

Witness Name: Dr James Cotton, Executive Medical Director NHS Tayside,
on behalf of NHS Tayside
Statement No: NHST-04944

Dated: 08 June 2026

ELJAMEL INQUIRY WRITTEN STATEMENT OF DR JAMES COTTON

I, Dr James Cotton, will say as follows:-

Appendix B - Part A – Your roles and responsibilities

1. **Please set out your qualifications. If there is more than one contributor to the statement, please set out the qualifications of each, with a description of which part(s) of the statement each one contributed and why.**
 - 1.1 Please see response to Question 2. NHS Tayside has listed the questions that each individual below has contributed to in Appendix 1 [NHST-04945].
 - 1.2 The individuals listed in response to Question 2 are all senior leaders within NHS Tayside who contribute to the strategic leadership of the organisation. They all form part of the Chief Executive Team (CET), which is the group of employees who directly report to the Chief Executive and assist them in the strategic leadership of NHS Tayside.
2. **Please explain your professional/ occupational background, in particular focussing on roles and the responsibilities which you held/ hold relevant to the neurosurgical department of Ninewells Hospital of Mr Eljamel. If you wish, you may exhibit a CV/ CVs with your statement.**

- 2.1 I am Nicky Connor, RGN, Bachelor of Nursing, MSc in Primary Care. I am Chief Executive of NHS Tayside, a position I have held since July 2024, and an executive member of NHS Tayside Board. I qualified from the University of Dundee in 1997. I was Chief Officer/Director of Health and Social Care in Fife from 2019 to 2024 and have previously held senior nursing leadership roles in NHS Fife. As Chief Executive I also hold the role of Accountable Officer for NHS Tayside.
- 2.2 I do not and have never practised clinically within the Neurosurgical department at Ninewells Hospital. I am also NHS Tayside's Accountable Officer, and this includes the Neurosurgery department. I worked at Ninewells Hospital while a student nurse between 1994 to 1997, before commencing a role as a registered nurse in February 1997.
- 2.3 I have contributed to the responses in this witness statement request that relate to the loss of the theatre logbooks at Ninewells Hospital as I have commissioned internal and external investigations relating to this matter in Part E, 114-117.
- 2.4 I am Dr James Cotton, MBChB, FRCP (Edin). I am the Executive Medical Director for NHS Tayside, Responsible Officer (RO), and an executive member of NHS Tayside Board. I qualified from the University of Dundee in 1996. I was appointed a Consultant Gastroenterologist in 2006 within NHS Tayside. I have been the Executive Medical Director, RO, and executive board member for NHS Tayside since 2024.
- 2.5 I do not and have never practised clinically within the neurosurgical department within NHS Tayside. However, as Executive Medical Director and RO, I do hold overall responsibility for the clinical practice of doctors working within the Neurosurgery department within NHS Tayside.
- 2.6 I have responded to the questions within this witness statement request that relate to the practice of Mr Eljamel as a doctor, and questions more generally regarding the custom and practice of doctors, as well as questions relating to professional and clinical governance, including those regarding the General Medical Council (GMC), and the questions that relate to previous reviews and investigations in Part B: 8g, 8h, 8i, 8l-8o, 8q, 8s, 8t, 8w, 8x, 8bb, 9a-9j, 10a (part), 10d, 10e, Part C: 13, 22-24, 31, 33, 34 Part E: 102, 109, 113-117 (with the exception of 114.26-114.50), Part F:

118, 119, 124-223, Part G: 224, Part H: 226-228. These areas fall within my area of expertise and responsibility.

- 2.7 I am Jane Duncan. I am the Director of Communications and Engagement for NHS Tayside. I completed a graduate journalism traineeship with DC Thomson newsrooms from 1993 to 1994. I worked as a journalist from 1993 to 2002 for DC Thomson news titles, and latterly as News Editor at the Evening Telegraph Dundee. I joined NHS Tayside in 2002 as a Corporate Communications Manager. I took up the role of Head of Corporate Communications for NHS Tayside in 2011 and was subsequently appointed Director of Communications and Engagement in May 2019. In this role, I have strategic and leadership responsibilities for the execution of internal and external communications to align with organisational goals. I provide advice to senior leadership on corporate communications and engagement.
- 2.8 I do not and have never worked or held responsibilities in relation to the Neurosurgical department within NHS Tayside. The Neurosurgical department, as an internal department of NHS Tayside, would receive all-staff, corporate communications messages and information in the same way and at the same time as all other departments. There were no specific Neurosurgery department internal or external communications channels which were the responsibility of corporate communications. External communications relating to the Neurosurgery department which would be the responsibility of the corporate communications team would be responses to ad hoc media inquiries and any proactive media and/or public communications related to the work of the neurosurgery department.
- 2.9 I have responded to questions within this witness statement request as they relate to my responsibilities regarding external communications Part C: 11, 12, Part H: 228. These areas fall within my area of expertise and responsibility.
- 2.10 I am Simon Dunn, RGN, BSc Nursing, MSc Leadership. I am the Executive Nurse Director for NHS Tayside, and an executive member of NHS Tayside Board. I qualified from the University of Dundee in 2004. I worked in three Health Boards across Scotland, NHS Fife, Healthcare Improvement Scotland and NHS Lothian, prior to joining NHS Tayside in 2021 as Corporate Nurse Director. During the relevant time period (1995-2015) the roles I held were; April 2004 –Sept 2007, Staff Nurse, Surgery NHS Fife, Sept 2007–May 2008, Staff Nurse, Surgery, NHS Lothian, May 2008-Feb 2009, Deputy Charge Nurse, Colorectal Surgery, NHS Lothian, Feb

2009-Jan 2014, Senior Charge Nurse, Colorectal Surgery/Gastroenterology, NHS Lothian, Jan 2015–Sept 2016, Clinical Nurse Manger Cardiology, NHS Lothian. I did not work at Healthcare Improvement Scotland during the relevant time period. I was appointed Executive Nurse Director, and an executive member of the NHS Tayside Board in November 2024. My role as Executive Nurse Director provides strategic and professional leadership for Nursing, Midwifery and Allied Health Professions across NHS Tayside.

- 2.11 I do not and have never practised clinically within the Neurosurgical department at Ninewells Hospital and/or NHS Tayside. However, as Executive Nurse Director, I do hold overall responsibility for the clinical practice of nurses working within the Neurosurgery department within NHS Tayside.
- 2.12 I am the joint Executive Lead for Clinical Governance in NHS Tayside. This role involves ensuring that NHS Tayside implements a clear Clinical Governance Framework and has a system and processes to assure the Clinical Governance arrangements up to Board Clinical Governance Committee.
- 2.13 I have responded to the following questions within this witness statement request that relate to clinical governance (including adverse events), whistleblowing, complaints and feedback in Part B: 8r, 8y, 10a (part), 10c, Part F: 120-123, Part G: 225, Part H: 228. These areas fall within my area of expertise and responsibility.
- 2.14 I am Margaret Dunning, MBA. I am the Board Secretary for NHS Tayside. I hold a Master of Business Administration from Abertay University (1996). I have worked in both NHS Fife and NHS Tayside. I started my career as a Domestic Services Manager, moving to Hospital Management prior to taking up my first corporate role as Corporate Services Manager for Dundee Healthcare NHS Trust in October 1994. I then became Corporate Services Manager for Tayside Primary Care Trust. These two posts involved responsibility for corporate governance and corporate communications. My first role with Tayside NHS Board was in 2002 as Head of Corporate Communications, this post involved responsibility for internal and external corporate communications, then Board Secretary from February 2004 to present. My role as Board Secretary provides strategic and professional leadership for Corporate Governance, Risk and Resilience Planning, Information Governance and Cyber Assurance, Patient Liaison Response Team (PLRT) and Public Inquiries

Support across NHS Tayside. I am also NHS Tayside's Senior Information Risk Owner (SIRO).

- 2.15 The role of SIRO is a senior management position with responsibility for information risk. That is the potential for harm arising from the way information is collected, stored, processed, shared, or used and for providing assurance that information risk is managed appropriately and effectively. From 1 April 2026 I will not be the NHS Tayside's Information Risk Owner nor have responsibility for Information Governance and Cyber Assurance in NHS Tayside. Additionally, from 1 June 2026 I will no longer have responsibility for PLRT.
- 2.16 I do not and have never worked in or held responsibilities in relation to the Neurosurgical department within NHS Tayside. In my role as Board Secretary, I do not have any responsibility for operational service delivery. The responsibility for complying with Corporate Governance, Risk and Resilience and Information Governance is the responsibility of neurosurgical department.
- 2.17 I have responded to the questions within this witness statement request that relate to the history of the NHS Trusts and NHS Board, the associated personnel and governance arrangements and structures of the Health Services in Tayside, and to those questions that relate to data protection and information governance in Part B: 3-8c, 8e, 8p, 8u, 8v, Part C: 20, Part E: 102-105, 110, Part H: 226-227d and 228. These areas fall within my areas of expertise and responsibility.
- 2.18 I am Sandra MacLeod, BSc. Nursing, MBA. I was the Interim Deputy Chief Executive for NHS Tayside, a seconded role since February 2023 until 27 February 2026. This role held Executive Lead responsibility for Mental Health & Learning Disability Adult services which are Board retained, Digital Directorate, Performance & Activity and Facilities, including Deputising for the Chief Executive when required. I have previously held posts as Chief Officer, Aberdeen City Integration Joint Board, and have previously held positions at Director level across private health and social care organisations. I completed my nurse training as an Enrolled Nurse (1986-1988) and then completed additional training to become a Registered General Nurse (1991-1993), working at Stracathro Hospital from 1988 to 1997. I held Registered Nurse registration from 1988 until 2023. I hold a BSc Nursing from Abertay University post registration (1996), a Master of Business Administration from Abertay University (2004), and a Project Management Qualification APM (2015).

- 2.19 I have not worked at Ninewells Hospital within a clinical environment, except during my training in 1991 (three-month training placement in paediatrics), and have not worked at Ninewells at any other time.
- 2.20 I have responded to the questions within this witness statement request that relate to medical records management and the Legal Team in Part B: 8z, Part E: 100, 101, 103-108, 111, 112, Part H: 228. This area falls within my area of responsibility.
- 2.21 I am Lynn Smith. I am the Chief Officer for Acute Services. I joined NHS Tayside in December 1993 after completing a BA(Hons) in Business Studies. I also hold a Postgraduate Diploma in Human Resource Management. I spent the first two years of my career working within the Site Management and Operational Services teams at Dundee Royal Infirmary (DRI), Ninewells Hospital and Dundee Dental Hospital, building a foundation of knowledge in key hospital support services and functions.
- 2.22 In 1995, I was appointed to the Deputy Site Manager/Associate Business Manager with responsibility for delivery of specific services, production and presentation of papers, and exposure to service data analysis and financial planning. I moved into the Research & Development Business Manager role in 1997 and was responsible for establishing the Research and Development function within NHS Tayside. In 1999, I was appointed to a Clinical Team Manager role in the Medicine Directorate and supported a flexible portfolio of service delivery within Gastroenterology, Respiratory, Infectious Diseases and Cardiology. In 2003, I was seconded into a 3-year Service Improvement Advisor role for the national Cancer Service Improvement Programme where I worked with multidisciplinary colleagues across the North of Scotland and nationally to review and redesign current cancer patient pathways to ensure efficient and effective care delivery models and also support delivery of 31 and 62 day targets.
- 2.23 In 2006, I returned to a Clinical Team Manager role within the Critical Care Directorate where I had managerial responsibility for service delivery at Stracathro Ambulatory and Diagnostic Treatment Service and Renal Services. During this period the Scottish Regional Treatment Centre (SRTC) at Stracathro was progressed and in 2008 I moved into the SRTC Contracts manager post for the final 12 months of independent sector framework model (Netcare).

- 2.24 In 2009, I moved into the Clinical Services Manager role for Specialist Services, Oncology, Haematology and Renal with responsibility to effectively manage the delivery of quality services whilst optimising available resources, aligned to local, regional and national strategy. In 2016, I was successfully appointed to the Associate Director, Access and Assurance role (where I also held the deputy role for the Chief Officer for Acute Services). As well as managerial leadership for the clinical services delivery within the Access portfolio, I also had the leadership role for delivery of the planned care and cancer care programmes in Acute Services.
- 2.25 I was appointed as Chief Officer for Acute Services in June 2024, having held the interim position since December 2023. My role as Chief Officer for Acute Services provides strategic leadership and direction in the planning, management and delivery of all clinical and non-clinical Acute Services within NHS Tayside.
- 2.26 The Neurosurgery department within NHS Tayside is one of the departments within my remit.
- 2.27 I have responded to the questions within this witness statement request that relate to the neurosurgery department, specialist services clinical care group, and acute services, including the organisation and management of these areas in Part B: 8d, 8f, 8j, 8k, Part C: 14-19m, 25-30, 32, Part E: 107, 108, Part H: 228. These areas fall within my areas of expertise and responsibility.
- 2.28 I am Elaine Watson, MA Leadership, CIPD. I am the Director of People and Culture. I hold an MA Leadership (Royal Roads University, British Columbia, Canada, 2013). I am a Chartered Member of the Chartered Institute of Personnel & Development (CIPD, Dundee College, 2000). I was appointed to the role of Director, People & Culture for NHS Tayside in September 2023 following 20 years in the Canadian health system. Prior to my time in Canada, I worked in the Human Resources Department of Dundee Teaching Hospitals NHS Trust and Tayside University Hospitals NHS Trust between 1995 and 2002. Initially as a Personal Assistant providing administrative support to the Director of Human Resources, and then as a Human Resources Advisor providing professional human resources support to various departments across the organisation. In my role as HR Advisor I may have been involved in human resources issues within the Neurosurgery department from time to time, however I did not have any dealings with Mr Eljamel. In my current role

I am responsible for all workforce practices, policies and governance across NHS Tayside.

- 2.29 I have responded to the questions within this witness statement request that relate to human resources, including those relating to the posts and positions that Mr Eljamel held, and associated documentation in Part B: 8aa, 10b, 10f, Part C: 21, 35-38, Part D: 39-99, Part H: 228. These areas fall within my areas of expertise and responsibility.

Appendix B - Part B –Structures and key individuals

3. Please provide an overview as to the NHST’s role, function and responsibilities over the relevant period with regard to the provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under its control.

3.1 Tayside Health Board, commonly known as Tayside NHS Board or NHS Tayside, is one of Scotland’s fourteen territorial Health Boards. It was established in 1974 by the National Health Services (Scotland) Act 1972 [NHST-04333]. It serves the population of the Tayside region, which encompasses the local authority areas of Angus, Dundee City, and Perth and Kinross. Acute healthcare services are also provided to North East Fife. The main legislation providing the legal framework for the NHS in Scotland is the National Health Services (Scotland) Act 1978 [NHST-04332].

3.2 The role, function and responsibilities of NHS Tayside changed significantly over the relevant period with regards to the provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under its control. Between 1993 and 2004 NHS Trusts had the responsibility of providing patient care. During this period, Health Boards were primarily responsible for the protection and improvement of the health of their resident populations and did not have direct responsibility for healthcare delivery. Neurosurgical care was delivered as part of the acute healthcare service and provided at DRI until its closure in 1998. Thereafter, the Neurosurgery Department relocated to Ninewells Hospital and Medical School, Dundee. Further information about the Neurosurgery department is included in the response to Question 14. DRI and Ninewells Hospital and Medical School operated under the supervision of Dundee Teaching Hospitals NHS Trust until it was dissolved on 1 April 1999. Ninewells Hospital and Medical School then operated under Tayside University Hospitals NHS Trust until 2004, and Tayside NHS Board thereafter.

3.3 The creation of NHS Trusts in Scotland was driven by UK-wide reforms introduced in the early 1990s. The key policy document was the White Paper “Working for Patients” (1989) [NHST-04334], which set out the internal market reforms for the NHS across the UK. These reforms aimed to separate purchasers and providers of

healthcare. It gave hospitals and other units the option to become self-governing NHS Trusts with greater financial and managerial autonomy.

- 3.4 In Scotland, these changes were implemented through secondary legislation and administrative orders under the framework of the National Health Service (Scotland) Act 1978 [NHST-04332], which was amended to allow the establishment of NHS Trusts.
- 3.5 From 1993, NHS Trusts operated as separate legal entities responsible for delivering healthcare services and employing their own staff. During this period, Tayside Health Board acted primarily as a commissioner and purchaser of healthcare services through a contracting process for the Tayside population.
- 3.6 Health Policy was devolved to the Scottish Parliament on 1 July 1999 under the Scotland Act 1998 [NHST-04335].
- 3.7 Prior to 1 April 1999 there were four NHS Trusts operating in Tayside:
 - Angus NHS Trust.
 - Dundee Healthcare NHS Trust.
 - Dundee Teaching Hospitals NHS Trust was the only NHS Trust by which neurosurgical services were provided in Tayside.
 - Perth and Kinross Healthcare Trust.
- 3.8 These four NHS Trusts were dissolved and replaced by the Tayside Primary Care NHS Trust and the Tayside University Hospitals NHS Trust on 1 April 1999. Tayside University Hospitals NHS Trust became responsible for neurosurgical services at Ninewells Hospital and Medical School from 1 April 1999 until 30 March 2004. Neurosurgical care was provided at DRI until its closure in 1998. Thereafter, the Neurosurgery department relocated to Ninewells Hospital and Medical School, Dundee. Neurosurgical care in Tayside was not routinely delivered elsewhere during the time period 1995-2004.
- 3.9 In May 2001, Rebuilding Our National Health Service [NHST-04434] introduced changes to the governance arrangements in NHS Scotland to promote partnership and collaboration across NHS Scotland, although the NHS Trusts would remain in

place until new unified NHS Boards were established. This was primarily a change to membership and role of Health Boards as opposed to a unification of the actual structures at this time.

- 3.10 In March 2003, Our National Health: a Plan for Action, a Plan for Change and the Scottish Executive guidance HDL(2003)11 [NHST-04336] "Partnership for Care, NHS Scotland's White Paper" [NHST-04337] announced arrangements to dissolve NHS Trusts as separate legal entities and for their functions, staff and assets to be transferred to new operating divisions of NHS boards.
- 3.11 Under the National Health Service Reform (Scotland) Act 2004 [NHST-04338], all Scottish NHS Trusts were dissolved and replaced by operating divisions reporting to the fifteen Scottish territorial Health Boards. In Tayside this formed the new local health system, with a single unified governing NHS Board accountable for improving the health of its local population and for delivering the healthcare required through the two Tayside operating divisions.
- 3.12 Following the dissolution of Tayside University Hospitals NHS Trust and Tayside Primary Care NHS Trust, their functions and services were brought under the governance of Tayside NHS Board. While the original NHS Trusts ceased to exist as separate legal entities, their operational structures were retained and reconfigured as two divisions. The Acute and Primary Care Operating Divisions were both established on 1 April 2004. The Acute Operating Division became responsible for neurosurgical services at Ninewells Hospital and Medical School. These arrangements remained until the establishment of a single delivery unit for NHS Tayside in 2006. The delivery unit was disbanded on 1 April 2011.
- 3.13 From 1 April 2011, NHS Tayside has continued to function as a unified Health Board with the following purpose, objectives and functions remaining in place since its formation as an NHS Board on 1 April 2001:
- 3.14 Purpose
- Efficient, effective and accountable governance of the local NHS system.
 - Strategic leadership and direction.

3.15 Overall Objectives

- Improve health of local people.
- Improve health services for local people.
- Focus on health outcomes and patients' experience of the local NHS system.
- Promote integrated health and community planning.
- Promote single focus of accountability for performance of local NHS system.

3.16 Key Functions

- Strategy development.
- Resource allocations.
- Implementation of Local Health Plan.
- Performance management.

