have historical -- I think that's Dundee 2 University is our aligned one. 3 Q. Yes, so they'd consult the archivist at Dundee 4 University, not any of the clinicians who had been 5 involved in the process? 6 A. For archiving, yes, it's the policy that's set out here. 7 Q. So does the archivist then hold a list of things that 8 are deemed to be of significant historical value and 9 they check it against that, or is a judgment being made 10 by the archivist? 11 A. I am unsure. 12 Q. Okay. Question 105, please. This was one of the 13 questions, I think, where there had been a lack of 14 understanding on our part as to who was answering this 15 question. Just to be clear again, because I don't want 16 to ask you questions about things that are not in your 17 area, but I think this was a question that we had 18 understood at one stage you were answering in totality, 19 but can you answer it in connection with the medical 20 records side? 21 A. So the medical records about accessibility would be -- 22 Q. Yes. That's for you, just to be clear, sorry. 23 A. Yes. 24 Q. And it says here: 25 "Records were accessible and understandable to Page 194	1 that would be something that needs to be determined 2 separately? 3 A. That's correct. 4 Q. Thank you. Question 107, please. You were asked about: 5 "What systems of document management and retention 6 have been in place within [NHS Tayside] since 7 Mr Eljamel's employment ... came to an end ..." 8 So this was the extension of that previous question 9 where we were talking about when he worked there and 10 what's happened since. So you've referred to the 11 policies that you referred to in the earlier questions 12 because some of them, of course, fell within this 13 period. Then you said: 14 "In 2016 NHS Tayside implemented an electronic paper 15 medical record tracking system named iFIT. iFIT 16 replaced the previous digital systems which had been in 17 place since 1995 and the paper tracer cards, which 18 recorded movements of the records ..." 19 So we mentioned the paper tracer cards. Is that you 20 just telling us that there was an evolution in the 21 systems for trying to work out -- you would keep a track 22 on where the records were, is that right? 23 A. That's correct. 24 Q. So it started off at one stage with paper, then it moved 25 to a digital system and in 2015 they got a better Page 196

1 quality digital system to do that? 2 A. Yes. 3 Q. And then, in 107.4, you say: 4 "NHS Tayside has further developed the 5 Electronic Patient Record (EPR), with the majority of 6 patient health records now being created, processed and 7 stored on electronic systems. While minimum patient 8 information is now added to the paper health record, 9 these are still retained. The NHS Tayside EPR is 10 a combination of multiple systems with different 11 implementation dates. Further information on EPR 12 systems in place from 1995 to date is provided ..." 13 In a certain document, which I think we've looked 14 at. So is this the matter you were talking about 15 earlier when you were saying that in more recent years 16 there's been an attempt to try to create and store 17 things more in the electronic systems? 18 A. Yes. 19 Q. And the use of that EPR, what is that? Is that 20 an electronic computer system? 21 A. It's a general term for holding electronic patient 22 records. I think it encompasses many things. 23 Q. So, it's a term which means holding it electronically? 24 It's not like Datix or something, it's not a computer 25 system? Page 197	1 the time had a query about the medical records and 2 requested that there was a retention placed on them. 3 Q. And you say that the do not destroy order was issued to 4 all of the health records library locations? 5 A. Yes. 6 Q. But not more widely? 7 A. No, it was requested that it was the health records 8 that -- it went directly from there to the head of 9 health records. 10 Q. So when you say the different locations, you mean the 11 ones in the different hospitals? 12 A. Yes. 13 Q. The library -- and we said earlier that that might be, 14 at least partially, a good thing to do because the 15 libraries would be the place that any neurosurgical 16 records would be held? 17 A. Yes. 18 Q. Because they're part of the library rather than part of 19 the department, if you like? 20 A. That's correct. 21 Q. But this doesn't relate to anything other than health 22 records kept in the libraries, is that right? 23 A. That's correct, yes. 24 Q. So it doesn't relate to any other medical records that 25 might be held in other places, albeit one would expect Page 199