3.17 In January 2019 the Scottish Government published the first edition of the Blueprint for Good Governance [NHST-04341] and this confirmed the five core functions of the NHS board as:

- *“Setting the Direction – Establish vision, values, and strategic priorities.*
- *Holding to Account – Ensure delivery of objectives and scrutinise performance.*
- *Assessing Risk – Identify, manage, and monitor strategic risks.*
- *Engaging Stakeholders – Involve patients, staff, partners, and communities in decisions.*
- *Influencing Culture – Shape and model an open, learning, and improvement-focused culture.”*

3.18 At the time of writing, these remain the current five core functions of the Tayside NHS Board.

4. Please provide an explanation of the role and status of the following bodies, with particular regard to any role which they played in the provision of neurosurgical services in Tayside over the relevant period:

(a) Dundee Healthcare NHS Trust (see NHST-00001, page 9)

- 4(a).1 Dundee Healthcare NHS Trust was one of four Tayside NHS Trusts and was operational from 1 April 1994 until it was dissolved on 1 April 1999. This NHS Trust had no responsibility for neurosurgical services.

(b) Dundee Teaching Hospitals NHS Trust (see NHST-00001, page 10; NHST-00206, page 1);

- 4(b).1 Dundee Teaching Hospitals NHS Trust was one of four NHS Trusts in Tayside and was operational from 1 April 1993 until it was dissolved on 1 April 1999.
- 4(b).2 Dundee Teaching Hospitals NHS Trust had operational responsibility for the provision and delivery of neurosurgery which was part of the Neurosciences Directorate. The Neurosciences Directorate transferred from DRI to Ninewells Hospital and Medical School in November 1998 [NHST-01582].

(c) Perth & Kinross Healthcare NHS Trust (see NHST-00001, page 12)

- 4(c).1 Perth & Kinross Healthcare NHS Trust was one of four NHS Trusts in Tayside and was operational from 1 April 1993 until it was dissolved on 1 April 1999. This NHS Trust had no responsibility for neurosurgical services.

(d) Tayside Health Council (see for example NHST-00002, page 11);

- 4(d).1 Tayside Health Council was an independent body established under Section 7 of the National Health Services (Scotland) Act 1978 [NHST-04332]. Each Health Board in Scotland had a local Health Council, the role of which was to represent the interests of the public in the planning and operation of NHS services within each local Health Board area.
- 4(d).2 The members of the Health Council were lay members, and the administrative staff were employed by Tayside Health Board.
- 4(d).3 Local Health Councils were dissolved on 1 April 2005 by virtue of section 8 of the National Health Service Reform (Scotland) Act 2004 [NHST-04338], as specified in the Dissolution of Local Health Councils (Scotland) Order 2005 [NHST-04339].

4(d).4 Tayside Health Council had no responsibility for neurosurgical services.

(e) Angus NHS Trust (see for example NHST-00002, page 11); and

4(e).1 Angus NHS Trust was one of four NHS Trusts in Tayside and was operational from 1 April 1993 until it was dissolved on 1 April 1999. This NHS Trust had no responsibility for neurosurgical services.

(f) Tayside University Hospitals NHS Trust (see for example NHST-00204, page 2).

4(f).1 Tayside University Hospitals NHS Trust, along with Tayside Primary Care NHS Trust, was created from the merger of the four previous NHS Trusts in Tayside.

4(f).2 Tayside University Hospitals NHS Trust was operational from 1 April 1999 until it was dissolved on 1 April 2004.

4(f).3 Tayside University Hospitals NHS Trust took over operational responsibility for the provision and delivery of neurosurgery from Dundee Teaching Hospital NHS Trust. Neurosurgery was part of the Neurosciences Directorate at Ninewells Hospital and Medical School, Tayside Primary Care NHS Trust did not have any responsibility for neurosurgical services.

5. Please provide an explanation of the areas related to the care of Mr Eljamel's neurosurgical patients in which the NHST (a) had exclusive responsibility; and (b) had shared competence with other government departments, agencies and public bodies over the relevant period. As regards (b) please set out how NHST's responsibilities overlapped or interacted with the responsibilities of those other bodies in that regard.

5(a).1 From 1 April 1993 to the date it was dissolved on 1 April 1999, Dundee Teaching Hospitals NHS Trust had exclusive responsibility for the acute care of neurosurgical patients, which would include patients Mr Eljamel treated from his start date in 1995.

- 5(a).2 From 1 April 1999 to the date it was dissolved on 1 April 2004, Tayside University Hospital NHS Trust took over exclusive responsibility for the acute care of neurosurgical patients, which would include Mr Eljamel's neurosurgical patients.
- 5(a).3 From 1 April 2004, NHS Tayside, as a unified NHS Board, replaced the split structure of Health Boards and NHS Trusts. NHS Tayside was exclusively responsible for planning, resource allocation, service delivery and governance for the acute care of neurosurgical patients in Tayside, which would include Mr Eljamel's neurosurgical patients. The NHS Board delegated responsibility to various Board Committees, and the NHS Board retained overall accountability.
- 5(a).4 The delivery of General Practice for Mr Eljamel's neurosurgical patients was the responsibility of Tayside and North East Fife General Practitioners (GPs) for the whole of the relevant period.
- 5(b).1 From 1 April 1993 until 1 April 2004, the internal market existed within the NHS in Scotland. NHS Tayside and Fundholding GPs purchased health care services through contracts from the NHS Trusts who were the providers of services. This was known as internal market with the purchaser / provider split.
- 5(b).2 NHS Tayside was the commissioner / purchaser of neurosurgical services for the Tayside and North East Fife populations through a formal contracting process.
- 6. Please provide a high-level overview of the structure of the NHST and a list of key individuals and their roles within the NHST over the relevant period, insofar as relevant to the neurosurgical service provided by it and the matters covered by the Inquiry's Terms of Reference and List of Issues by way of organogram if necessary. In particular, please explain the period for which the structural document at NHST-00203 (dated February 2000) is an accurate illustration of the broad corporate structure of NHST.**
- 6.1 Where known, a list of key individuals and their roles within the NHS Tayside health system over the relevant period from 1 April 1994 to 2015, insofar as relevant to the neurosurgical services, is listed under Questions 14 and 17.

6.2 The structural documents [NHST-00204; NHST-00203] are accurate illustrations of Tayside University Hospitals NHS Trust in 1999 and 2000. This structure remained in place until 2004, when its functions and services were brought under the governance of Tayside NHS Board.

6.3 From 1 April 2004 the operational service delivery operated under the supervision of the Divisional Acute Services Committee until 1 April 2006. From that date operation service delivery was the responsibility of the Delivery Unit Committee until 1 April 2011, and thereafter Tayside NHS Board.

6.4 A list of Tayside Board Members and their roles within NHS Tayside over the relevant time period is included in Appendix 2 [NHST-04945]. This provides lists of the key individuals and their roles in these corporate bodies over the relevant period, outlined below:

1 April 1994 to 1 April 1999:

- Dundee Teaching Hospitals NHS Trust.
- Tayside Health Board.

1 April 1999 to 1 April 2004:

- Tayside University Hospital NHS Trust.
- Tayside Health Board.

1 April 2004 to 1 April 2006:

- Tayside NHS Board.
- NHS Tayside's Divisional Acute Services Committee.

1 April 2006 to 1 April 2011:

- Tayside NHS Board.
- NHS Tayside's Delivery Unit Committee.

1 April 2011 to 1 April 2015:

- Tayside NHS Board.

6.5 The operational delivery structure during the relevant period broadly followed a divisional model. Acute services were organised into divisions, within which sat

clinical care groups, and individual speciality services such as Neurosurgery. This model was in place in 1999.

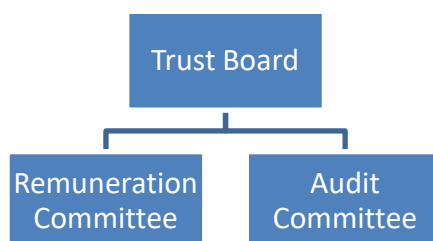
- 6.6 In 1995 within Dundee Teaching Hospitals NHS Trust Neurosurgery was part of the Neurosciences Directorate [NHST-00001].
- 6.7 Shortly after its establishment, Tayside University Hospitals NHS Trust Board, considered a paper on 30 June 1999 along with an accompanying organogram [NHST-00204]. This organogram illustrates the NHS Trust's structure at that time.
- 6.8 The document contained in NHST-00203 accurately reflects the Tayside University Hospitals NHS Trust structure from 2000, prior to the introduction of additional management tiers.
- 6.9 In around 2010, Associate Medical Directors were introduced, with responsibility for large clinical areas, for example all of Surgery, Anaesthesia and Critical Care. They were introduced as an additional tier of management, with associated nursing and non-clinical (business) managers. They reported to the Operational Medical Director (a post introduced at around the same time).
- 6.10 The structure for Neurosurgery is shown in the included present-day acute services organogram [NHST-04342; NHST-04343; NHST-01573] and remained largely the same throughout the relevant period as outlined in response to Question 8(j).

7. In particular, please set out the corporate structures, groups, committees, working groups, specialist bodies and other investigatory or decision-making bodies with responsibility for the systems within NHST relating to matters covered by the ToRs including a broad description of the remit of each and how their roles in this regard (a) interacted with each other and (b) changed over the relevant period (including but not limited to those bodies set out in the question immediately below).

- 7.1 The corporate structures are set out in the following sections. NHS Tayside has listed the remits of the Clinical Governance Committee (or its equivalent) which it considers relevant to the work of the Inquiry.

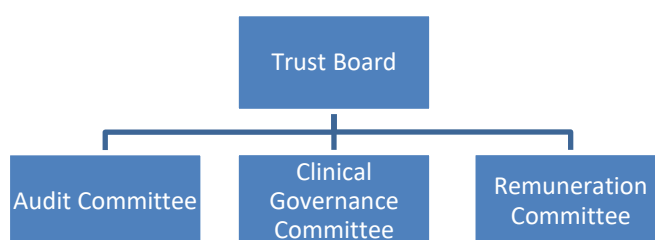
7.2 1 April 1994 to 31 March 1999 - Dundee Teaching Hospitals NHS Trust

7.3 Dundee Teaching Hospitals NHS Trust had two standing committees from its inception to 31 March 1999: Clinical Governance was first defined / introduced to the NHS in Scotland by NHS MEL(1998)75 [NHST-00231]. This circular provided guidance on the implementation of clinical governance in the NHS in Scotland with effect from 1 April 1999. Prior to this, Dundee Teaching Hospitals NHS Trust had a Quality Strategy [NHST-04414]. Before the term Clinical Governance was in use in the NHS, the term 'Quality' was used to describe the strategy to deliver the highest possible standard of healthcare, with a focus on safe, effective and person-centred care.



7.4 1 April 1999 to 20 March 2004 - Tayside University Hospitals NHS Trust

7.5 The standing committee structure of Tayside University Hospitals NHS Trust was as follows:



7.6 The Clinical Governance Committee's remit as of 1999 was as follows:

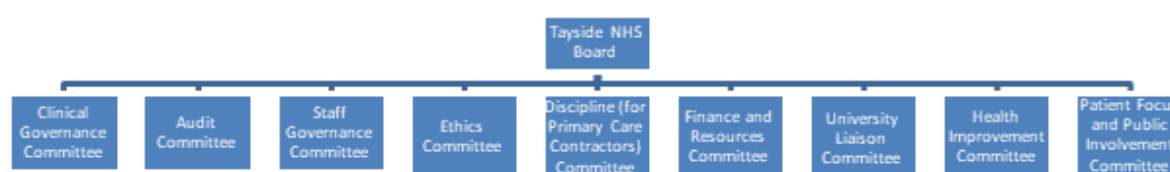
- To support clinical staff in improving quality of care.
- To be responsible for the oversight of the clinical governance of the Trust so as to assure the Board that the arrangements were working.
- To ensure and report to the Trust Board that appropriate structures were in place to undertake the activities which underpinned clinical governance.

- To bring to the attention of the Trust Board regular reports on the operation of the system and specific reports on any problems that emerged.
- To ensure systems were in place within which judgement was exercised so as to reduce the possibility of poor performance and to ensure that wherever possible problems were remedied before questions of discipline arose.
- To ensure the care delivered within the Trust met agreed standards.
- To ensure that unacceptable clinical practice will be detected and addressed.
- To prepare a report for inclusion within the Trust's Annual Report, giving a full account of their activities related to clinical governance which should also include "the report card to the community" and should include graphic presentations (as recommended by Chris Wilson, Consultant to the Scottish Office on Clinical Governance).
- To ensure the recommendations following Fatal Accident Inquiries and complaints were applied.
- To view the results of Clinical Audit and Critical Incident Reporting.
- To be assured of corrective action following patient and staff surveys.
- To agree clinical performance indicators with pertinent staff.

[NHST-04497].

7.7 2001 - 2003 Tayside NHS Board Standing Committee Structure

Prior to 2001 Tayside Health Board had no responsibility for direct service delivery.



7.8 The Clinical Governance Committee had the following key roles [NHST-04701_32]:

- Systems assurance - to ensure that clinical governance mechanisms were in place and effective throughout the local NHS system. Tayside University Hospitals NHS Trust had its own Clinical Governance Committee (as noted in 7.5 above) as did Tayside Primary Care NHS Trust.
- Public Health governance - to ensure that the principles and standards of clinical governance were applied to the health improvement activities of the Tayside NHS Board.

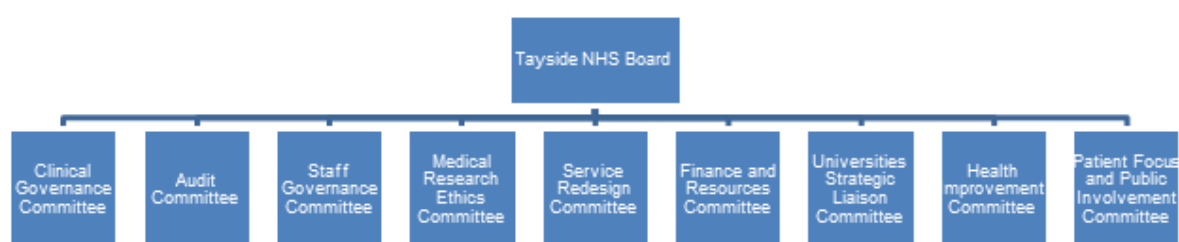
- To assure the Tayside NHS Board and the citizens of Tayside of the quality of the care provided for the people served.
- To monitor improvements in the quality of care provided for the people served by NHS Tayside.

7.9 The work of the committee covered the following areas:

- Quality and Clinical Effectiveness.
- Quality Indicators.
- Risk Management.
- Patient Participation.
- Patient Satisfaction.
- Staff Training and Education.
- External Assessment.
- Accreditation and Complaints.

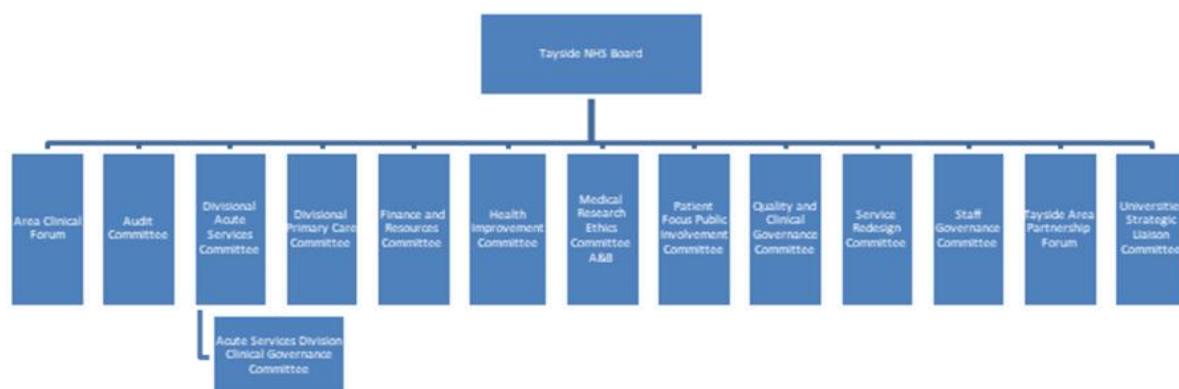
The remit of the Clinical Governance Committee is as detailed in *NHST-04941*, this provides further information on how the Clinical Governance Committees for each Trust interacted and worked jointly between Tayside University Trust and Tayside NHS Board to deliver high quality modern healthcare in Tayside.

7.10 2003 - 2004 Tayside NHS Board Standing Committee Structure



7.11 The Clinical Governance Committees key roles were the same as in years 2001-2003.

7.12 2004 – 2005 Tayside NHS Board Standing Committee Structure

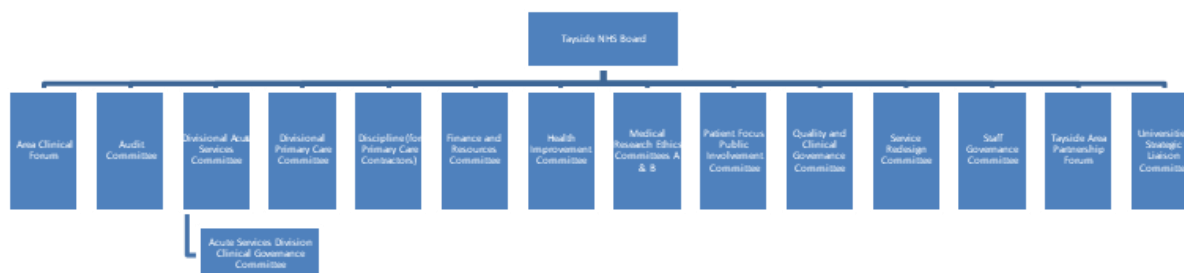


7.13 The key roles of the Quality & Clinical Governance Committee (previously the Clinical Governance Committee) were the same as in years 2001-2004. In the diagram above the Acute Services Division Clinical Governance Committee is shown reporting to the Divisional Acute Services Committee. Neurosurgical Services was a service within Acute Services therefore the Acute Services Division Clinical Governance Committee is relevant to the Inquiry's ToR.

7.14 The standing committee structure in 2004-2005 changed to reflect the inclusion of the Divisional Acute Services and Divisional Primary Care Committees.

7.15 A sub-committee of the Divisional Acute Services Committee was the Acute Services Division Quality & Clinical Governance Committee. This sub-committee provided assurance to the Board through the Acute Services Divisional Committee that clinical governance mechanisms were in place and effective throughout the Division, all in accordance with approved Board policies.

7.16 2005 - 2006 Tayside NHS Board Standing Committee Structure

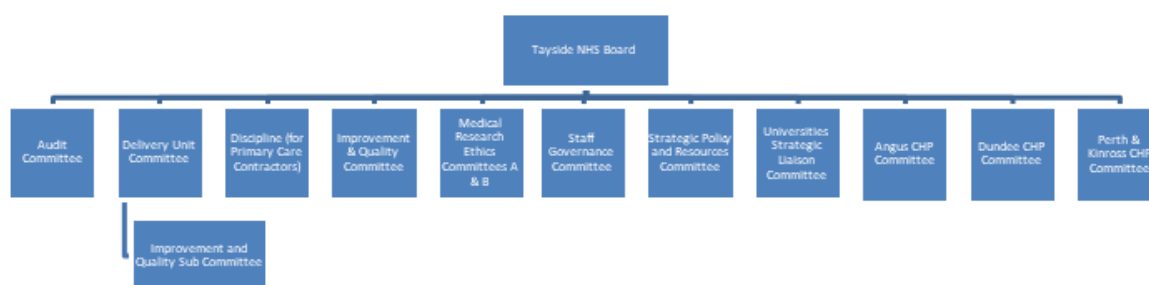


7.17 The key roles of the Quality & Clinical Governance Committee (previously the Clinical Governance Committee) were the same as in years 2001-2005. In the diagram above the Acute Services Division Clinical Governance Committee is shown reporting to the Divisional Acute Services Committee. Neurosurgical Services was a service within Acute Services therefore the Acute Services Division Clinical Governance Committee is relevant to the Inquiry's ToR.

7.18 The remit of the Acute Services Division Quality & Clinical Governance Committee was to:

- Approve and monitor clinical governance activity, ensuring appropriate action was taken where necessary.
- To review reports from internal clinical and non-clinical departments and external organisations i.e. inspector bodies such as Audit Scotland.
- To approve, monitor and take appropriate action in relation to action plans.

7.19 2006 - 2008 Tayside NHS Board Standing Committee Structure



7.20 The purpose of the Improvement & Quality Committee (previously the Clinical Governance Committee then the Quality & Clinical Governance Committee) was to provide Tayside NHS Board with the assurance that [NHST-04702_11]:

- Mechanisms were in place and effective throughout NHS Tayside to support improvement.
- The principles and standards of Partnership for Care 2003 [NHST-04337] were applied to the improvement activities of NHS Tayside.
- Clinical/health governance mechanisms were in place and effective throughout the whole of NHS Tayside including social inclusion, public health and health improvement activities.
- To ensure a strategic framework for patient and public involvement was in place including support for members of the Public Partnership (health) Groups (PPGs) and to monitor and evaluate this.

- To ensure the governance arrangements for equality and diversity.

The remit of the Improvement & Quality Committee is as detailed in *NHST-04702_11*.

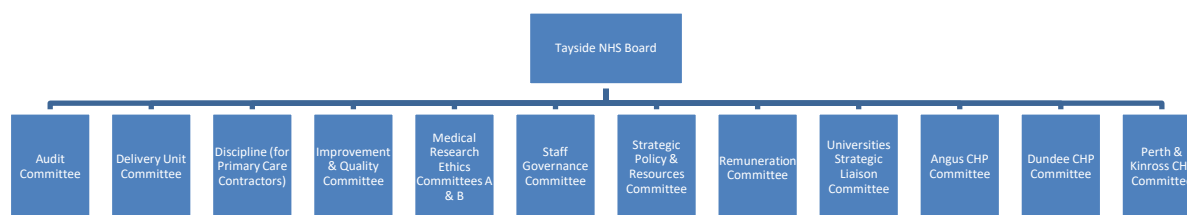
7.21 The Delivery Unit Committee also established an Improvement & Quality Sub-Committee to consider matters of clinical governance on its behalf.

7.22 The purpose of the Improvement and Quality Sub-Committee was to provide NHS Tayside with the assurance that *[NHST-04519]*:

- Effective mechanisms were in place throughout the local NHS system to support improvement.
- The principles and standards of Partnership for Care (2003) *[NHST-04337]* were applied to the improvement activities of NHS Tayside.
- Clinical Governance mechanisms were in place and effective throughout the whole of the NHS system including health improvement activities.
- A strategic framework for patient and public involvement was in place and to monitor and evaluate this.
- Governance arrangements were in place for equality and diversity.

The remit of the Improvement & Quality Sub-Committee is as detailed in *NHST-04519*.

7.23 2008 – 2009 Tayside NHS Board Standing Committee Structure



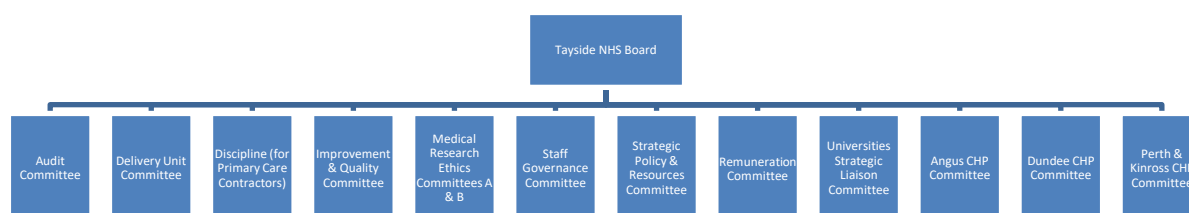
7.24 The purpose of the Improvement & Quality Committee remained the same as years 2006-2008, however was expanded to provide Tayside NHS Board with the following further assurances:

- A strategic framework for the Better Health, Better Care: Action Plan *[NHST-04672]* was in place.

- NHS Tayside had effective policies and management arrangements covering all aspects of Information Governance. The basis of the scope of these requirements was the NHS Quality and Improvement Scotland Clinical Governance and Risk Management Standards and the Information Governance Standards as laid out in the Information Governance Toolkit, which was an online environment that is no longer accessible to NHS Tayside. The governance arrangements for research and development were in place and were effective throughout NHS Tayside [NHST-04663].
- Educational governance arrangements were in place and were effective throughout NHS Tayside.

The last meeting of the Improvement and Quality Sub-Committee was in early 2008 as this Sub-Committee was stood down.

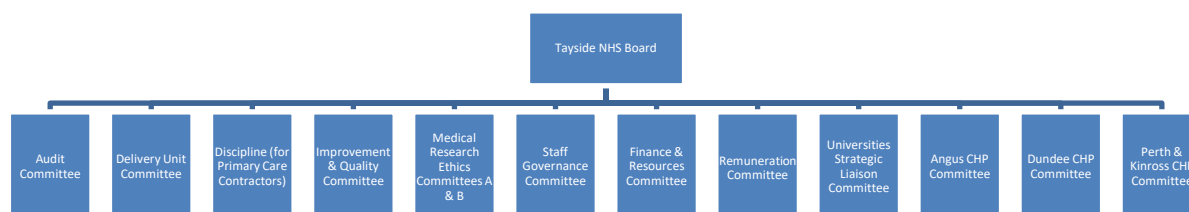
7.25 2009 – 2010 Tayside NHS Board Standing Committee Structure



7.26 The purpose of the Improvement & Quality Committee remained the same as 2008-2009.

There was no Improvement and Quality Sub-Committee in this period.

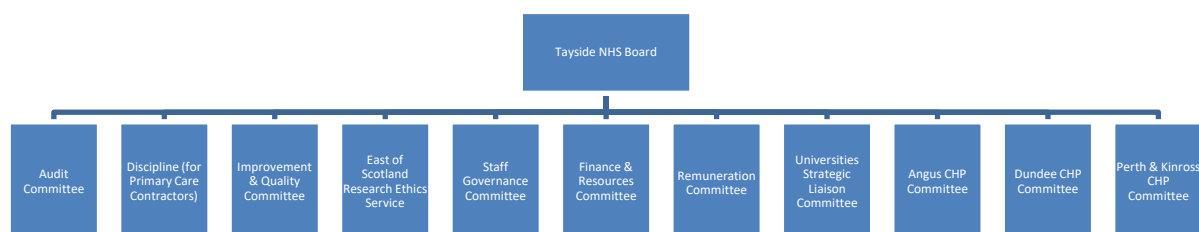
7.27 2010 – 2011 Tayside NHS Board Standing Committee Structure



7.28 The purpose of the Improvement & Quality Committee remained the same as 2008-2009.

There was no Improvement & Quality Sub-Committee in this period.

7.29 2011 – 2015 Tayside NHS Board Standing Committee Structure



7.30 The purpose of the Improvement & Quality Committee remained the same as years 2008-2009.

8. Please set out the identity and roles of key individuals within those bodies over the relevant period and the nature of the nature and remit of their roles, including but not limited to the following (with equivalents where the designation of particular roles or groups have changed over the years) with particular regard to the matters covered by the Inquiry's Terms of Reference and provisional List of Issues:

8.1 The names and roles of key individuals have been listed in Appendix 2 [NHST-04945]. They have been compiled from minutes of the various organisations during the relevant period.

(b) The Board of NHST and its members including the distinction between its executive and non-executive members;

8(b).1 The identity of these individuals is provided in Appendix 2 [NHST-04945].

8(b).2 Executive and non-executive members have collective corporate responsibility for the organisation and are jointly accountable for the Board's decisions.

8(b).3 Executive members hold leadership and operational management roles and are responsible for implementing the strategies approved by the Board, managing the day-to-day operations and are accountable for the performance of the organisation.

8(b).4 Non-executive members should not engage in the organisation's day-to-day operational matters. They have a responsibility to provide challenge, scrutiny and to hold executives to account.

(c) The Chair, Vice Chair, Chief Executive, Executive Medical Director, the General Manager and Board Secretary of NHST;

8(c).1 The identity of these individuals is provided in Appendix 2 [NHST-04945].

8(c).2 Where "Corporate Service Manager" is mentioned, this refers to a senior administrator responsible to the Chief Executive of one of the NHS Trusts. This role had some similar functions as the Board Secretary but would not have other portfolios or manage other corporate functions.

(d) The clinical groups of NHST, including but not limited to the clinical group for surgery and oncology and the clinical group for specialist services and their directors and managers;

8(d).1 A present day organogram of Acute Services can be seen within NHST-01573.

8(d).2 The title of Specialist Services Clinical Director changed over the relevant period. Any gaps may reflect missing information or that the role did not exist under that title during those years.

8(d) Specialist Services – Clinical Director			
No.	Dates	Role	Name
1.	1995 -1997	Director Manager Neurosciences	Mr T. R. K. Varma
2.	2000	Clinical Group Director, Specialist Services	Mr Arthur Morris
3.	2004	Clinical Director, Specialist Services	Dr J Howard Stevenson
4.	Circa 2005 - 2009	Clinical Director, Specialist Services	Dr Richard Roberts
5.	Circa 2009 – Nov 2013	Clinical Director, Specialist Services and Oncology	Mr Philip McLoughlin

6.	Nov 2013 - Spring 2018	Clinical Director, Specialist Services and Oncology	Dr Colin Fleming
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8(d).3 Over the relevant period, the organisational structure and terminology for operational management roles evolved. The titles Clinical Care Group Manager, Clinical Services Manager, and Clinical Team Manager were used at different times to describe roles that carried broadly equivalent operational management responsibilities within Specialist Services and Surgery & Oncology.

8(d).4 Where no postholder is recorded for a particular year, this may reflect that the role (or its specific title) did not exist in that form at that time.

8(d).5 These roles have therefore been mapped together and are presented in the table below as a single, continuous record of operational management across the relevant period.

Year	Specialist Services (Equivalent Roles)	Surgery & Oncology (Equivalent Roles)
1995 – 1999	Hazel Scott	Unknown (post holder not recorded)
2000	Hazel Scott	Eileen McKenna/ Karen Orr/ Tejinder Chima
2001 – 2002	Hazel Scott	Evelyn Fleck/ Tejinder Chima
2003	Hazel Scott	Tejinder Chima
2004	Hazel Scott/Dawn Weir	Tejinder Chima
2005 – 2006	Dawn Weir	Tejinder Chima
2007	Dawn Weir	Unknown (post holder not recorded)
2008	Dawn Weir	Derek Wilson
2009 – 2014	Lynn Smith	Derek Wilson
2015	Wendy Croll	Derek Wilson

8(d).6 The title of Surgery & Oncology Clinical Group Director changed over the relevant period. Any gaps may reflect missing information or that the role did not exist under that title during those years.

8(d) Surgery & Oncology – Clinical Group Director			
No.	Dates	Role	Name
1	Present as at: 5 Dec 2002 2 Oct 2006 11 Sep 2008	Clinical Group Director Surgery and Oncology	Mr Nick Townell

(e) Medical and nursing directors (including the NHS Tayside executive medical director, deputy medical director and associate medical directors) with responsibilities which were relevant or potentially relevant to the practice of Mr Eljamel;

8(e).1 Tayside NHS Board Medical Directors / Executive Medical Directors, and the Nurse Directors / Executive Nurse Directors is provided in response to Question 6.

8(e).2 The table below gives NHS Tayside's Medical Directors and Associate Medical Directors who were either employed in Dundee Teaching Hospitals NHS Trust, Tayside University Hospitals NHS Trust or who held positions within the Acute Service Division and Single Delivery Unit. In around 2010, Associate Medical Directors were introduced, with responsibility for large clinical areas, for example all of Surgery, Anaesthesia and Critical Care. Where no postholder is recorded for a particular year, no evidence has been found that indicates that this role was in place between these dates or who held the role if that role existed.

8(e) Dundee Teaching Hospitals - Director of Medical Services			
No.	Dates	Role	Name
1	1 Apr 1994 – 31 Mar 1995	Dundee Teaching Hospitals NHS Trust Director of Medical Services	Dr Derek Maclean
2	1 Apr 1995 – 31 Mar 1996	Dundee Teaching Hospitals NHS Trust Director of Medical Services	Dr Derek Maclean

3	1 Apr 1996 – 31 Mar 1997	Dundee Teaching Hospitals NHS Trust Director of Medical Services	Dr Derek Maclean
4	1 Apr 1997 – 31 Mar 1998	Dundee Teaching Hospitals NHS Trust Director of Medical Services	Dr Derek Maclean
5	1 Apr 1998 – 31 Mar 1999	Dundee Teaching Hospitals NHS Trust Director of Medical Services	Dr Derek Maclean

8(e) Tayside University Hospitals – Medical Director

No.	Dates	Role	Name
1	1 Apr 1999 – 31 Mar 2000	Tayside University Hospitals NHS Trust Medical Director	Dr Derek Maclean
2	1 Apr 2000 – 31 Mar 2001	Tayside University Hospitals NHS Trust Medical Director	Dr Derek Maclean
3	1 Apr 2001 – 31 Mar 2002	Tayside University Hospitals NHS Trust Medical Director	Mr Michael Lyll
4	1 Apr 2002 – 31 Mar 2003	Tayside University Hospitals NHS Trust Medical Director	Mr Michael Lyll
5	1 Apr 2003 – 31 Mar 2004	Tayside University Hospitals NHS Trust Medical Director	Mr Michael Lyll

8(e) Divisional Acute Services Committee – Medical Director and Deputy Medical Director

No.	Dates	Role	Name
1	1 Apr 2004 – 31 Mar 2005	Divisional Acute Services Committee Medical Director	Mr Michael Lyll
2	1 Apr 2005 – 31 Mar 2006	Divisional Acute Services Committee Medical Director	Mr Michael Lyll
3	1 April 2005 – 31 Mar 2006	Division Acute Services Committee Deputy Medical Director	Dr Mike Jones

8(e) Delivery Unit Committee – Medical Director			
No.	Dates	Role	Name
1	1 Apr 2006 – 31 Mar 2007	Delivery Unit Committee Medical Director	Prof Stuart Forsyth
2	1 Apr 2007 – 31 Mar 2008	Delivery Unit Committee Medical Director	Prof Stuart Forsyth
3	1 Apr 2008 – 31 Mar 2009	Delivery Unit Committee Medical Director	Prof Stuart Forsyth
4	1 Apr 2009 – 30 Jun 2009	Delivery Unit Committee Medical Director	Prof Stuart Forsyth
5	1 Sep 2009 – 31 Mar 2010	Delivery Unit Committee Deputy Medical Director	Mr Nick Townell
6	1 Apr 2010 – 30 Jun 2010	Delivery Unit Committee Deputy Medical Director	Mr Nick Townell

8(e) Operational Unit – Medical Director			
No.	Dates	Role	Name
1	1 Jan 2014 - March 2014	Medical Director, Operational Unit (noted in Board Minute 27 February 2014)	Dr Alan Cook
2	1 April 2014 – 31 March 2015	Medical Director, Operational Unit	Dr Alan Cook
3	1 April 2015 – 31 March 2016	Medical Director, Operational Unit	Dr Alan Cook
4	1 April 2016- 31 March 2017	Medical Director, Operational Unit	Dr Alan Cook
5	1 April 2017- 31 December 2018	Medical Director, Operational Unit	Dr Alan Cook
6	March 2018 – 31 March 2019	Interim Medical Director, Operational Unit then Medical Director, Operational Unit then Deputy Medical Director, Acting Medical Director	Prof P Stonebridge

8(e) Associate Medical Directors			
No.	Dates	Role	Name
1	As at 1 Oct 1998	Dundee Teaching Hospitals NHS Trust Associate Medical Directorate	Dr Mike Jones
2	July 1999 – date not known	Tayside University Hospitals NHS Trust Associate Medical Director, Angus	Mr Nick Townell
3	July 1999 – Spring 2001 Spring 2001 – date not known	Tayside University Hospitals NHS Trust Associate Medical Director, Dundee Tayside University Hospitals NHS Trust Deputy Medical Director	Dr Mike Jones
4	July 1999 – before December 2002	Tayside University Hospitals NHS Trust Associate Medical Director, Perth	Mr Bob Murdoch
5	June 2001 – later than December 2002	Tayside University Hospitals NHS Trust Associate Medical Director, Dundee	Dr Bill Morrison
6	As at December 2002	Tayside University Hospitals NHS Trust Associate Medical Director, Perth	Mr Greig Murray
7	April 2004 – date not known	Division Acute Services Committee Associate Medical Director, Angus	Mr Nick Townell
8	April 2004 – date not known	Division Acute Services Committee Associate Medical Director, Dundee	Dr Bill Morrison
9	April 2004 – date not known	Division Acute Services Committee Associate Medical Director, Perth	Mr Greig Murray
10	The information of what position was held and by		

	whom is not recorded in the records held following April 2004 to 2015		
Associate Medical Director for Surgery			
11	1 Sep 2009 - 2013	Associate Medical Director for Surgery	Dr John Colvin
12	Nov 2013 - later than 2015	Associate Medical Director Surgery	Dr Phil McLoughlin
13	Jan 2018	Associate Medical Director, Surgical Directorate	Professor Peter Stonebridge
Associate Medical Director's for Medicine			
14	1 Sep 2009 – 2015	Associate Medical Director for Medicine	Dr David Johnston
Associate Medical Director, Access			
15	1 Sep 2009 – 30 June 2010	Associate Medical Director, Access	Mr Nick Townell
16	1 Aug 2010 – 31 Mar 2011	Associate Medical Director, Access	Dr Alan Cook
17	1 April 2011 – 31 Mar 2012	Associate Medical Director, Access	Dr Alan Cook
18	1 April 2012 – 31 March 2013	Associate Medical Director, Access	Dr Alan Cook
19	1 April 2013 – 31 Dec 2013	Associate Medical Director, Access	Dr Alan Cook
20	Early 2014 – on around 2017	Associate Medical Director, Access	Dr Gavin Main
Associate Medical Director for Professional Governance			
21	No evidence has been found to indicate that this role existed between 1995		

	and 30 November 2012		
22	1 Dec 2012 – Oct 2016	Associate Medical Director for Professional Governance	Dr Musheer Hussain

8(e).3 Further information regarding the introduction of the Associate Medical Director role is included in response to Question 6.

(f) Clinical leads with responsibilities which were relevant or potentially relevant to the practice of Mr Eljamel;

8(f).1 Clinical leads are responsible for delivery and performance of clinical services. By adhering to clinical governance frameworks, they promote safe, high-quality care. They also provide leadership, support and mentoring to clinical teams as appropriate to provide the best possible care for patients.

8(f) Clinical Lead for Neurosurgery			
No.	Dates	Role	Name
1	Pre 1995 – 1997	Clinical Lead for Neurosurgery It is unlikely that this is the same role as Director Manager Neurosciences (see 8(d) above), and it cannot be confirmed whether it was a dual role	Mr T R K Varma (Neurosciences Director Manager)
2	1997 – 2009	Clinical Lead for Neurosurgery	Mr Sam Eljamel
3	2009 - 2013	Clinical Lead for Neurosurgery	Mr Eric Ballantyne
4	2013 – circa end 2016/early 2017	Clinical Lead for Neurosurgery	Mr David Mowle
5	circa end 2016/early 2017 – 2018	Clinical Lead for Neurosurgery	Mr Eric Ballantyne
6	2018 – 2024	Clinical Lead for Neurosurgery	Mr David Bennett
7	2024 - present	Clinical Lead for Neurosurgery	Miss Heinke Pulhorn

- (g) **The Head of Quality and Clinical Effectiveness, Clinical Effectiveness Co-ordinator and Quality Co-ordinator, insofar as their responsibilities which were relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00204, page 6);**

- 8(g).1 The Head of Quality and Clinical Effectiveness reported to the Director of Nursing and Patient Services [NHST-00203]. As terminology changed from Quality and Clinical Effectiveness to Clinical Governance, the title and the remit of the post evolved [NHST-01513].

No	Year(s)	Designation	Name
1	1995 – 1998	Director of Nursing and Quality Quality Co-ordinator [NHST-04414]	Miss Janet Roy Mrs Verity Marshall
2	1998 – date unknown	Head of Quality and Clinical Effectiveness	Evelyn Fleck
3	1999–2004	Clinical Governance Co-ordinator (Acute)	Hazel Borland
4	2005 -2020	Clinical Governance Coordinator (Acute)	Tracey Passway

- 8(g).2 These roles would have been relevant to the practice of Mr Eljamel, insofar as they were responsible for developing the corporate structures, policy and strategy which underpinned quality, clinical effectiveness and clinical governance, which all consultants would have been expected to be aware of and adhere to. In addition, Clinical Governance Coordinators provided specific support to Clinical Governance Chairs, to ensure that governance processes were developed and implemented effectively.