1 A. No, no. 2 Q. Understood. You tell us, at 107.5, about some of the do 3 not destroy notices. 107.6, you tell us about the do 4 not destroy notice that was issued by the Inquiry, is 5 that right? 6 A. That's correct. 7 Q. And we've been through that already, for various 8 important reasons with Ms Connor. But 107.5, you tell 9 us that: 10 "An NHS Tayside with a Do Not Destroy order was 11 issued by the then NHS Tayside Medical Director ... on 12 26 April 2023 ... to instruct the Health Records 13 Department not to destroy any health records still in 14 existence of patients who were seen or operated on by 15 Mr Eljamel. The instruction was to retain these for 16 a minimum of a further ten years. This order was 17 communicated to all NHS Tayside Health Records Library 18 locations on 26 April 2023 and actioned with immediate 19 effect ..." 20 So this is a period in time before the Inquiry, it's 21 the year before, in fact? 22 A. That's correct. 23 Q. Do you know why it was that was issued in April 2023? 24 A. My understanding is that was as part of the commission 25 of the due diligence report. The medical director at Page 198	1 neurosurgical records to be in the libraries. Is that 2 right? 3 A. Yes, that is correct. 4 Q. So for example, if it were possible that someone was 5 having neuro-oncology treatment, which is a recognised 6 field, it's possible that some records would be held 7 relating to that patient in the neurosurgery records 8 within the library, but would be held within the 9 oncology department separately? 10 A. They may well be, but oncology is for the lifetime of 11 the patient. 12 Q. Right, I see. But in any other department where someone 13 might have received treatment where there was 14 a record -- one of the departments that doesn't hold it 15 in the library, then they wouldn't have received that 16 communication? 17 A. Not as far as I'm aware. 18 THE CHAIR: Sorry, Mr Dawson, can I just pick up on one 19 point. I may have misheard you, because I was trying to 20 write down what you were saying, but you referenced 21 an individual called the "head of health records" in 22 your answer a moment ago. Did you say that whoever that 23 was, the head of health records, was cited on this do 24 not destroy notice in 2023? 25 A. They were -- there was an email, I think it's one of the Page 200

1 exhibits, an email from the executive medical director 2 at the time directly to health records, requesting that 3 they put in an extended retention on any files that were 4 Mr Eljamel's patients. 5 THE CHAIR: All right, thank you. 6 MR DAWSON: Thank you, sir. And that 2003 (sic) do not 7 destroy order wasn't circulated in respect of any other 8 records other than health records, is that right? 9 A. That's my understanding. 10 Q. But by way of contrast with the Inquiry's do not destroy 11 notice, which related to information that may be of 12 relevance to the work of the Inquiry, is that right? 13 A. Yes. 14 Q. Which is a wider category of documentation? 15 A. Yes. 16 Q. And are you aware of whether there were any other -- are 17 these the only do not destroy notices that were issued 18 in connection with records in the hospital? 19 A. I'm not aware of any others that were issued. 20 Q. Right, thank you. 21 A. Sorry, there are other do not destroy -- or other 22 retention for other inquiries or other areas, but not 23 specifically for the Eljamel -- 24 Q. For the Eljamel matters? 25 A. Yes. Page 201	1 Q. Are you aware of any systems which are designed to try 2 to monitor whether people comply with the provisions of 3 those policies? 4 A. No, I'm not aware, other than when the policies are 5 being implemented, if we're relating to subject access 6 requests or just general -- sorry, I'll retract. No, 7 I'm not aware. 8 Q. Okay, thank you. One of the matters that I discussed to 9 some extent with Ms Connor when she was here was various 10 issues that had arisen in the way in which documents 11 were used and processed, which had resulted in there 12 being a number of data breaches. That's obviously 13 something that relates to data protection in general but 14 it has an operational component to it as well. Some of 15 those are in relation to health records, as well as 16 wider types of records. Some of them are in relation to 17 health records of former patients of Mr Eljamel. Is 18 that something you can help us with? My understanding, 19 we were told, is that you couldn't help us with things 20 to do with data protection, or can you help us with 21 that? 22 A. With regards to specific -- 23 Q. Well, can you help us with it at all? 24 A. I just have a broad understanding of the data 25 protection. Page 203