- (h) The Director of R&D, Dean and Postgraduate Dean, insofar as their responsibilities which were relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00204, page 6);

Directors of Research and Development 1995-2014			
No.	Dates	Role	Name
1	Pre 1997	Not known if role existed	Unknown
2	1997 – 2001	Director of Research and Development	Professor Roland Jung
3	2001 – 2009	Director of Research and Development	Professor Ellie Dow
4	2009 – 2016	Director of Research and Development, titled changed to Director of Tayside Medical Science Centre (TASC) on Jan 2010	Professor Jill Belch CBE

- 8(h).1 The NHS Tayside Research and Development (R&D) Director had responsibility for the oversight of research governance processes for clinical research projects conducted in NHS Tayside in accordance with the related regulation and legislation for ethically and regulatory approved trials. They carried corporate responsibility for the oversight of research & development throughout NHS Tayside [NHST-01621]. Please refer to Question 8(o) for more detailed information.
- 8(h).2 Deans of Medicine (or equivalent) from 1995 to 31 July 2015 are below. NHS Tayside holds records that the individuals detailed below held this title. NHS Tayside has no records in relation to the identity of a Postgraduate Dean. It should be noted that both of these positions were roles with the University of Dundee/NHS Education for Scotland, and NHS Tayside did not employ these individuals.

8(h) 2. Deans of Medicine (or equivalent) 1995-2015			
No.	Dates	Role	Name
1	1995 – 2003	Dean (Faculty of Medicine, Dentistry & Nursing)	Professor David Levison
2	2003 – 2006	Dean of Medicine	Professor Brian Burchell

3	2006 – 2011	Vice-Principal & Head of College (Medicine, Dentistry & Nursing)	Professor Irene Leigh
4	Apr 2007 – Sep 2009	Dean of School of Medicine	Professor Martin Pippard
5	Oct 2009 – Dec 2011	Dean of School of Medicine	Professor John Connell
6	Jan 2012 – 15 Jun 2012	Gap / Acting Deans – likely internal interim coverage	
7	16 Jun 2012 – 17 Aug 2014	Dean of School of Medicine	Professor Andrew Morris
8	Aug 2014 – 31 Jul 2015	Joint Acting Deans of School of Medicine	Professors Jill Belch & Gary Mires

- (i) **Head of Patient Services, insofar as their responsibilities which were relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00204, page 9);**

8(i).1 The above referenced paper states that the “*Head of Patient Services will include staff dedicated to patient process redesign, and to bed management*”. NHS Tayside has no evidence to show that this post was relevant to the practice of Mr Eljamel.

- (j) **The specialist services department of NHS Tayside, and any equivalent body undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;**

8(j).1 During the relevant period, the Specialist Services Department - and any equivalent body carrying out a similar function - operated within an organisational structure introduced in 1999. Other names for this function include Directorates or Clinical Groups, under which sat the Neurosciences Department 1995-1997, Specialist Services 2000-2009, Specialist Services and Oncology 2009-2018, Specialist Services 2018- current [NHST-04728]. This structure defined seven clinical groups and five corporate directorates. Each clinical grouping was led by a Clinical Group Director, which would be a senior clinician who maintained clinical commitments and had additional managerial responsibility for the group.

- 8(j).2 Supporting each Clinical Group Director was a Clinical Group Manager – a senior full-time manager accountable for the day-to-day operational management of the grouping. The Clinical Services Manager would be an equivalent job title to Clinical Group Manager. Clinical Team Managers reported to Clinical Group Managers and were responsible for management of a small number of services within the Clinical Group. Further information on the structure and hierarchy can be found in *NHST-04599*. Within each specialty, there was also a Clinical Lead (consultant leading subspecialties on a part-time basis, also referred to as Lead Clinician) and Clinical Team Manager, responsible for the day-to-day running of services. A job description for Lead Clinician / Clinical Leader can be found in *NHST-04599_13*. Key functions of the Clinical Lead included providing appropriate clinical, scientific and professional leadership to the Group Management Team, management of specialty specific operational matters and lead role in clinical governance for the specialty.
- 8(j) 3 Mr Eljamel served as Neurosurgery Clinical Lead between 1997-2009. On review of Mr Eljamel's job plans, the Clinical Lead time allocation was generally low. For example:
- 1997 job plan – referred to as variable [*NHST-01640*].
 - Between 2003 and 2009 job plans were relatively static with clinical leadership activities not allocated at specific times or locations [*NHST-04642*; *NHST-04629*; *NHST-04644*].
 - 1.5 hours clinical leadership meetings and other associated work
 - 0.5 hours governance.
- 8(j).4 Clinical Group Directors reported to the Deputy Medical Director and Medical Director, who in turn reported to the Chief Executive. Under this structure, Neurosciences fell within the Specialist Services Clinical Group.
- 8(j).5 The individuals occupying the Clinical Group Director roles evolved and changed over the years as staffing and organisational needs shifted. See response to Question 8(d) which provides a list of the postholders' names, and the period they held these roles.
- 8(j).6 A broadly similar structure remains in place today. Neurosurgery remains part of Neurosciences and continues to sit under the Specialist Services Clinical Care Group (CCG). The CCG has a Clinical Director, a Clinical Care Group Manager,

and a Lead Nurse - the three senior roles often referred to as the “triumvirate”. Clinical Leads work at a specialty level, Clinical Directors work at a group level. Clinical Leads report to Clinical Directors. There is still a Neurosurgery Clinical Lead in place.

8(j).7 This triumvirate now reports into the Division of Patient Access and Assurance which reports to the Chief Officer, Acute Services, who reports to the Chief Executive [NHST-00203; NHST-01505].

(k) The surgical directorate of NHS Tayside, and any equivalent body undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;

8(k).1 Please see response to Question 8(d) which lists all known identities of the surgical directorate over the relevant period.

(l) The clinical governance directorate of NHST, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00203, page 4);

8(l).1 In NHS Scotland, clinical governance was officially introduced on 1 April 1999. This implementation followed the Scottish Executive Health Department’s guidance, MEL(1998)75 [NHST-00231] issued on 27 November 1998, which required NHS bodies to establish systems for corporate accountability for clinical performance to ensure that quality of care was integrated into governance frameworks alongside financial oversight.

8(l).2 Another Scottish Executive Health Department circular, MEL2000(29) [NHST-04344] was issued on 2 June 2000 which provided further guidance on the implementation of clinical governance.

8(l).3 At an informal NHS Trust Board Meeting on Friday 9 April 1999 [NHST-04704], it was recorded that the Tayside University Hospital NHS Trust Chief Executive was the Accountable Officer who had overall responsibility for the delivery of clinical governance with the Medical Director and Nurse Director having delegated responsibility for clinical governance.

- 8(l).4 The Directorate of Nursing and Quality were responsible for the reporting structures, policy and strategy relating to Clinical Effectiveness, Quality and Clinical Governance from 1995, whilst the titles of directorates have evolved during the reporting period [NHST-00203].
- 8(l).5 The remit of this directorate would have been relevant to the practice of Mr Eljamel, insofar as all staff would have been expected to be aware of and comply with reporting structures, policy, procedures, processes and strategy, relating to Clinical Effectiveness, Quality and Clinical Governance.
- (m) The clinical leadership directorate of NHST, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00203, page 4);**
- 8(m).1 The clinical leadership directorate relevant to Mr Eljamel is listed below. The Clinical Lead reported to the Clinical Director, who reported to the Associate Medical Director, then the Operational Medical Director and then the Executive Medical Director.
- 8(m).2 Clinical Lead, Neurosurgery
The identity of the Clinical Leads, Neurosurgery is provided in response to Question 17.
- 8(m).3 Clinical Director, Specialist Services
The identity of the Clinical Directors, Specialist Services is provided in response to Question 8(d).
- 8(m).4 Associate Medical Director Surgery
The identity of the Associate Medical Directors Surgery is provided in response to Question 8(d).
- 8(m).5 Operational Medical Director
The identity of the Operational Medical Directors is provided in response to Question 8(e). The post of Operational Medical Director was introduced in around 2010.

8(m).6 Executive Medical Director (previously Medical Director pre-2010)

The identity of the Executive Medical Directors is provided in response to Question 6.

(n) **The clinical network development directorate of NHST, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00203, page 4);**

8(n).1 NHS Tayside has no further evidence for this directorate other than the information referred to above, which sets out the clinical governance and clinical leadership roles and responsibilities.

(o) **The R&D liaison directorate of NHST, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00203, page 4);**

8(o).1 Prior to 2010, the NHS Tayside R&D Director had responsibility for the oversight of research governance processes for clinical research projects conducted in NHS Tayside, in accordance with the related regulation and legislation for ethically and regulatory approved trials and carried corporate responsibility for the oversight of research and development throughout NHS Tayside.

8(o).2 Tayside Medical Science Centre (TASC) was formally established on 1 January 2010 to combine the research strengths of the University of Dundee with those of NHS Tayside within a single organisational framework. Under the overarching Heads of Agreement and Memorandum of Understanding (MoU) documents [NHST-01594; NHST-01596], TASC's remit is the implementation of research governance processes for clinical research projects conducted in Tayside in accordance with the related regulation and legislation. The first MoU was effective from 1 January 2010, for three years [NHST-01594], with renewal in 2013-15, and again in 2016-18. There were subsequent interim documents [NHST-04677; NHST-04678; NHST-04679; NHST-04680; NHST-04681; NHST-04682] over a period ahead of a new TASC Memorandum of Agreement between the University of Dundee and NHS Tayside, effective from 31 August 2020 [NHST-01596].

8(o).3 The first Heads of Agreement was effective May 2009, for a duration of five years [NHST-01595] and thereafter renewed on a five-year cycle. TASC carries corporate

responsibility for the management of research and development throughout Tayside and provides an integrated and streamlined service for all clinical staff. Leadership of TASC is provided by the Tayside Research & Development Director (identity provided in response to Question 8(h)) who is also the Director of TASC. This director has operational responsibility and works closely with the Senior Research & Development Manager [NHST-01621]. The TASC offices are co-located with the East of Scotland Medical Research Ethics Service within Ninewells Hospital and Medical School. A key aim of TASC is to provide the infrastructure to facilitate research for all health professionals and to promote a strong culture of research within the NHS. The mission is to “facilitate trusted, high quality and innovative clinical research to improve health outcomes for the people of Tayside and beyond” [NHST-04345].

- 8(o).4 The UK Policy Framework for Health and Social Care Research [NHST-04346] requires that all clinical research involving human participants, their organs, tissues or data must have an identified sponsor who takes responsibility for the initiation, management and the financing of a clinical study. For studies falling under the Medicines for Human Use (Clinical Trials) Regulations 2004 [NHST-04347], there are additional legal requirements for which the sponsor has responsibility. In Tayside, sponsorship may be accepted by NHS Tayside and/or the University of Dundee and is organised through the TASC Sponsor Office and led by the Research Governance Team in TASC. The TASC Sponsor Office represents both organisations. The Research Governance Team reviews study documents and conducts a risk assessment for a study to ensure that risks are identified and mitigated against. This oversight is retained through the lifecycle of the project, covering monitoring, adverse events, amendments, breaches, annual reports and end of study closures. Archiving of trials sponsored or co-sponsored by an institution is managed through Research Governance within the role of the Good Clinical Practice Archivist.
- 8(o).5 Details of the TASC Quality Management System, including policies and standard operating procedures, are provided with this response NHST-01511.

(p) The LHCC liaison directorate of NHST, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00203, page 4);

8(p).1 Following the Health Act 1999 and Designed to Care, Renewing the National Health Service in Scotland White Paper [NHST-04349], NHS Scotland undertook several significant primary care reforms. This included the introduction of Local Health Care Co-operatives (LHCCs).

8(p).2 The introduction of LHCCs was supported by guidance issued by the Scottish Executive Health Department – LHCC Development MEL(1999)13 [NHST-04348].

8(p).3 The objectives of LHCCs are as set out at paragraph 81 of "Designed to Care" [NHST-04349_21]:

- Identifying the health care needs of the local population in partnership with public health.
- Planning and developing primary care services to meet patient need within a defined level of resources devolved from the Primary Care Trusts (PCT).
- Supporting the development of member practices.
- Supporting clinical quality and standards.
- Supporting clinical governance within the PCT.
- Supporting development of those who deliver the services through education, training, research and audit.
- Promoting the development of extended primary care teams.
- Promoting equity of access to primary care services for all patients covered by the LHCC.
- Working with other agencies to improve the health of the local population.

8(p).4 LHCCs in Tayside operated until 2004. Their remit, however, would not be relevant to the practice of Mr Eljamel.

(q) The clinical governance committees for all the clinical groups in the acute division within NHS Tayside, insofar as their remit was relevant or potentially relevant to the practice of Mr Eljamel, in particular but not limited to the clinical governance committee for the neurosurgery department (specialist services group);

8(q).1 The Clinical Governance Committees established for the clinical groups within the Acute Division of NHS Tayside are relevant to the professional practice of Mr Eljamel. Specifically, Neurosurgery fell within the remit of the Specialist Services Clinical Group (subsequently referred to as the Clinical Care Group) and was subject to oversight and review through the clinical governance meetings. The Clinical Governance Committee Meeting (29 July 1999) *NHST-04452* provides details of proposals for the establishment of Clinical Governance sub groups. A Clinical Governance progress report [*NHST-04713*] was presented to the TUHT Board Meeting on 26 April 2000. Within this report [*NHST-04713*] was a summary of activities relating to the Specialist Services Clinical Group.

8(q).2 These Clinical Governance Groups reported to an Acute/Secondary Care Clinical Governance meeting [*NHST-01703*; *NHST-01704*; *NHST-01705*], which reported to the Clinical Governance Committee.

8(q).3 *NHST-01572* records that Mr Eljamel was a Chair of the Clinical Governance Committee of the Specialist Services Group from 2006 to 2010. *NHST-01703* confirms that Mr Eljamel was the Clinical Governance Chair for Specialist Services in 2007. These roles followed the definition within MEL(1998)75 [*NHST-00231*].

8(q).4 Other individuals who held the role of Clinical Governance Chair for Specialist Services, documented in Clinical Governance Report for SD EMT [*NHST-04350*] and Clinical Governance Annual Report 2000-2001 [*NHST-04736*], are as follows:

- Dr Colin Fleming in 2001 (start and end dates unconfirmed)
- Dr Jonathan O’Riordan (unconfirmed start date to 2012)
- Mr Sam Majumdar (2012 to unconfirmed end date)

8(q).5 The responses to Questions 6 and 7 provide the high-level overview of reporting from the Acute Clinical Governance meeting to the Board.

8(q).6 The response in Question 7 includes the remit of the Acute Services Division Quality and Clinical Governance Committee.

(r) The complaints and feedback service/ team of NHS Tayside, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;

8(r).1 NHS Tayside has no corporate record demonstrating who held relevant roles in the Complaints and Feedback team between 1995-2000. NHS Tayside believe that this information would have been destroyed, following our retention policy.

8(r).2 2000 – 2002

- Marion Ross, Complaints Manager, Tayside University Hospitals NHS Trust (September 2000 and February 2001)
- March 2001-2002 NHS Tayside has no corporate record of who held the role of Complaints and Feedback leadership and/or management post.

8(r).3 2003 - 2004

- Hazel Schofield, Complaints and Claims Manager

8(r).4 2005 - 2007

- Hazel Schofield, Complaints and Claims Manager
- Pat O'Connor, Head of Risk Management and Patient Safety: Complaints and Claims Manager reported to Head of Risk Management and Patient Safety

8(r).5 2008 - 2011

- Margaret Simpson Acting Board Nurse Director, had delegated executive responsibilities for complaints
- Hazel Schofield, Complaints and Claims Manager, managed the Complaints and Advice Team
- Arlene Napier, Acting Head of Safety Governance and Risk, supported Hazel Schofield with the Complaints and Advice Team

8(r).6 2012

- Alison Moss, Complaints and Feedback Team Lead
- Arlene Napier, Head of Safety Governance and Risk

8(r).7 2013 – February 2020

- Alison Moss, Complaints and Feedback Team Lead

(s) The improvement and quality committee of the NHST, and any equivalent committee undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;

8(s).1 Please see responses and evidence provided to Question 8(t).

(t) The clinical and care governance committee of the NHST Board, and any equivalent committee undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;

8(t).1 The first iteration of the Clinical Governance Committee was in 1999-2001 and was part of the structure of the Tayside University Hospital NHS Trust, as shown in response to Question 7. Question 7 starts from 2001. Clinical Governance was introduced into NHS Scotland from 1 April 1999. Prior to this Dundee Teaching Hospitals NHS Trust had a Quality Strategy [NHST-04414].

8(t).2 During the period of 2001-2004 there was a Clinical Governance Committee within the structure of Tayside University Hospital NHS Trust, and also a Clinical Governance Committee as part of the Tayside NHS Board. This is demonstrated within the response to Question 7.9 [NHST-04941].

8(t).3 The role of Tayside NHS Board Clinical Governance Committee for 2001 included the following: Systems assurance – to ensure that clinical governance mechanisms are in place and effective throughout the local NHS System [NHST-04701_32].

8(t).4 The NHS Tayside Clinical and Care Governance Committee has had different titles from the date of its creation in 2001 to 2015. These are listed below:

- 2001-2004 - Clinical Governance Committee.
- 2004-2006 - Quality and Clinical Governance Committee.
- 2006-2015 - Improvement and Quality Committee.

- 8(t).5 The Committee is responsible for providing assurance to the Board that robust governance systems are in place across clinical services, including clinical practice. In the relevant period, its remit included the monitoring of clinical risk, incident reporting and learning from adverse events, endorsing policies such as infection control and medicines management, and monitoring compliance with national standards. The Committee oversaw educational and professional development and supported the delivery of safe and effective care. The Committee had a pivotal role in promoting patient safety, clinical effectiveness, and continuous improvement.
- 8(t).6 The Inquiry has previously received information from NHS Tayside regarding the Clinical Governance Committee (and its iterations listed above) *[NHST-00022 – NHST-00040; NHST-00226 – NHST-00230]*.
- (u) **The committee on medical ethics of the NHST, and any equivalent committee undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00002, page 9);**
- 8(u).1 The NHS Research Ethics Service was developed in response to the exponential growth in writing regulations, laws, codes of practice and guidelines for medical research. The first Research Ethics Committee (REC) was formed in the UK in 1966. In 2000 the Central Office for Research Ethics Committee (COREC) was established within the UK Department of Health, becoming the National Research Ethics Service (NRES) in 2007. In 2004, one UK-wide REC application form replaced individualised local REC application forms, with local administration support still provided for each REC in each Health Board area. Tayside had one REC.
- 8(u).2 Tayside Committee on Medical Ethics was established in 1990 *[NHST-04665]*. Although the name of the committee does not include research within it, by examining the documentation available, NHS Tayside has identified that a role of this Committee was to review research proposals *[NHST-04665_5; NHST-04664_2]*.
- 8(u).3 In 2007, the existing Tayside REC was split into two committees – Tayside REC A and Tayside REC B – to accommodate the review of increasing numbers of student

projects, primarily from fourth year medical students. In addition to this, a further REC was created by merging the RECs from NHS Fife and NHS Forth Valley. As a result, the administration support for all three RECs within the East of Scotland (NHS Fife, Forth Valley and Tayside) was centralised to NHS Tayside.

- 8(u).4 Due to a reduction in the number of ethics applications received across the UK, Tayside Committee on Medical Research Ethics A and Tayside Committee on Medical Research B merged from 1 October 2011. The merged Committee has been renamed East of Scotland Research Ethics Service (EoSRES) REC 1, and Fife and Forth Valley REC has been renamed East of Scotland Research Ethics Service (EoSRES) REC 2, in line with the rest of Scotland and the Research Ethics Service Centres throughout the UK [NHST-01622].

- 8(u).5 Mr Eljamel was a member of the Tayside Committee on Medical Research Ethics Committee B, which merged with Tayside Committee on Medical Research Ethics Committee A in 2011, becoming the East of Scotland Research Ethics Service (EoSRES) REC 1.

- 8(u).6 Mr Eljamel was appointed to the committee on 1 June 2009 and attended his first meeting on 11 September 2009. His last committee meeting was recorded as the 19 July 2013 with the same leaving date recorded in the EoSRES REC 1 annual report 01/04/2013 to 31/03/2014 [NHST-01707].

- 8(u).7 Mr Eljamel attended twenty-three committee meetings and four sub-committee meetings. [NHST-01708 – 01736; NHST-04417 – 04432]

- 8(u).8 During his tenure as a committee member, Mr Eljamel submitted four research applications to Tayside committees (three to Committee A, one to EoSRES B), and four research applications to NHS Fife and Forth Valley committees. Details of the applications can be found in Appendix 3 [NHST-04945].

- 8(u).9 There was no conflict of interest for the three applications submitted to Committee A, 09/S1401/67, 10/S1401/44, 10/S1401/52, as Mr Eljamel was not on this committee. However, he was a member of Committee B for the fourth application 11/ES/0025 which was initially submitted to Committee B for the meeting of 9 September 2011. The application was therefore transferred to Committee A meeting of 30 September 2011 to mitigate any potential conflict of interest.

(v) The university liaison committee/ directorate of NHST, and any equivalent committee/ directorate undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00002, page 9; NHST-00203, page 4);

8(v).1 In Scotland the University Liaison Committees were formally established under the National Health Service (Scotland) Act 1978 [NHST-04332]. Section 8 of the 1978 Act specifically provides for University Liaison Committees as part of the local advisory bodies structure within NHS Scotland.

8(v).2 These committees were strategic advisory bodies for the Health Board areas with a University Medical School. The University Liaison Committees would therefore not have been relevant to the practice of Mr Eljamel.

(w) Any other committee(s) within NHST, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel (see for example NHST-00002, page 8);

8(w).1 NHS Tayside is not aware of additional committees or further relevant information which has not already been included in response to this question.

(x) The directorate of medical education of NHST, and any equivalent body undertraining a similar function during the relevant period, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;

8(x).1 Each of the fourteen territorial Health Boards has a Director of Medical Education (DME) who is employed by the Health Board and is responsible for strategic oversight of the delivery of high quality undergraduate and postgraduate education and training.

8(x).2 The DME ensures that the Health Board meets the regulatory standards required of a Local Education Provider (LEP) and that medical education is undertaken in a collaborative manner working with the Scotland Deanery and medical schools.

8(x).3 The DME role was established in 2012, and the Directorate of Medical Education was formally established in 2013. Prior to 2012, there were ad hoc arrangements

primarily led on a Trust-by-Trust basis. NHS Tayside has no documented evidence on what the exact arrangements were.

8(x).4 The DME role has been held by the following individuals:

- Professor Dilip Nathwani (2012-2016)
- Dr John Davidson (2016-2021)
- Dr Maximillian Groome (acting from 2021 and formally appointed in 2022-present)

8(x).5 Between 1995 and 2002 the following structures existed, although medical education in Scotland was fragmented across several bodies.

8(x).6 Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) (1993-2002), was a national body that oversaw postgraduate medical and dental training. This body oversaw four regional Deaneries. The four regional Deaneries in Scotland (North, East, South-East, and West) ceased to exist in August 2014 when NHS Education for Scotland (NES) reorganised postgraduate medical education into a single Scotland Deanery.

No.	Dates	Role	Name
1	1997 - Sept 2015	Postgraduate Tutor then Postgraduate Dean East of Scotland Deanery	Dr Philip Cachia
2	2015	Postgraduate Dean (East Region)	Professor Clare McKenzie

8(x).7 NHS Tayside has no record of who held the Postgraduate Dean role prior to 1997.

8(x).8 These Deaneries coordinated training programmes, supervised trainees, and worked with local Health Boards and Universities.

8(x).9 On 31 March 2002 NHS Education for Scotland (NES) was established by the NHS Education for Scotland Order 2002. NHS NES is a national body, which became responsible for the following areas:

- Postgraduate medical education.

- Dental, pharmacy, nursing, and AHP education.
- Workforce development.
- Quality assurance of training.
- Supporting medical schools and Health Boards.

8(x).10 Between 2002 and 2014 Scotland moved toward a nationally coordinated system of medical education.

8(x).11 From 2014, regional deaneries transitioned into a Scotland Deanery under NES.

(y) The clinical governance corporate team of NHS Tayside, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;

8(y).1 The Executive Leads were responsible for the development of strategy, frameworks and policy. The Clinical Governance teams within the organisational structure were responsible for various operational activities. These included, for example, the maintenance of adverse event reporting systems and supporting the coordination of governance processes. Please also refer to the responses to Questions 8(g) and 8(l), which set out other key individuals and responsibilities.

8(y).2 The remit and scope of the roles within this team would have been relevant to the practice of Mr Eljamel, as the Clinical Governance team engaged with all staff, including those with Clinical Governance lead roles, for example, the chairperson/s of clinical governance meetings (Clinical Governance Chairs).

8(y).3 The Clinical Governance Team, including the role of Clinical Governance Co-ordinator for acute [NHST-01513], was also responsible for supporting the implementation of NHS Tayside's clinical governance strategy across Acute Services. This included activities such as training, facilitation, and the coordination of governance processes and Clinical Governance Chairs meetings. An example of an agenda and a draft minute is provided [NHST-01512].

8(y).4 Within each clinical and non-clinical care group, there was an identified lead for Clinical Governance, who would be part of the Clinical Governance Chairs meetings. Mr Eljamel was identified as a Clinical Governance Chair for Specialist Services [NHST-01703]. NHST-01572_4 records that Mr Eljamel was a Chair of the Clinical Governance Committee of the Specialist Services Group from 2006 to 2010.

NHST-01703_3 confirms that Mr Eljamel was the Clinical Governance Chair for Specialist Services in 2007.

8(y).5 The NHS Tayside Clinical Governance Strategy 2013–2016 [NHST-01623], defines the role of Chairs of Clinical Governance subgroups as providing “*leadership and support for clinical governance across their local speciality area*”. Please see paragraphs 10(a).1 to 10(a).13. In Tayside the professional clinical staff have the role as Chairs of the Clinical Governance Sub-Groups within their job plan, reinforcing the multidisciplinary nature of Clinical Governance.

8(y).6 Key individuals within the Clinical Governance team during the relevant period are provided below:

No	Year	Designation	Name
1	1995 – 1998	Director of Nursing and Quality Quality Co-ordinator [NHST-04414]	Miss Janet Roy Mrs Verity Marshall
2	1998 to date unknown	Head of Quality and Clinical Effectiveness	Evelyn Fleck
3	1999 - 2004	Clinical Governance Coordinator Acute	Hazel Borland
4	2005 - 2020	Clinical Governance Coordinator Acute	Tracey Passway
5	2008 - 2010	Acting Head of Safety, Governance and Risk	Arlene Napier
6	2010 - 2017	Head of Safety, Governance and Risk	Arlene Napier

8(y).7 The Strategy for Patient Safety, Clinical Governance and Risk Management 2008 – 2011 [NHST-04400], provides an organisational chart which demonstrates the Clinical Governance team reporting to the Chief Executive.

- (z) **The legal claims team of NHS Tayside, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel;**

8(z).1

No.	Year	Designation	Name
1	1995 – unknown	Unknown	Unknown
2	2004/2005	Nursing Directorate	Hazel Borland
3	2004/2005 – 2007/2008	Head of Risk Management	Patricia O'Connor
4	2007/2008 – 2013	Head of Risk Management	Arlene Napier
5	2013 – 2020	Business Unit Team Manager/ Service Manager	Sarah Lowry
6	2013 – 2020	Business Unit Team Manager/ Head of Cancer Intelligence & Legal Claims	Tom Jarosz- Cromie

- (aa) **The human resources department of NHS Tayside, insofar as its remit was relevant or potentially relevant to the practice of Mr Eljamel; and**

8(aa).1 List of HR Directors since 1995

8(aa).2 Please note – dates may not be exact and may overlap based on changing organisations over the relevant period.

	Dates	Dundee Teaching Hospitals NHS Trust – Role	Name
1	1995 - 1999	Director of Human Resource Management	Mr John Cowie
	Dates	Tayside University Hospitals NHS Trust – Role	Name
2	1999 – 2001	Director of Human Resources	Mr Peter Murphy
3	2001 – 2004 April 2004 – March 2005	Director of Human Resources (Acute Services Division)	Mrs Janice Torbet
	Dates	Tayside NHS Board – Role	Name

4	Oct 2001 (or earlier) – March 2005 (or later)	Director of Human Resources - by May 2005 job title is Associate Director of HR (Staff Governance & Employee Relations)	Mr John Cowie
5	1 Oct 2004 – 30 Nov 2007	Director of Strategic Human Resources and Workforce Development	Mr Alan Boyter
6	1 December 2007 – 31 August 2008	Director	Unknown
7	1 Sept 2008 – 31 Dec 2011	Director of Workforce	Mr Alex Killick
8	1 January 2012 – 31 March 2012	Director of Workforce	Unknown
9	April 2012 – Nov 2022	Director of Workforce <i>(Mr Doherty held other leadership positions within HR between 2000 and 2022).</i>	Mr George Doherty

8(aa).3 Other relevant individuals within HR/Corporate Since 1995

	Dates	Role	Name	Reason for inclusion
1	1990 – 1999	Employee Relations Manager, then Deputy Director of Human Resources (exact dates of roles not known) - Dundee Teaching Hospitals NHS Trust	Mrs Annie Ingram	
	1999 - 2003	Clinical Group Manager – Critical Care – Tayside		

	Dates	Role	Name	Reason for inclusion
	2003-2012 2012 - 2019 2018 - 2019	University Hospitals NHS Trust Seconded to North of Scotland Regional Planning Group from NHS Tayside Employed by NHS Grampian including Deputy Chief Executive <i>(seconded from NHS Grampian)</i>	Mrs Annie Ingram	Commissioned the Tracey Gillies report in 2019
2	1995 - 2023	Associate Director of Workforce (previously HR Business Lead for the Surgical Directorate)	Mrs Lorraine Fraser	Provided HR support re Mr Eljamel in lead up to clinical supervision and suspension
3	1995 - 2004	Medical Staffing Officer	Mrs Elizabeth Blair	Led recruitment and appointment process for Mr Eljamel
	1999 – 2022	Deputy Director of Workforce	Mr Christopher Smith	Senior HR leader during relevant period.
5	April 2005 –	Head of Human Resources (Acute Services Division)	Jennifer Jamieson	Senior HR leader during relevant period.

	Dates	Role	Name	Reason for inclusion
	March 2006			

(bb) Any other positions within bodies with responsibilities relating to management or oversight of systems relevant or potentially relevant to the professional practice of Mr Eljamel.

8(bb).1 NHS Tayside is not aware of any further additional information beyond that which is provided above.

9. Please explain how the role of NHST over the relevant period fitted with the role/ remit of the following key organisations which did or could have had a role in the oversight of aspects of the professional practice of Mr Eljamel:

(a) The Scottish Executive/ Scottish Government;

9(a).1 Health became a devolved matter on 1 July 1999, therefore the remit of the above bodies was to set national health policy and to hold NHS Boards and/or NHS Trusts to account.

9(a).2 The Scottish Executive/Scottish Government would have no direct oversight of aspects of an individual's professional practice.

(b) Insofar as relevant to the provision of healthcare over the relevant period, the UK Government;

9(b).1 Remit: To oversee reserved bodies (e.g., GMC and HSE) and health policy in England.

9(b).2 Oversight: It would have no direct oversight of aspects of an individual's professional practice.

(c) Healthcare Improvement Scotland and its predecessor organisations;

- 9(c).1 Remit: Scotland's national improvement and scrutiny body for healthcare quality and patient safety; conducting inspections, issuing standards, and supporting improvement in clinical governance.
- 9(c).2 Oversight: It would have no direct oversight of aspects of an individual's professional practice.

(d) NHS Education for Scotland and its predecessor organisations;

- 9(d).1 Remit: National body for medical education, training, and workforce development in NHS Scotland.
- 9(d).2 Oversight: It would have no direct oversight of aspects of an individual's professional practice but would have oversight of training environment, seeking feedback from trainees that may provide intelligence on clinical practice.

(e) The University of Dundee;

- 9(e).1 Remit: Academic partner for teaching and research.
- 9(e).2 Oversight: It would have no direct oversight of aspects of an individual's professional practice relating to NHS Tayside but would have oversight of Mr Eljamel's professional practice within the University of Dundee.

(f) The Royal College of Surgeons (Edinburgh) and other relevant Royal Colleges;

- 9(f).1 Remit: To set professional standards, curricula, examinations, and fellowship, and to provide guidance, peer advice, and quality initiatives. It does not regulate licensure.
- 9(f).2 Oversight: It would have no direct oversight of aspects of an individual's professional practice.

(g) The Royal College of Surgeons;

- 9(g).1 Remit: The remit of the Royal College of Surgeons (RCS), and all royal colleges is the promotion of high standards for the education, training of doctors through their careers. They play a role in influence and shaping healthcare across the UK, in addition to advocating for improvements in clinical quality public health.
- 9(g).2 Oversight: On a day-to-day basis the RCS do not have oversight on individual clinician practice. They may however be asked by organisations to provided external assessment on individual clinicians or services.

(h) The General Medical Council;

- 9(h).1 Remit: Statutory regulator of doctors across the UK - registration, revalidation, fitness to practise.
- 9(h).2 Oversight: The GMC's regulatory processes operate alongside NHS Tayside's duties and responsibilities as employer.

(i) The British Medical Association; and

- 9(i).1 Remit: Trade union and professional association representing doctors. It negotiates contracts and advocates policy but is not a regulator.
- 9(i).2 Oversight: The role of the British Medical Association (BMA) is to provide organisational support and representation to clinicians who are BMA members employed by NHS Tayside. It potentially influences workplace policies and culture but does not directly oversee clinical performance or fitness to practise.

(j) The Health and Safety Executive.

- 9(j).1 Remit: UK's national regulator for workplace health and safety, responsible for enforcement and guidance across sectors, including healthcare. Its regulatory framework applies to NHS Tayside's operating theatres and clinical environments.
- 9(j).2 Oversight: It would have no direct oversight of aspects of an individual's professional practice.

10. Please explain the main principles of policies and practices within NHST, including how and these evolved over the relevant period, insofar as they were relevant or potentially relevant to the practice of Mr Eljamel, relating to the following:

(a) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3) including but not limited to its Clinical Governance Strategy, its Assurance Framework for Clinical Governance, whistleblowing systems, morbidity and mortality meetings, other internal monitoring meetings and line management within the neurosurgical department;

10(a).1 Clinical Governance

10(a).2 The broad system for clinical governance has been directed by clinical governance strategies over the years. Clinical governance as a term was new in 1995 and not formally defined until the NHS MEL(1998)75 [NHST-00231]. The following sets out how clinical governance has evolved over the period 1995 – 2014.

10(a).3 The introduction of “Quality Strategy” (1995–1998) [NHST-04414] was an early precursor to clinical governance. The purpose of the strategy was to emphasise the need for quality to be managed to ensure consistency of services and provide a framework for quality that is comprehensive, coherent, systematic, and continuous. The strategy was supported by a two-year work programme and led to the establishment of a Quality Steering Group.

10(a).4 This was supported by a “Procedure for the Reporting of Untoward Incidents” [NHST-04353] in 1997. This formal procedure for reporting untoward incidents was approved, and the front page of this procedure details a Policy Statement requiring adherence to this process.

10(a).5 Following introduction of the NHS MEL(1998)75 [NHST-00231], the concepts of clinical governance and clinical performance indicators were presented by the Medical Director to the Trust Board (Trust Board Meeting 25 June 1998 [NHST-

04415]. A Quality and Clinical Effectiveness Report [NHST-04412] describes the first meeting of the Trust's Quality and Clinical Effectiveness Working Party and the development of a Quality and Clinical Effectiveness Framework.

- 10(a).6 In December 1998, a proposal for groupings of care groups across the organisation identified a proposed structure for the Clinical Governance service [NHST-04411].

- 10(a).7 In 1999, the NHS MEL(1999)76 [NHST-04410] was issued to support clinical effectiveness and it presented a proposal for clinical governance structure, processes and models and included the arrangements for the first Clinical Governance Committee [NHST-04413].

- 10(a).8 Throughout 1999 - 2000, reports on the progress of clinical governance were presented to the Trust Board and Clinical Governance Committee (see Appendix C: Question 8k).

- 10(a).9 In 2000, the NHS MEL(2000)29 [NHST-04344] was published and in 2001, a draft Clinical Governance Strategy [NHST-04416] which outlined its purpose, implementation plans, objectives and priorities, was presented at the Trust Board meeting on 30 May 2001.

- 10(a).10 Throughout 2001 – 2004: progress and annual reporting on Clinical Governance was reported to the Clinical Governance Committee (see Appendix C: Question 8k). The "Adverse Incident Management (AIM) Policy" [NHST-04354] was approved in 2002, replacing previous procedures for reporting clinical incidents. This policy set out for all staff, the process of reporting a clinical incident.

- 10(a).11 Between 2005 and 2014, NHS Tayside moved to a more integrated clinical governance system. The emphasis was on patient safety, risk management, complaints handling, and person-centred care. Key changes included committee restructuring, updated policies, clearer reporting routes, and modernised incident and feedback systems. This included the establishment of the Clinical Quality Forum, in 2011, which reported to the Improvement and Quality Committee.

- 10(a).12 In 2008, a Strategy for Patient Safety, Clinical Governance and Risk Management was developed [NHST-04400]. The Acting Head of Safety, Governance & Risk reported strengths and challenges to tighten system controls. The committee

formalised the Clinical Governance Corporate Risk [NHST-04706] illustrating an organisation-wide approach to identifying, mitigating and reporting risk and the Medical Director adopted the Lead Executive role for clinical governance.

10(a).13 During this period, a number of strategies, frameworks and policies were also established and implemented. These included:

- The Adverse Event Management (AEM) Policy (formally known as AIM) [NHST-01553; NHST-04354] was established in 2002 and reviewed annually. This policy strengthened incident reviews and learning governance.
- The Strategy for Quality Improvement and Patient Safety 2005 – 2008 [NHST-04707].
- The “Strategy for Patient Safety, Clinical Governance and Risk Management 2008 – 2011 [NHST-04400]. This strategy described the integration of Safety, Governance and Risk teams. It built upon two previous strategies: The Strategy for Quality Improvement and Patient Safety 2005 – 2008 [NHST-04707] and the Risk Management Strategy [NHST-04451].
- Significant Event Management (SEM) Policy [NHST-01552]. This introduced in 2012, covering “all accidents, incidents and near misses which either caused, or could have caused injury or death to individuals or damage or loss to NHS Tayside property.”
- The “Clinical Governance Strategy 2013-16” [NHST-01623], which was supported by the corporate Clinical Governance team, through training and support with adverse event management (including managing the SCEA process).
- The Care Assurance and Measurement Framework which was presented to the Improvement and Quality Committee on 9 October 2014 [NHST-01510]. This outlined how clinical governance would develop through the use of data and quality improvement.

10(a).14 Mortality and Morbidity

10(a).15 Prior to 2018, there was no consistent local or national guidance regarding Morbidity and Mortality (M&M) reviews. The Scottish Mortality and Morbidity Programme (SMMP) (2018) identified examples of good practice across NHS Scotland. Its survey, however, highlighted significant variation in the structure, processes, and

outputs of M&M meetings. This 2018 document has now been archived by Public Health Scotland (previously ISD) and is not accessible, but SMMP Practice Guide 2017 [NHST-04721] provides further background on the programme.