1 Q. Thank you. 2 A. Yes. 3 Q. Thank you for clarifying that. 111.3, please. This was 4 in the context of telling us about systems that had been 5 in place relating to subject access requests, but you 6 make a more general comment there, whereby: 7 "NHS Tayside's policies are made available and 8 communicated to staff across NHS Tayside. The policies 9 have version controls applied, are regularly reviewed 10 and updated to reflect legislative changes, and are 11 approved through Tayside NHS Board's governance 12 processes." 13 So that's talking about the various policies and 14 important information relating to, I think, subject 15 access requests and other matters pertaining to document 16 management that you've mentioned earlier, is that right? 17 A. That's my understanding, yes. 18 Q. Are you aware of there being -- or are you aware of 19 systems which are designed to try to monitor whether the 20 recipients of those policies read them? 21 A. No, I'm not aware of any systems. 22 Q. Are you aware of any systems which exist relating to 23 those policies which are designed to try to monitor 24 whether people who have received them understand them? 25 A. No, I'm not aware. Page 202	1 Q. Right, but in relation to data breaches that have 2 occurred and how they have occurred, is that something 3 you can help us with? 4 A. Unless they have been within the scope of my portfolio 5 then, no. For example, I was -- there was a data breach 6 that had occurred within health records. I'm aware of 7 that and the escalation and the learning process from 8 there. 9 Q. But was that related to Eljamel patients? 10 A. Yes, my understanding it was. 11 Q. Right. So can you tell us about that, please? 12 A. That was an incident that occurred, whereby -- 13 Q. Sorry to interrupt, without any patient names or 14 anything. I'm sure you wouldn't anyway. 15 A. No, where a spreadsheet was shared with additional -- to 16 somebody seeking a subject access request and additional 17 information was shared with them. 18 Q. Okay. 19 A. Of other patients. 20 Q. I see. So someone put in a subject request which, as 21 we've discussed already, is to do with one's own 22 information and in that, some information about other 23 patients appeared, which obviously should not have done? 24 A. That's correct. 25 Q. In relation to that sort of thing, what systems exist to Page 204

1 try to prevent that? I could imagine, for example, 2 there being, because this is sensitive personal data, 3 the requirement to have checks or different people check 4 things. Does that exist? 5 A. Yes, that does exist and I think the learning from there 6 was that it was a file that had been shared as opposed to 7 a single sheet, if you like a workbook -- an Excel 8 workbook instead of a single sheet that had been shared. 9 So yes, it was checked, but it was a human error issue. 10 Q. Right, because -- 11 A. So it was then escalated, reported to ICO and usual 12 process put in place, and apologies given and people 13 notified of the data breach. 14 Q. That doesn't sound much like an investigation into what 15 happened, but are you sort of telling us someone made 16 an error, but it doesn't tell us much about the systems. 17 You know, how could that have happened? 18 A. Okay, it happened because someone shared a full Excel 19 worksheet instead of just a worksheet, if you like, 20 a workbook instead of a worksheet. 21 Q. But that's just a fact. That's what happened. 22 A. Yes, it is. 23 Q. What I'm interested in is trying to work out how does 24 the system enable that to happen? So, for example, 25 I don't run systems like this, but when you're sharing Page 205	1 policies and everything, the legislation that you've 2 listed for us, a lot of it is designed to try to make 3 sure that information of that nature is controlled in 4 the way that people access it. So, do you understand 5 that that can have that effect? 6 A. I absolutely understand that. 7 Q. Thank you. Sir, I have no further questions for 8 Mrs MacLeod. 9 Mrs MacLeod, at this stage I offer all of the 10 witnesses the opportunity to add something if they'd 11 wish to do so to the evidence they've already given so 12 I'd invite you to do that, if you'd like to? 13 A. I would just like to say I have tried to be as honest 14 and open with my -- and give the Inquiry information 15 that I can. I hope that I have been of some help. And 16 I totally understand how difficult this is for patients 17 and their families and the time it has taken for us to 18 get here, and the difficulties that they've experienced 19 in sometimes engaging with NHS Tayside. I hope that the 20 Inquiry is successful and goes some way to help a lot of 21 learning. 22 THE CHAIR: Thank you. We'll take a short break now, 23 Mrs MacLeod. The reason for that is that there may be 24 further questions that are proposed by other 25 participants in the Inquiry, and we have to check what Page 207