- 10(a).16 NHS Tayside has a history of engagement with the Scottish Audit of Surgical Mortality (SASM). The SASM Annual Report 2010 demonstrates local participation [NHST-01706]. SASM was a voluntary audit reviewing all hospital deaths under surgical care, regardless of whether an operation was performed. Each case undergoes peer review, and findings are summarised in the annual report.
- 10(a).17 In 2009, NHS Tayside achieved a surgical proforma return rate of 71.9%, with proformas completed by the surgeon responsible for the patient's care. National data shows that 70.9% of returned proformas related to neurosurgical deaths, although the proportion specific to NHS Tayside is unknown.
- 10(a).18 Further data indicates that 79.7% of NHS Tayside's returned cases were discussed at local M&M meetings. The term "returned cases" refers to the cases submitted by NHS Tayside to SASM for inclusion in the national audit. The SASM Report 2010 [NHST-01706] relates to national data from 2009 and as part of this report demonstrates that all data submitted to SASM evidenced that nationally 100% of neurosurgical cases were discussed at local M&M meetings. The reason a figure for NHS Tayside neurosurgery is not available, is that SASM reported neurosurgical data only at a national level in the 2010 report and did not break these figures down into individual health boards.
- 10(a).19 Ninewells Hospital and Medical School participated in a pilot project involving Anaesthesia and General Surgery. The aim was to compare outcomes from local departmental M&M reviews with those from the external SASM process. The 2010 SASM report noted that "neurosurgical departments, among others, already discuss all their deaths locally and complete their SASM proforma as a team." [NHST-01706_19].
- 10(a).20 Evidence from 2013 confirms that multidisciplinary, clinical effectiveness M&M meetings were held within the Neurosurgery department, with documented learning points and actions [NHST-01536; NHST-04709; NHST-01534; NHST-01535]. SASM was suspended nationally in May 2010 due to Caldicott Guardians concerns relating to patient confidentiality due to the use of a postal system.

10(a).21 Professional Governance

10(a).22 General Medical Council framework 1995-2014

Between 1995 and 2005, the General Medical Council (GMC) substantially shaped the regulatory framework for doctors in the UK, focusing on setting clear professional standards and strengthening fitness-to-practise processes.

10(a).23 In 1995 the GMC published its first edition of Good Medical Practice (GMP) [NHST-04355], the core guidance that defines the standards of conduct, performance and ethics expected of all UK doctors. This was the first positive statement of expected standards and applied across specialties and grades.

10(a).24 During this period the GMC operated under the Medical Act 1983 [NHST-04501], which provided its statutory basis for registration, professional conduct rules, education standards, and disciplinary processes. Amendments such as the Medical (Professional Performance) Act 1995 [NHST-04502] strengthened GMC powers relating to performance and voluntary removal from the medical register.

10(a).25 In terms of fitness to practise, the GMC's rules and procedures evolved, culminating in the General Medical Council (Fitness to Practise) Rules Order of Council 2004 [NHST-04503], which formalised how concerns about a doctor's conduct, health, or performance were to be investigated and adjudicated.

10(a).26 Plans for revalidation required doctors to regularly demonstrate ongoing fitness to practise were developed in this decade. This was first proposed in 1998 and embedded legally by amendments to the Medical Act by 2002, although full implementation extended beyond 2005.

10(a).27 Between 2005 and 2014 the governance of the medical profession and regulation by the GMC underwent significant reform, shifting away from traditional self-regulation toward a more accountable, patient-centred framework. The GMC's disciplinary procedures were professionalised, with independent adjudication and new fitness-to-practise procedures introduced.

10(a).28 PCS(DD)2001/2 [NHST-04409] is the NHS Scotland circular issued on 12 January 2001 that introduced compulsory annual appraisals for all consultants from 1 April

2001. This was the first formal national requirement for consultant appraisal in Scotland. [NHST-04406; NHST-04407; NHST-04408].

- 10(a).29 In response to this, NHS Tayside appointed a medical appraisal lead and a programme manager to oversee the introduction of medical appraisal for consultants and SAS doctors in secondary care. Please see the table below which outlines who held these roles over the relevant period. Each consultant was required to maintain a portfolio of evidence for annual appraisal. This was a paper-based system and required the central training of large numbers of consultants to act as appraisers.

No.	Year	Designation	Name
1	2000-2006 (approx.)	Appraisal Lead	Professor David Rowley
2	2007-2014 (approx.)	Appraisal Lead	Professor Musheer Hussain
3	2015-2019 (approx.)	Appraisal Lead	Mr David Mowle

- 10(a).30 A regulatory reform in this period was the introduction of the Responsible Officer (RO) role in 2010 and medical revalidation in December 2012, requiring licensed doctors to regularly demonstrate that they remain up-to-date and fit-to-practise through structured appraisals and reflection, rather than relying on intermittent complaints or sporadic reviews. This supported continuous professional accountability and quality improvement.

- 10(a).31 The RO role in the NHS is governed by the Medical Profession (Responsible Officers) Regulations 2010 [NHST-04406], later amended in 2013 (and updated again in 2025). These regulations require every designated body (such as an NHS Health Board) to appoint an RO. In 2010 NHS Tayside appointed the Executive Medical Director to the RO role. The RO is legally accountable for monitoring doctors' fitness to practise, overseeing appraisals, and making revalidation recommendations to the GMC. For trainees, the RO is the Medical Director of NES.

- 10(a).32 Whistleblowing

- 10(a).33 The National Whistleblowing Standards for the NHS in Scotland became effective from 1st April 2021. In relation to the reference period 1995-2013, NHS Tayside had the following local board policies:

10(a).34 The NHS Tayside Whistleblowing Policy [NHST-01694], effective from April 2013, was available to all employees, workers and ex-employees of the organisation. This policy supported staff to raise a concern under the Public Interest Disclosure Act 1998 (PIDA) [NHST-04505]. Examples of public interest concerns described within the policy included malpractice, fraud, abuse in care, omissions in care, substantial poor performance or outcomes, danger to public safety or damage to the environment. The policy described how concerns could be raised and how they would be handled.

10(a).35 The NHS Tayside Voicing Concern Policy (May 2010-April 2013) [NHST-04402] was available to all employees (including casual or temporary staff) who had concerns relating to patient safety, delivery of care, health and safety of employees or visitors, or the impairment of the viability or integrity of the organisation. Examples of concerns described within the policy include malpractice, fraud, abuse in care, omissions in care, substantial poor performance or outcomes, danger to public safety or damage to the environment. The policy described how concerns could be raised and how they would be handled and the policy took full account of the provisions of the Public Interest Disclosure Act 1998 [NHST-04505].

10(a).36 From May 2011, NHS Tayside followed the national PIN policy Implementing & Reviewing Whistleblowing Arrangements in NHS Scotland [NHST-04401]. There is no record of any policy in place within NHS Tayside prior to 2011 or any national requirement.

(b) Broad systems and rules about work patterns in NHST, working in private practice whilst employed by NHST (ToRs 2/ 3) and about supervision/ training of junior colleagues (ToR 2);

10(b).1 Work systems and rules were governed by the consultant contract, including working in private practice. During the relevant period there were two contracts. From 1995 to 2004, consultants were still working under the 1948 contract with incremental updates — and private practice was governed by that older framework NHS Tayside does not hold a copy of the 1948 contract, and it is no longer available from online sources. See for example, The Hospital Medical and Dental Staff Terms and Conditions of Service Handbook published by the Scottish Executive in April

2003 [NHST-01574]. NHS Tayside does not hold any handbook that was used prior to April 2003.

- 10(b).2 Consultants could undertake private practice so long as it did not interfere with NHS duties. There was no cap on private work, and consultants could organise it independently. The contract did not require detailed job plans, making it challenging for Health Boards to monitor or limit private work.
- 10(b).3 From 2004, a new contract was introduced (April 2004) [NHST-01575]. The new contract allowed Boards to plan consultants' work around the needs of patients and the service, limit consultants' working hours in line with the European Working Time Directive (EWTD) and make it easier for the NHS to recruit and retain consultants.
- 10(b).4 The new contract aimed to reduce conflicts around private practice and contained conditions that:
- NHS must have first call on consultant time.
 - Private practice must not conflict with NHS duties.
 - Consultants must declare private commitments.
 - Job plans specify all NHS and private work.
 - Extra PAs (EPAs) regulate private practice during NHS time.
- 10(b).5 The 2004 Scottish consultant contract was amended on 26 March 2009, specifically the Code of Conduct for Private Practice PCS(DD)2009/1 [NHST-04404].
- 10(b).6 The contract was enforced by annual job planning work patterns for consultants which are generated by a weekly timetable of Programmed Activities (PAs) - which are sometimes referred to as "sessions" - in support of a job plan. The job plan would broadly outline the number of PAs for each area of activity, one PA being a four (4) hour block. The job plan would also outline the expected on-call rota arrangements. Consultant Neurosurgeon on-call responsibilities are outlined in response to Question 19(f).
- 10(b).7 The national consultant terms and conditions handbook in place at the time of Mr Eljamel's appointment has been replaced by more recent versions of the terms and conditions handbooks. The Hospital Medical and Dental Staff Terms and Conditions

of Service Handbook published by the Scottish Executive in April 2003 [NHST-01574], however, confirms that consultants were able to undertake private practice provided that their gross income from such work did not exceed 10% of their gross salary. There was an obligation on the employee to certify annually that private practice income did not exceed 10% of their gross salary.

10(b).8 In general terms, consultants are expected to undertake the training and supervision of doctors in training, and this was the case as set out in Mr Eljamel's appointment letter [NHST-01540_2]. This would involve delivering practical training to enable trainee doctors to perform surgical procedures and to manage patients in the ward to the level of their training requirement. The trainee doctor would then be assessed and supported to the required capabilities and competence as set out in the national curriculum [NHST-04405]. There is no evidence that further documentation was held within NHS Tayside which set out consultants' obligations in relation to the training and supervision of doctors in training other than that set out in agreed job plans. Please refer to paragraph 19(m).2.

(c) Complaints and feedback systems within NHST, statistical evidence relating to the nature and timing of formal complaints about Mr Eljamel (ToRs 4 and 5) including but not limited to its Adverse Incident Management Policy (including any policy relating to near misses), its Significant Event Management Policy, Significant Event Analysis reviews and its Datix system;

10(c).1 Statistical information related to the handling of complaints about Mr Eljamel can be found in response to Question 224.

10(c).2 The complaints team used the Complaints and Advice Management System (CAMS) prior to Datix (complaints module) implemented in 2011. Further information regarding this system can be found in response to Question 106.

10(c).3 There is a module user guide dated 2011 for the Complaints Module in Datix. This is called the 2011 Datix Rich User Guide doc [NHST-01509]. There was no documentation retained in relation to the operation of the previous system following the implementation of the Complaints Module within Datix.

- (d) **Internal and external information sharing systems within NHST incumbent upon medical professionals, including candour with patients/ relatives, professional colleagues and regulatory bodies, including with the GMC (ToR 7);**
- 10(d).1 Between 1995 and 2014, NHS Tayside operated within a UK-wide and Scotland-specific governance framework that evolved significantly over the relevant period. The systems below reflect what was incumbent upon medical professionals.
- 10(d).2 Before the statutory Duty of Candour (2018), doctors were already bound by a professional duty under GMC guidance:
- 10(d).3 *Good Medical Practice* (1995, 1998, 2001, 2006, 2013 editions) required doctors to be open and honest when things go wrong, explain adverse events, apologise and take steps to prevent recurrence [NHST-04355 - NHST-04359]. Medical professionals were obliged to share relevant information with the GMC where concerns arose about a doctor's conduct, competence or health. NHS Tayside holds no evidence that there were any local policies or guidance in relation to the implementation of Good Medical Practice, over the relevant period.
- 10(d).4 Internally, clinicians were expected to share information openly through clinical governance processes, incident reporting systems, Significant Adverse Event Reviews, and routine communication with colleagues to support safe, coordinated care. In addition, information could be shared with other bodies such as the police when necessary to prevent or investigate serious crime or protect individuals from harm, and with the Scottish Government through established reporting channels covering adverse events, performance, safety and public-health matters. Together, these systems created a framework in which medical professionals were expected to communicate transparently with patients, colleagues, regulators and public authorities to maintain safety, quality and trust in care.
- (e) **Information sharing systems incumbent upon NHST relating to the professional practice of medical professionals, including candour with patients/ relatives, regulatory bodies, including the GMC, the police and the Scottish Government (ToR 13); and**

- 10(e).1 Between 1995 and 2014, NHS Tayside operated within a framework that required information-sharing to ensure safe professional practice of medical staff. During this period, doctors were bound by the GMC's duties of a doctor. (See 10(d).3). NHS Tayside supported this through clinical governance systems including adverse-event reporting and reviews and patient-communication processes. NHS Tayside was also responsible for sharing information with the GMC whenever concerns arose about a doctor's conduct, competence or health, and from 2012 this included statutory duties linked to revalidation through the RO. NHS Tayside is required to share information with the Police when necessary to prevent or investigate serious crime, comply with legal processes, or protect individuals from harm. Decisions are governed by the Data Protection Act 1998 [NHST-04466], and the common law confidentiality and Caldicott principles. Throughout the period, the organisation also shared information with the Scottish Government on adverse events, performance, safety and public-health matters as part of the national clinical governance system introduced in 1999 and strengthened through the 2000s. Internally, NHS Tayside developed and maintained systems for monitoring quality, safety and professional conduct - including risk management, adverse incident reporting, clinical governance committees and medical staffing oversight — to ensure that information relevant to patient safety and professional standards was escalated appropriately across the organisation and to external bodies when required.
- 10(e).2 NHS Tayside was required to share information with Police Scotland (and previous regional police forces) when a serious crime was suspected. This includes; deaths requiring investigation, risk of harm to others, court orders or warrants that required disclosure.
- (f) NHST rules relating to clinical supervision, suspension, dismissal and removal of the name of a neurosurgeon from the GMC medical register (ToRs 8 to 11).**
- 10(f).1 The procedures relating to suspension and dismissal for the period in question are laid out in NHS Tayside's Disciplinary Procedures for Hospital Medical and Dental Staff [NHST-01579]. The document covers the entire relevant period, it is a collection of documents that were issued relating to Medical and Dental Disciplinary procedures from 1990, with addendums which were incorporated into the document, in 1994, 1999 and 2001. These procedures are separated into two

routes: personal conduct; and professional conduct and competence. The mechanisms for investigation of the latter are different depending on the potential disciplinary outcome as a result of the level of misconduct or competence.

- 10(f).2 The procedures require a review point to determine whether the conduct is personal or professional, allowing the investigation to take the appropriate route through the procedures. In either case disciplinary action would not be taken until such time as an investigation had taken place. Investigations are to be conducted under the direction of the Medical Director.
- 10(f).3. The procedures note that following the investigation, a decision on whether or not to convene a formal disciplinary hearing must be taken. They broadly outline the format a hearing must take and the levels of sanction, including dismissal in cases of gross misconduct, amongst others.
- 10(f).4 The procedures also note the process for suspension. They note that this does not constitute disciplinary action; would always be on full pay; and is pending potential disciplinary action based on the outcome of the investigation. They note a requirement to review suspensions on a four weekly basis and for the employee to be notified in writing.
- 10(f).5 There is a requirement on employers of employees who require registration with the GMC to notify the GMC of any concerns about fitness to practice, as appropriate. Further information on this will be available from the GMC.

Appendix B - Part C – The NHS Tayside neurosurgical service and the work of Mr Eljamel

General

11. On 10 September 2025, the BBC reported that:

**“Dr James Cotton, executive medical director of NHS Tayside stated that...
"We know that many people have experienced considerable distress as patients of Mr Eljamel and we understand that in many cases we have added to that trauma in the way that we have handled ongoing complaints and concerns. We are sincerely sorry for this."**

Please explain what NHST was apologising to patients for, in particular what trauma they accept they caused, when and how?

11.1 The above statement was given to the media on 9 September 2025 as NHS Tayside’s response to The Eljamel Inquiry Preliminary Hearing held on that day. The context for the statement was an acknowledgement from NHS Tayside that the hearing marked a very important day for the patients and families of patients of Mr Eljamel, recognising the protracted nature of the matters which are the subject of the Inquiry.

11.2 The apology on behalf of NHS Tayside by its Executive Medical Director, Dr James Cotton, was in recognition that it has not handled the matter of complaints and concerns raised by patients and families in a person-centred way. The Scottish Government Review of Outstanding and Unresolved Concerns regarding Mr Eljamel published in 2022 [NHST-04351] identified that NHS Tayside should offer better ongoing support for patients in more complex, long-running matters. The NHS Tayside Due Diligence Review published in 2023 [NHST-00075] identified that responses to complaints and concerns had lacked consistency, and that processes to investigate significant concerns had been variable. There was no trauma-informed approach for Mr Eljamel’s patients prior to the establishment of the Patient Liaison Response Team (PLRT) in 2023. NHS Tayside accepts it has let down patients in the way that it has engaged with them, and this is demonstrated by the fact that the Due Diligence Review was not undertaken until 2023, nearly 10 years following Mr Eljamel’s departure from NHS Tayside. Many patients have been

affected by NHS Tayside's poor engagement with them, and it is recognised some have suffered traumatic responses. The apology was offered in that regard.

12. It was also reported that:

"Dr Cotton added that since the publication of NHS Tayside's 2023 Due Diligence Review into Eljamel, the board had "fully committed to making improvements where failings have been identified."

Please explain what failings NHST have been identified relating to the systems surrounding the professional practice of Mr Eljamel to which the 2023 review related and what improvements have been made as a result.

12.1 The Due Diligence Review 2023 [NHST-00075] identified failings related to clinical, professional and corporate governance. In terms of the systems surrounding the professional practice of Mr Eljamel, it was found that there were a number of signals emerging in NHS Tayside to suggest there may be issues with his clinical practice and communications with patients and colleagues. These emanated from complaints and clinical governance processes and were the reason that the Royal College of Surgeons (RCS) was commissioned to carry out a review in 2013. Further information can be found in response to Question 124.

12.2 The failings identified in the Due Diligence Review 2023 included:

- "inadequate clinical supervision when Mr Eljamel was placed under indirect supervision when he should have been directly supervised in theatre.
- inadequate senior input to the supervision arrangements resulting in inadequate assessment of risk and consideration of patient safety.
- no action taken when the RCS sent an interim report [NHST-00072] to NHS Tayside in October 2013 raising concerns of probity, poor communications and poor behaviours by Mr Eljamel.
- the conclusion that patients were placed at potential risk of harm due to the inadequacy of the supervision arrangements; and
- the ceasing of an internal investigation into Mr Eljamel by NHS Tayside after he intimated his retirement in early 2014.

- 12.3 An Action Plan [NHST-01681] was developed following the Due Diligence Review 2023 [NHST-00075] to progress the recommendations made by the Executive Medical Director. The actions to strengthen clinical, professional and corporate governance have been embedded into NHS Tayside's governance and business systems and continue to be reported through the Clinical Governance Committee.

The NHS Tayside neurosurgical service

- 13. Please explain the role and responsibility of Ninewells Hospital as a teaching hospital over the relevant period, in particular as that status impacted upon the functioning of the neurosurgical department.**

13.1 Ninewells Hospital has been a teaching hospital since opening in 1974, and this status continues to present day. This means its medical staff are not only delivering patient care but also training future doctors, both undergraduate and postgraduate, and advancing medical knowledge through research. NHS Tayside is responsible for providing an educational environment to facilitate the delivery of the clinical components of the undergraduate and post graduate curriculum.

13.2 The Neurosurgery department was located at DRI prior to its move to Ninewells Hospital on 16 November 1998. Teaching was also undertaken at DRI.

- 14. Please explain organisation of the neurosurgical unit at Ninewells Hospital over the relevant period, including key individuals, roles and responsibilities, with particular regard to the matters covered by the Inquiry's Terms of Reference and List of Issues.**

Please set out the identity of other individuals with whom Mr Eljamel worked over the relevant period and their roles (a) within the neurosurgical unit at Ninewells Hospital and (b) within other departments with whom Mr Eljamel regularly came into contact in his neurosurgical work, including but not limited to the neuro-oncology department, the neuro-radiology department, the neurology department, the paediatric department, the anaesthetic department, the intensive therapy unit and pain management services

- 14.1 From 1995 to 1998, Neurosciences was located at DRI, which included the departments of Neurosurgery, Neurology, Neurophysiology, Neuroradiology and the Pain Clinic *[NHST-01504; NHST-01521]*.
- 14.2 From 1995 to 1998, the Neurosurgical ward had a total of 27 beds, which included a high dependency area and three paediatric beds. The Neurosurgical theatre, which was housed in the same building, was entirely dedicated to Neurosurgery and staffed at all times by Neurosurgical theatre nurses.
- 14.3 The Neuroscience department, including the Neurosurgical service, was transferred from DRI to Ninewells Hospital on 16 November 1998 and was one of the last services to transfer from DRI prior to its closure *[NHST-01582; NHST-01583]*.
- 14.4 The Neurosurgical service formed part of the Neurosciences Department and was under the remit of Dundee Teaching Hospitals NHS Trust up until 1 April 1999. Responsibility then transferred to Tayside University Hospitals NHS Trust, where it remained until 1 April 2004. Following the dissolution of that Trust, NHS Tayside was established as a unified Board assuming operational responsibility for the Neurosurgical service, which provided general neurosurgical services for patients in Tayside and North-East Fife, covering Perth Royal Infirmary as well as Stracathro Hospital, and maintained close links with the neighbouring Fife Acute Hospitals *[NHST-01505]*.
- 14.5 The Neurosciences Department, including the Neurosurgical service, became part of the Specialist Services Clinical Group in 1999 when the structure was introduced. The Neurosciences Department encompassed Neurosurgery, Neurology, Clinical Neurophysiology, Chronic Pain Service, with the addition of Neuropsychology and Neuropsychiatry. Following the relocation of the department in 1998, from a dedicated neurosurgical unit at DRI to Ninewells Hospital, a dedicated Neurosurgical ward was established at Ninewells Hospital, comprising 18 acute adult beds and four high dependency beds. Neurosurgical intensive care was provided within Ninewells General Intensive Therapy Unit (ITU). Paediatric patients were looked after in the Paediatric wards. A close liaison has also always existed with the Brain Injury Rehabilitation Centre based at the Royal Victoria Hospital in Dundee *[NHST-01505]*.

- 14.6 The Neurosurgery department in Tayside has been a member of the national Managed Service Network (MSN) for Neurosurgery since its inception in 2009 [NHST-04433]. This network was established in 2009 and is responsible for ensuring a national approach to the development of Neurosurgical services, implementation and assessment of nationally agreed service standards and care pathways, and for the promotion of nationally coordinated research and development [NHST-01505].
- 14.7 A list of Clinical Directors and Managers for Specialist services is provided in response to Question 8(d), along with other individuals' roles and identities of relevance.
- 14.8 The unit was staffed by three full time consultant neurosurgeons from 1995, including the position filled by Mr Eljamel. These posts comprised a combination of substantive and locum appointments. In 1998, Mr Varma retired and was temporarily replaced by locum consultants until the recruitment of Mr Ballantyne in 2000 and Mr Mowle was recruited to replace Mr Gentleman (see Appendix 4 Table 1 [NHST-04945] and further details in paragraphs 19.1, 19.2, 19.3, 19(a).1, 19(a).2). This staffing arrangement remained in place until 2011, when a fourth consultant Neurosurgeon was appointed.
- 14.9 The junior medical staff that staffed the Neurosurgery unit were rotational neurosurgical registrars and junior and senior house officers. Some of these posts were dedicated to the Neurosurgical unit, while others were shared with other medical or surgical services (registrars and house officers are now referred to as resident doctors). These doctors worked under the direct supervision of consultant neurosurgeons and provided cover for the neurosurgical wards. Their numbers varied over the years. Between 2009 and 2014, job descriptions show that the Neurosurgical department was supported by six middle grade doctors (these could be ST1-ST5, Clinical Fellows, or Specialty Doctors, either attached to the unit or rotating). In addition, there were three Foundation Year Doctors (previously known as junior or senior house officers JHO/SHO). Furthermore, there were a number of honorary fellows and research fellows attached to the unit from time to time. Where documents have been identified that listed the names of any of the middle grade doctors, juniors, seniors or research, these have been included in Appendix 4 [NHST-04945]. Please refer to paragraphs 19.1, 19.2, 19.3, 19(a).4 for further details.

- 14.10 In 1995, the most senior nurse on the Neurosurgical ward was known as the Matron. In the 2000s, this role became the Senior Charge Nurse. Two Senior Charge Nurses covered the period from 1994 to 2014, each serving as the most senior member of the Neurosurgical ward's nursing team. Please refer to paragraphs 19.1, 19.2, 19.3, 19(a)3, for further details.
- 14.11 NHS Tayside do not hold records for every individual who has worked on the surgical unit. Records would have been destroyed over time in line with retention policies [NHST-00050 – NHST-00063]. Employee records (paper files) are typically retained for six years from the date of termination. Due to system limitations in the legacy HR information systems in place in the relevant period, post titles were not held. Further, systems would have been updated to reflect changes in organisational structure over time. In addition, staffing within the unit changed frequently due to rotations, retirements, secondments, and training arrangements, resulting in reliance on organisational knowledge where formal documentation was no longer available. The Neurosurgical unit operates as a multidisciplinary environment. The wider team includes, but is not limited to, nursing staff, medical staff, medical students, research fellows, allied health professionals, catering and kitchen staff, nursing students, clinical psychologists, and mental health teams. This is in addition to administrative and support roles such as administrative staff, ward clerks, porters, domestic services, and temporary or agency personnel. Please refer to paragraphs 19.1, 19.2, and 19.3 for further details.
- 14.12 The names, where they are known, are included in Appendix 4 (Individuals whom Mr Eljamel worked with 1995 to 2015) [NHST-04945].
- 14.13 Mr Eljamel would have come into regular contact with multiple departments and individuals from other services in NHS Tayside during the relevant period. Staff in these departments also changed frequently over time. The individuals have been identified through job descriptions at the two anchor points (1995 and 2011) have been provided in Appendix 4 [NHST-04945]. Their names and roles have been extracted from job descriptions, organisational charts, and recruitment documents available for those years [NHST-01504; NHST-01505; NHST-01522]. The 2013 Royal College of Surgeons Report [NHST-00072] identified key individuals that Mr Eljamel worked directly with and interviewed them as part of the review. Their names are also included in Appendix 4 [NHST-04945].

15. What neurosurgical services were provided in other facilities under the control of NHST over the relevant period, with particular regard to the facilities where Mr Eljamel worked?

15.1 In 1995, DRI was the main site for Neurosurgery. It is mentioned in the job advertisement that Mr Eljamel applied to, that there was a 'Head Injury' clinic provided in Stracathro Hospital by Mr D Gentleman. However, there is no other evidence of this clinic, and it is therefore likely that it ceased following Mr Gentleman's retirement in 1998. There is no evidence that other consultant neurosurgeons, including Mr Eljamel, provided any neurosurgical services outside of DRI, although job descriptions did expect consultants to undertake domiciliary visits where required [NHST-01521]. Further information about the Neurosurgery services offered after the service moved to Ninewells Hospital in 1998 can be found in response to Question 13 and 14.

16. Please explain:

a) The geographical area for which these services were responsible and how this changed over time, including any effect which any such changes had on the workload of the NHST neurosurgical service; and

16(a).1 In addition to the information provided in response to Questions 13, 14 and 15, in 1995 the Department of Neurosurgery provided a Neurosurgical service for Tayside and North-East Fife. In addition, NHS Tayside provided spinal surgery for South-East Fife. These services were delivered in DRI until 1998, with an estimated catchment population of 600,000–700,000 [NHST-01521_2].

16(a).2 After the closure of the DRI in 1998 [NHST-01582; NHST-01583], the Neurosurgery department in Ninewells Hospital also attracted referrals for Functional Neurosurgery from all over Scotland. In addition to Tayside and North-East Fife, the Neurosurgical department also provided acute neurosurgical services to South-East Fife in the form of spinal surgery [NHST-01505]. By 2011, departmental activity included over 1200 neurosurgical admissions, 1500 new outpatient attendances and over 980 operations per year. This data was obtained from a consultant

neurosurgeon job description from 2011 which references the range and volume of activity undertaken through the NHS Tayside Neurosurgical Department [NHST-01505].

- 16(a).3 In the RCS Report in 2013 [NHST-00072], during the course of interviews, a number of issues relating to the consultant neurosurgeons' job plans were raised. The RCS Review Team heard that the department had taken on many degenerative spinal cases from Fife. This had added to the surgeons' workload and changed their scope of practice to being predominantly spinal work. Consultant Neurosurgeons did not consider it feasible to keep taking on patients from Fife without additional support. The report concluded that workload had been increased by NHS Tayside taking on more cases from outside its established catchment area, including parts of East and South Fife.

b) The waiting times obligations of the NHST neurological service and how they changed over time, including any effect which any such changes had on the workload of the NHST neurosurgical service.

- 16(b).1 NHS Tayside has assumed that the Inquiry means 'Neurosurgical service' in the above question and have provided an answer accordingly.

- 16(b).2 Prior to 2003 (and between 1995 and 2003), waiting lists and waiting times were already recognised - according to the National Audit Scotland report [NHST-04435] as important measures of how effectively a healthcare system responds to service demand. At that time, the following waiting lists were collected and managed by individual Trusts:

- True inpatient (IP) / day case (DC) waiting list – for IP or DC treatment. This list carried a waiting time guarantee, except where a guarantee exception code was applied.
- Deferred waiting list – for patients who were temporarily unavailable for treatment for a range of reasons, including illness, extended holidays, or work commitments. Treatment was postponed for the period of unavailability. This list carried no waiting time guarantees, and once placed on the deferred list, a patient could not be transferred back to the true waiting list.

- Planned repeat waiting list – where a patient was initially admitted from the true waiting list but subsequently required a planned series of repeat treatments, such as regular cystoscopies every three months.

- 16(b).3 Between 1995-2003, there were no formal waiting lists for follow-up outpatient clinic appointments or for outpatient procedures and treatments.
- 16(b).4 The Audit Scotland report Tackling Waiting Times in the NHS in Scotland (2006) [NHST-04436] set out the national waiting time standards that were in place between 2003 and 2007 and the planned reductions thereafter. The report confirmed that, for IP treatment, DC procedures, and new outpatient appointments, no patient to whom the waiting time standard applied should wait more than six months by the end of 2005. It further outlined the Scottish Government's commitment to a more ambitious target, namely that waiting times across these categories would be reduced to a maximum of eighteen weeks by the end of 2007.
- 16(b).5 On 31 December 2007, the "New Ways of Defining and Measuring Waiting Lists" [NHST-01585] was introduced by Public Health Scotland/Scottish Government and was updated in April 2010. Subsequently, the Patient Rights (Scotland) Act 2011 [NHST-04437], which supports the Scottish Government's vision for a high-quality NHS that respects the rights of patients, their carers and all the people who deliver NHS services was introduced. The Act established in law the Treatment Time Guarantee (TTG) [NHST-04438], once a patient has been diagnosed as requiring IP or DC treatment, a Health Board must take all reasonably practicable steps to ensure that the patient's treatment starts within twelve weeks (eighty-four days) of the treatment having been agreed.
- 16(b).6 As far as TTG is concerned, in relation to Neurosurgery and Mr Eljamel, more evening and weekend lists were introduced - evidenced through email communications and letters [NHST-01516] and payment trails for additional evening clinics held September 2010, May 2011, July 2011 and September 2011 [NHST-01518]. In 2013, email communication from Mr David Mowle, Consultant Neurosurgeon, indicated that the pressure of meeting waiting times targets had led to a tendency to add too many cases to the operating list, to comply with clinical need and the requirement to meet waiting time targets [NHST-01517].

16(b).7 In a letter to the Medical Director in 2013 [NHST-01516], Mr Eljamel noted that the increased workload and the impact of TTG resulted in the creation of weekly emergency clinics run by registrars, as some patients could not be seen in the usual non-emergency outpatient clinics due to long waiting times. Additionally, registrar-led general clinics were often run concurrently with Mr Eljamel's specialist clinics. Registrar-led clinics were not typically the result of a formal decision by a single person or a board, but rather reflected longstanding professional practice in consultant-led services. Mr Eljamel's consultant contract letter from 1995 [NHST-01540_2] stated that he has "*continuing clinical responsibility for the patients in [his] charge, allowing for all proper delegation to, and training, of [his] staff*". This approach is also reflected in Good Medical Practice published by the General Medical Council, which formalises the principle that doctors may delegate clinical tasks where appropriate competence and supervision are in place, while retaining overall accountability for patient care [NHST-04355; NHST-04356; NHST-04357; NHST-04358; NHST-04359].

16(b).8 Waiting time targets for NHS Tayside from 2003 to the present day are outlined in the table below:

Date target came into effect	Target for new outpatient appointment	Target for hospital inpatient or day case treatment
31 December 2003	No targets set for outpatient appointments	9 months (274 days)
31 December 2005	26 weeks (182 days)	26 weeks (182 days)
31 December 2007	18 weeks (126 days)	18 weeks (126 days)
31 March 2009	15 weeks (105 days)	15 weeks (105 days)
31 March 2010	12 weeks (84 days)	12 weeks (84 days)
31 December 2011	12 weeks (84 days)	9 weeks (62 days)
1 October 2012	12 weeks treatment time guarantee applies alongside the overall 18 weeks referral to treatment target	

17. Please set out the key individuals working within the Ninewells hospital neurosurgical team, including lead clinicians within the department. Please also set out including the broad responsibilities of each, insofar as relevant to the professional practice of Mr Eljamel, in particular line management responsibilities for Mr Eljamel/ responsibility for (a) surgery planning discussions and (b) the organisation of his clinical sessions?

17.1 The key roles that Mr Eljamel worked most closely with in the Ninewells Hospital neurosurgical team were as follows:

- the consultant neurosurgeons within the unit, including the clinical leads who oversaw service planning, governance, day-to-day organisation;
- the senior charge nurse on the ward;
- a neuroanaesthetist;
- theatre staff that Mr Eljamel worked with; and
- Mr Eljamel's own administrative/secretarial team.

17.2 The identity of the individuals in those roles, that NHS Tayside has been able to identify, are listed in Appendix 4 *[NHST-04945]*.

17.3 Consultant neurosurgeons formed the core senior clinical group within the department. Each consultant retained overall responsibility for their own named patients, including elective surgical planning and review of clinic outcomes. The consultants were collectively responsible for participation in on call rotas, contributions to departmental governance, elective theatre allocations and multidisciplinary team (MDT) activities. Individual surgical planning discussions are the responsibility of each individual consultant surgeon directly with their patient as part of the consent process. Planning the theatre lists happens in discussion with the theatre teams and anaesthetic team to ensure lists are appropriately filled and equipment available. The organisation of a consultant's clinical workload (which includes outpatient and surgical sessions) is undertaken annually as part of the job planning process in discussion with the Clinical Lead *[NHST-00245; NHST-01504; NHST-01505; NHST-01540; NHST-01521; NHST-04439; NHST-01542; NHST-01543; NHST-01640; NHST-04518; NHST-01547; NHST-04600; NHST-04788; NHST-04628; NHST-04629; NHST-04642; NHST-04644]*.

- 17.4 The table below demonstrates the individuals who held the role of Clinical Lead for Neurosurgery between 1995 to 2016.

Clinical Lead for Neurosurgery 1995 – 2018			
No.	Date	Role	Name
1	Pre 1995-1997	Neurosciences Director (Dundee Teaching Hospitals NHS Trust)	Mr T. R. K. Varma
2	1997-2009	Clinical Lead for Neurosurgery	Mr Eljamel
3	2009-2013	Clinical Lead for Neurosurgery	Mr Eric Ballantyne
4	2013-2016	Clinical Lead for Neurosurgery	Mr David Mowle

- 17.5 The Clinical Lead is a consultant role within a clinical service which is assumed in addition to regular clinical duties, with a key remit being clinical and professional governance. It is common practice for this role to be undertaken for a fixed term. It involves:

- providing professional advice on the strategic and operational leadership of the Neurosurgical Service.
- overseeing clinical governance and providing expert clinical advice regarding a single clinical service.
- quality improvement and service development activities.
- support and key roles in formal discussions around consultant job planning, resource allocation, theatre utilisation, service delivery planning and performance reviews.
- liaising with hospital management and allied services.

NHST would ask the Inquiry to note that part of the information in this paragraph is from organisational intelligence and current staff knowledge and experience of the Clinical Lead role.

- 17.6 The Clinical Group Director is responsible for a group of clinical services within their Clinical Care Group providing professional clinical advice to the managerial clinical care group manager, responsible for clinical and professional governance and overseeing strategic planning.

17.7 The names of the individuals who held the role of Clinical Director for Specialist Services are listed in Question 8(d)1.

18. Please explain the nature and frequency of normal working practices and meeting/ engagement patterns between the neurosurgical unit within Ninewells Hospital and other departments within the service offers (sic) by NHST, including:

18.1 The Neurosurgical unit within Ninewells Hospital is required to have working relationships with a range of clinical departments to deliver patient care. From employee recollection, these relationships were established in the mid-1990s and were maintained throughout the relevant period, and some continue to present day and, with regular joint meetings, shared MDTs and collaborative clinical activity form part of routine practice.

b) (Sic) The radiology department, including the facilities available for and the use of pre-operative, intraoperative and post-operative imaging;

18(b).1 Close collaboration with radiology and neurosurgery is integral to neurosurgical practice. In 1995, radiology facilities were adjacent to the Neurosurgical ward in DRI. Based on employee recollection and organisational memory, there were regular meetings between Radiology, Neurology and Neurosurgery teams every Friday morning in DRI which continued when the teams moved to Ninewells. In these weekly MDT meetings, imaging was reviewed as part of case discussions as is standard practice, to formulate management plans. Over and above this, if image interpretation for urgent or emergency cases was required, informal contact between Neurosurgery and Radiology happened during routine working hours and out of hours as required. These meetings continued until the end of the relevant period as indicated in a 2014 job description for a locum neurosurgical consultant [NHST-04439].

c) The anaesthetic department;

- 18(c).1 Neurosurgeons work closely with consultants in Neuroanaesthesia and the wider surgical theatre teams to deliver safe patient care. This is standard practice which continues to date and would have been the case from 1995 onwards. Neurosurgeons and neuroanaesthetists would normally have a regular (same) operating day each week so that there could be consistent team working and consultant to consultant discussions around appropriate patient management could take place.

d) The neurology department;

- 18(d).1 There is close cooperation between the Neurology and Neurosurgery departments through shared management of epilepsy surgery and a well-established epilepsy programme, joint management of functional neurosurgery cases, and co-supervision of trainees, fellows and research students. Through reviews of job adverts and job plans from as early as 2009 [NHST-04441], there is an indication that regular meetings took place with neurology and neurosurgery case conferences [NHST-04440] as part of the clinical Neurosciences meetings on Friday mornings – during which junior doctors and registrars in Neurology and Neurosurgery took turns to present a patient case - with Neurosurgery, Neuroradiology and Clinical Neurophysiology, as well as the weekly neuroradiology-neurosurgery-neurology x-ray meetings (see 18(b).1), a joint functional neurosurgery clinic, joint deep brain stimulation clinic, and regular MDT discussions for complex neurological – neurosurgical patients [NHST-01547]. NHS Tayside found no evidence to accurately indicate when these meetings started. A weekly job plan proposed in a locum consultant neurosurgeon job description from 2014 shows a weekly Friday morning Neuroradiology/Neurosciences academic meeting [NHST-04439], indicating that these meetings continued until at least the end of 2014.

e) The intensive therapy unit;

- 18(e).1 NHS Tayside has no evidence to suggest that there has ever been any joint M&M's/meetings between the Intensive Therapy Unit (ITU) and Neurosurgery. If patients are admitted to the ITU they are managed by the ITU team with input from the admitting Neurosurgical team/consultant as required.

f) The paediatric department;

18(f).1 From employee recollection and organisational memory, the Neuroradiology meeting was the main meeting that involved Neurosurgery and Paediatrics and has been established since 1995 (see response 18(b).1). Mr Eljamel's Weekly schedule in 2012 [NHST-01547] outlined that this meeting was held on a Friday morning at 8am and was titled "Neuro X Ray Meeting". The term 'Neuro X Ray Meeting' is likely to have been used interchangeably with the term 'Neuroradiology Meeting', as both appear to be listed at the same time weekly. During this meeting, the Neurologists, Neuroradiologists and Neurosurgeons would discuss cases including paediatric cases. All Neuro-oncology discussions were with Edinburgh not Tayside consultants. Additionally, in job descriptions as early as 2009 [NHST-04442], there is a mention of a Paediatric Neurology weekly meeting. NHS Tayside has no evidence to indicate when this meeting started or whether this was separate to the Neuroradiology Meeting mentioned above. These meetings are likely to have continued until the end of the relevant period (see answers 18(b)1 and 18(d)1).