1 spreadsheets like that, would it not be some good idea 2 to have somebody else check it before it's sent out, 3 that seems simple? 4 A. Yes, it would, yes. 5 Q. And is that something that is done? 6 A. That wasn't something that was done at that time, is my 7 understanding. 8 Q. As I'm standing here, I could think about multiple ways. 9 You could have an alert that would come up to say to 10 someone: are you sure you're sending this out to the 11 right person and it's not got other information on it? 12 Or something like that. Could that exist? 13 A. Yes. There is a process and a checklist that people go 14 through. Unfortunately, it wasn't gone through. There 15 has been systems that have been put in place now. For 16 example, things are not live Excel sheets, it's pdf 17 documents and things that are sent. 18 Q. Okay. So, as I'm sure you understand -- 19 A. It's quite significant, yes. 20 Q. -- these things are -- you know, it may seem, when 21 you're working in hospital with documents and things 22 like that, and you're not interacting with people like 23 clinicians do, but in reality, that is something that we 24 know has affected a lot of people and that has 25 undermined trust in the systems. Because all of the Page 206	1 the position is first. So, if you go with Ms Miller, 2 she'll look after you in the meantime. 3 A. Okay. Thank you. 4 (4.12 pm) 5 (A short break) 6 (4.22 pm) 7 THE CHAIR: Mr Dawson. 8 MR DAWSON: Nothing further, sir. Thank you. Thank you 9 Mrs MacLeod. 10 A. Thank you. 11 THE CHAIR: Well, Mrs MacLeod you'll have gathered there are 12 no further questions for you to answer. That brings 13 your evidence session to an end. I extend my thanks and 14 those of the Inquiry for your attendance and for giving 15 evidence before us this afternoon. You're free to go. 16 A. Thank you very much. Thank you. 17 (Witness withdrew) 18 Housekeeping 19 THE CHAIR: I take it no further witnesses this afternoon. 20 MR DAWSON: No further witnesses, sir. That brings our 21 section 1 hearings to a close. 22 As was set out at the beginning of the hearings, our 23 plan remains to have hearings in section 2 of our 24 evidential plan, commencing in the week of 30 November 25 of this year, over a three-week period. But in the Page 208

1 meantime, the work of the Inquiry will continue behind 2 the scenes as always. 3 THE CHAIR: A point I'm about to emphasise, but thank you 4 very much, Mr Dawson. 5 At the outset of these hearings about a month ago 6 I expressed the hope that you would find their content 7 informative. 8 A considerable amount of evidence has been led since 9 I spoke to you at that point in time and all of that 10 will be scrutinised and analysed as we move ahead with 11 evidential plans. 12 It does remain for me to express my appreciation of 13 the hard work of the Inquiry team in their preparation 14 for and presentation of these hearings. 15 I also thank core participants and those 16 representing them for their contributions to these 17 proceedings. 18 But I also extend my thanks to those who have 19 followed the evidence from elsewhere. Knowing that you 20 are doing so is, itself, a source of support and 21 encouragement to the whole of the team in its 22 endeavours. 23 The end of these hearings happens to coincide with 24 a Friday afternoon, so I extend to you all best wishes 25 for a good weekend, and I assure you that we will be Page 209	1 INDEX 2 PAGE 3 PROFESSOR1 4 ANNE-MAREE FARRELL (continued) 5 PROFESSOR KIERAN WALSH1 6 (continued) 7 DR FAY GILDER1 8 (continued) 9 Questions by1 10 COUNSEL TO THE INQUIRY (continued) 11 Housekeeping125 12 MRS SANDRA MACLEOD131 13 (affirmed) 14 Questions by131 15 COUNSEL TO THE INQUIRY 16 Housekeeping208 17 18 19 20 21 22 23 24 25 Page 211
1 back in touch with you again shortly. 2 These hearings are now adjourned. 3 (4.25 pm) 4 (Section 1 hearing concluded) 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 210	

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