18(f).2 Acute cover was provided by the Neurosurgeon on call for paediatric emergency cases, and acute treatment carried out if the patient's condition was life threatening, and the treatment was able to be provided on site. If the patient required transfer, there would be discussion between the Neurosurgical consultant on call in Ninewells with the Edinburgh Paediatric Neurosurgeons if requiring transfer. The MSN for Neurosurgery in 2009 produced guidelines [NHST-04443] to be followed for Paediatric Neurosurgery. No earlier national guidelines have been identified during NHS Tayside's searches for information. Based on employee recollection, Mr Ballantyne had paediatric experience, therefore paediatric cases would be referred to him at first instance, and he would operate on some locally and liaise with Edinburgh where required. However, there were no formalised arrangements or structured pathways in place.

g) The oncology department;

18(g).1 Neurosurgeons work closely with the Oncology department for the management of brain tumours. This is standard and accepted clinical practice in the UK and would have been the case between 1995 and 2014. The collaborative work typically includes regular MDT meetings, ongoing joint clinical decision making relating to surgical intervention, chemotherapy, radiotherapy and palliative care pathways and

in some centre joint neuro-oncology clinics. From 2009-2014, Mr Eljamel held a monthly joint Neuro-oncology clinic with a Neuro-oncologist, participated in a weekly Friday morning Neuro-oncology MDT (which continued until the end of the relevant period) [NHST-04439; NHST-04440] and was involved in joint planning and coordination for surgical, chemo-radiotherapy and palliative pathways [NHST-01547]. This was confirmed by a current consultant oncologist, Dr Hannah Lord who commenced employment in 2009. The oncologist also confirmed that the joint Neuro-oncology clinic and the weekly Neuro-oncology MDT were already in existence by the time she commenced her post in 2009 and that she personally participated (and continues to participate) in these activities both with Mr Eljamel and Mr Ballantyne. It has not been possible to determine when these clinics and meetings commenced prior to 2009. This is due to the absence of electronic records in that period, the inability to locate paper records (which are likely to have been destroyed in accordance with records management policies [NHST-00050 - NHST-00063]) that would confirm the historical arrangements, and inability to identify other staff members who have reliable recollection of when the clinics and MDTs would have started.

h) Pain management services; and

- 18(h).1 Based on employee recollection since 1995, it has been standard practice for the Neurosurgical department and pain management services to work jointly in the assessment and management of patients with chronic pain. Such joint working was not exceptional and formed part of routine service delivery – a practice that continues to date. The two teams have shared cases involving neuromodulation, neuro-stimulation and functional procedures, coordinated assessment for invasive and non-invasive therapies, and attended joint meetings and case discussions. A current consultant pain anaesthetist, Dr Gail Gillespie, confirms that quarterly spinal cord stimulation assessment meetings were held jointly with the neurosurgical team and that these clinics and joint assessments have been running for the entirety of their tenure, which exceeds 18 years (i.e. at least from 2006 until the end of the relevant period). It has not been possible to determine the exact date of commencement of the clinics for reasons mentioned in 18(g).1.

i) Other departments of services within NHST with which the neurosurgical service regularly worked or came into contact.

18(i).1 Monthly joint specialist clinics which the Neurosurgical department was involved in over the relevant period included the following:

- 3rd Wednesday: Pituitary clinic (Endocrinology and Neurosurgery).
- 4th Wednesday: Skull-base clinic (ENT and Neurosurgery).

18(i).2 The Neurosurgical department had weekly joint consultant ward rounds with Physiotherapy and Occupational Therapy, and regular ward-based MDT meetings involving Nurses, AHPs, Social Workers and Neuro-rehabilitation teams [NHST-01547].

19. Please explain the basic staffing arrangements and working practices of the neurosurgical unit within Ninewells Hospital over the relevant period, including:

19.1 The information provided below in response to all parts of Question 19 has been taken from job plans, recruitment material, internal communications, operational reviews and other organisational records, which have been produced as evidence throughout this request. In addition, the MSN for Neurosurgery has been used as a key source where audit findings are referenced (see response to Question 14.5 that describes the responsibilities of the MSN). The MSN was established in 2009 to ensure nationally consistent, equitable Neurosurgical Services across Scotland. It developed shared service standards, common care pathways and a coordinated approach to service development and research. Any MSN audit reference below will refer to the external audit conducted by the MSN team in 2012 into the Neurosurgical Unit in Ninewells Hospital, extracted from the published local report [NHST-01519; NHST-01520].

19.2 Throughout the period in question, the Neurosurgical unit operated as a consultant-led service, supported by a multidisciplinary workforce. Staffing arrangements and working practices were broadly consistent with those of UK neurosurgical units during the same period and evolved incrementally in response to demand, workforce development and national policy changes.

19.3 It has not been possible to identify the names of every member of staff who may have worked within the unit during this period nor to determine with precision year on year changes in staff numbers across all professional and support groups. This is due to the absence of a comprehensive electronic workforce system during the relevant period, the routine destruction of historical and HR records in accordance with records retention policies and the passage of time with associated staff turnover. Where individual staff members are named in this summary, they are named based on reliable document references identified or/and reliable employee recollection and has been limited to where there is a reasonable degree of confidence as to accuracy.

19.4 Please refer to paragraphs 14.1-14.13 for an overview of the organisation of the neurosurgical unit.

a) The staffing of the unit with surgical, nursing and administrative staff and how that changed over the period;

19(a).1 Consultant Neurosurgical staffing: the names and numbers of all substantive (permanent) consultant neurosurgeons who worked within the unit during the relevant period have been identified. They are presented in Appendix 4 Table 1 [NHST-04945]. They formed the senior medical leadership of the unit. It has not been possible to identify the names of the locum consultant neurosurgeons who may have worked within the unit during the relevant period, as outlined in paragraph 19.3 above.

19(a).2 In 1995, there were three consultant Neurosurgeon posts, Mr Varma, Mr Gentleman and the vacant post Mr Eljamel applied for. [NHST-01521]. In 1998, based on employee recollection and organisational memory and no evidence identified to the contrary, Mr Varma retired and was temporarily replaced by locum consultants until the recruitment of Mr Ballantyne in 2000, when Mr Mowle was also recruited to replace Mr Gentleman. Up until 2011 the unit maintained a staffing level of three consultant surgeons. The number of consultants increased to four with the recruitment of Mr Lim in 2011. Mr Lim worked in NHS Tayside until 2014.

- 19(a).3 Nursing staffing: The names of the Senior charge nurses have been identified and are set out in Appendix 4 Table 2 [NHST-04945]. However, it has not been possible to identify the full names of every nurse who worked within the Neurosurgical unit, year by year changes to nursing rotas or the precise numbers of nursing staff employed in each individual year across the entire period. The limitations are outlined in paragraph 19.3. Using recollection of current staff, NHST Tayside has included the names of all the nurses who are currently working within the unit who were also in post during parts of the relevant period, as well as those who have retired recently and whose service during that period is reliably known. These individuals are also included in Appendix 4, Table 2 [NHST-04945].
- 19(a).4 Junior and middle grade medical staff: The Neurosurgical department was supported by six middle grade doctors (these could be ST1-ST5, clinical fellows, or specialty doctors, either attached to the unit or rotating). In addition, there were three foundation year doctors (previously known as junior or senior house officers JHO/SHO). Furthermore, there were a number of honorary fellows and research fellows attached to the unit from time to time. The earliest evidence of this is present in job descriptions from 2009 [NHST-04442]. Subsequent job descriptions indicate that this remained the case until the end of the relevant period. No evidence is found for detailed junior medical staffing on the unit prior to 2009. Some names of middle grade neurosurgical doctors working between 2010 and 2013 have been identified through referenced documentation and included in Appendix 2 Tables 3, 4, 5, 6 [NHST-04945]. There is however no single repository that captured the full names of all middle grade doctors who worked in the unit across the entire period, noting that many of the doctors would have rotated across several services and specialities on a yearly or quarterly basis. It has not been possible to identify the names of all the doctors who may have worked within the unit during the relevant period, as outlined in paragraph 19.3 above.
- 19(a).5 Administrative staffing: Based on reliable employee recollection and organisational memory, there were two medical secretary posts in DRI in 1995-1998 - Fiona Mclean and Frances (last name not recalled) - that did not support specific neurosurgical consultants but provided an administrative function for the whole team. When the department moved to Ninewells Hospital there were two medical secretaries supporting three consultants. This is based on current employee recollection. The next point at which admin staffing can be evidenced with

documentation is 2013 by reference to an organisational structure document [NHST-01522] which outlines the number of administrative staff as follows:

- One part time Ward Administrative Assistant.
- Four Secretaries (three band 4 and one band 3).
- One part-time Clerical Assistant (band 2).
- Mr Eljamel was appointed a Medical Secretary, Sandra Grady, from August 2005 to December 2013 [NHST-01522; NHST-01523].

It has not been possible to identify the names of all the administrative staff who may have worked within the unit during the other years of the relevant period as outlined in paragraph 19.3 above.

19(a).6 Certain individuals who worked within or outside the Neurosurgical unit but in closely related roles, have been identified where their names and involvement was explicitly documented. This includes individuals named in the job description to which Mr Eljamel applied in 1995, [NHST-01504] and individuals identified in consultant job descriptions for recruitment around 2010-2011. They have been included due to reliable documentary evidence in Appendix 2, Tables 7 and 8 [NHST-04945]. It has not been possible to identify the names of all the staff who may have worked within or closely with the unit during the other years of the relevant period as outlined in paragraph 19.3 above.

19(a).7 A breakdown of the numbers of staff where accurately identified, is included here and broken down by professional group:

- Theatre staffing: During the relevant period, Neurosurgery had one neurosurgical operating theatre with dedicated Neurosurgical theatre nurses, who also provided out-of-hours cover. This remained the case throughout the period.
- Anaesthesia: Ten theatre sessions were allocated to support elective Neurosurgical theatre activity throughout the week and throughout the relevant period. This is based on current anaesthetic employee recollection. No evidence was found to the contrary in job descriptions and plans.
- Advanced Nurse Practitioners (ANPs) (band 8a). Roles were introduced to the Neurosurgical unit approximately late 2011. The first ANP was June Finnie

followed by Samantha Weaver from employee recollection and organisational memory.

- Nursing leadership around 2011 *[NHST-01505]*
 - One Head of Nursing (covering Neurosciences, Dermatology and Chronic Pain).
 - One band 7 Senior Charge Nurse (Neurology and Neurosurgery).
- Ward nursing staff around 2011 *[NHST-01505]*
 - Three band 6 Nurses.
 - 23.58 Whole Time Equivalent (WTE) band 5 Nurses 5.7 WTE band 2 Nurses.

19(a).8 By way of explanation, Whole Time Equivalent (WTE) is a term frequently used within the NHS to express staffing levels as an equivalent number of full-time hours, taking account of the fact that some employees within the NHS work less than full-time hours.

b) Roles, responsibilities and hierarchy within the unit, including the role of clinical lead and amongst the consultants;

19(b).1 It was custom and practice for departments to follow a clear hierarchical structure between 1995 and 2014, which continues to this date. NHS Tayside would ask the Inquiry to note that the information below is based on the recollection of NHS Tayside employees who have worked across Tayside from 1995. NHS Tayside found no evidence to indicate that the position below was any different from 1995 onwards, except from changing titles for job roles.

19(b).2 The roles and responsibilities of a Clinical Lead are outlined in the response at paragraph 17.5. NHS Tayside would ask the Inquiry to note that part of the information in this paragraph is from organisational intelligence and current staff knowledge and experience of the Clinical Lead role.

19(b).3 Consultant Surgeons in the UK are senior doctors who have completed their specialist training and are required to be listed on the GMC specialist register in order to practice independently. They have ultimate clinical responsibility for patient care, including operative care, emergency admissions, outpatient clinics, MDT attendance and supervision of junior medical staff.

- 19(b).4 Elective and emergency workloads were allocated according to agreed job plans and departmental arrangements.
- 19(b).5 Consultants contributed to teaching, training, audit, clinical governance, and departmental management. They retained professional discretion over flexible sessions for clinical administration, patient communication and coordination with other departments. Annual job planning took place between each doctor and their line manager to agree responsibilities and clinical activity. Consultants were required to undertake these discussions with the Clinical Lead, focusing on their contribution to service delivery, education and service development. Following this, their job plans would be signed in agreement with the Clinical Director.
- 19(b).6 Between 1995 and 2005, doctors working at middle-grade level were commonly appointed as Senior House Officers and Specialist Registrars. Following the introduction of Modernising Medical Careers in 2005, middle-grade medical staff were re-designated as Specialty Trainees.
- 19(b).7 These doctors were in formal postgraduate training and supported the delivery of emergency care, operating theatre activity, inpatient ward care, and outpatient clinics. They provided on-site senior medical cover during on-call periods, supervised junior medical staff (including pre-registration and junior trainees), and contributed to the coordination and day-to-day management of ward activity under consultant supervision.
- 19(b).8 Senior trainees, once deemed competent, could undertake aspects of operative work independently. They were able to review patients in clinic and subsequently discuss management plans with the supervising consultant. Trainees were also, at times, undertaking additional on-call shifts to support gaps at more junior levels.
- 19(b).9 Foundation doctors (previously known as junior house officers/senior house officers) were responsible for the day-to-day ward management, preparing discharge summaries, initial patient assessments, ongoing reviews, and assisting in clinics and theatre where opportunity arose. A neurosurgery foundation doctor handover document from circa 2013 [NHST-04440] outlines some of the responsibilities of foundation doctors rotating on neurosurgery. NHS Tayside has identified no evidence to suggest that this was different prior to this date.

- 19(b).10 Band 7 and band 6 nurses oversaw ward operations, patient flow and specialist neurosurgical nursing care. Band 5 staff supported general ward nursing. Due to increased workload, this led to the formalisation of supporting roles such as ANPs. ANPs supported clinics, complex patient reviews, and continuity between inpatient and outpatient care. At times they also received referrals to the Neurosurgical unit.
- 19(b).11 The administrative and secretarial team provided secretarial support, clinic administration, theatre list preparation, and handled all correspondence including letters to patients, phone calls and communication with patients, appointment booking, attendance records and administrative aspects of records related to patient care.

c) How cases were typically referred to the unit;

- 19(c).1 There are usually three main pathways of referral to the Neurosurgical unit, NHS Tayside has no indication that this was different between 1995-2014. The three typical main pathways are:
- Emergency referrals: the majority of cases are referred through the Emergency Department (some from other hospitals or inpatient teams). These are typically discussed with the on-call consultant or registrar by phone, who provides initial advice and determines further advice, management, or transfer.
 - Elective referrals: from GPs or consultant colleagues, usually triaged by consultants who vet referrals and determine clinical priority then allocate them or ask the administrative/secretarial teams to allocate them to appropriate outpatient clinics.
 - Internal referrals: from other specialties within Ninewells such as Neurology, Oncology, Orthopaedics, ENT etc., and are typically handled through discussion with the registrar or direct consultant-to-consultant discussions.
- 19(c).2 Until 2012, all Emergency referrals to the Neurosurgical Team were recorded in a physical book called the “yellow book” which was carried by the on-call registrar [NHST-01519]. Following this, the Neurosurgical unit adopted an excel spreadsheet referral system containing referral data, which still runs to date [NHST-04683].

d) How staff rotas would typically be devised;

- 19(d).1 For the relevant time period, rotas were developed to reflect the full range of clinical and supporting activities required within the service. This included theatre sessions, outpatient clinics, ward responsibilities, on-call duties, educational commitments, and flexible sessions (i.e. for research, management and administrative roles).
- 19(d).2 Consultant rotas and job plans
- 19(d).3 Between 1995 and 2004 there was no requirement for formal job planning and no requirement for annual job planning reviews. In 2004 a new contract was implemented the first major change since 1948. From 2004 to 2014 Consultant activity was set out through the annual job planning process undertaken with the Clinical Lead, agreed with the Clinical Group Director. A standard consultant job plan consisted of ten Programmed Activities (PAs, or sometimes referred to as “sessions”), which are scheduled blocks of work, typically four hours long, that make up a doctor's contractual duties.
- 19(d).4 Consultant on-call rotas were divided equally across the consultant body and ensured continuous senior availability, supported at all times by middle grade and foundation level doctors. Neurosurgical consultants worked closely together and were flexible to ensure rota cover where needed.
- 19(d).5 The Clinical Lead, with management support, coordinated consultant rotas to ensure prospective cover and alignment with service needs. Theatre and clinic sessions were allocated according to job plans, with middle-grade doctors assisting in theatre and, at times, ANPs assisting in clinics where appropriate [NHST-01505; NHST-01696].
- 19(d).6 Middle-grade and junior doctor rotas
- 19(d).7 Rotas for trainees and middle-grade doctors (this term is explained in the response at paragraph 19(b).6) were based on a combination of service requirement, educational needs and compliance with national training guidelines. These rotas provided continuous 24/7 cover and were designed in line with Human Resources (HR) and statutory working-time regulations, including mandated rest periods

between shifts. It is typical for middle grade doctors to manage their own rotas, taking it in turn to lead on this activity which supports educational and organisational development. This is supported by consultants within the service. Foundation year doctors' rotas are also usually organised by one of the foundation year doctors and supported by administrative staff. This arrangement is stated in a handbook for junior medical staff in neurosurgery dated 2017 and NHST Tayside has evidence to suggest the practice was different in earlier years [NHST-04467].

19(d).8 Nursing rotas

19(d).9 Ward nursing staff typically worked to a fixed rotational pattern, with varying days off agreed with senior nursing leadership. Rotas were built to ensure safe staffing levels across shifts, while meeting professional, legislative and hospital workforce requirements.

19(d).10 All rotas were required to comply with current workforce regulations, including limits on working hours, rest periods and safeguarding requirements for staff in training [NHST-01524; NHST-01525].

e) Theatre lists, including the use/ availability of neurosurgical theatres and general surgery/ other theatres or facilities for neurosurgical operations;

19(e).1 During the relevant period, the Neurosurgical Unit always had one dedicated operating theatre, staffed by a team of Neurosurgical theatre nurses and operating department personnel who also provided out of hours cover. This ensured that emergency cases could be accommodated at any time, supported by continuous consultant and registrar level on call availability.

19(e).2 In 1995, ten elective theatre sessions supported continuous elective neurosurgical theatre activity throughout the week. This model remained in place until 2015 with the ten elective theatre sessions shared between the four consultant neurosurgeons [NHST-01504; NHST-01505].

19(e).3 When necessary neurosurgical procedures could be undertaken in general surgical theatres.

- 19(e).4 The MSN audit in 2012 [NHST-01519] reported that Ninewells Neurosurgical Unit met standard statement 4.2 which states that operative neurosurgery will be performed in theatres specially and specifically equipped for neurosurgery and staffed by personnel experienced in its techniques, that the centre had continuous availability of anaesthetists with neuroanaesthetic experience, and that operating theatre personnel experienced in neurosurgery theatre techniques were available 24 hours a day [NHST-01524; NHST-01521].

f) On call arrangements;

- 19(f).1 Consultants participated in an on-call rota, which operated as 1:3 (on call 1 day in 3) from 1995 to 2011, moving to 1:4 from 2011 once the fourth consultant was appointed, as explained in response to Question 14.8. Weekend cover was shared equally, and it was standard practice for a consultant to be on call from Friday morning until Monday morning.
- 19(f).2 By 2011, consultants worked a system of fixed weekday on-call days with weekend on-call duties rotating through the 1:4 cycle. On-call periods ran for 24 hours (09:00 to 09:00). Consultant job plans reflected participation in pro rata neurosurgical on call rota.
- 19(f).3 When a consultant was on call, there was also a middle grade doctor on call and a foundation doctor/SHO providing resident (on-site) cover [NHST-01546; NHST-01505; NHST-01525].

g) Ward rounds;

- 19(g).1 Daily ward rounds have always taken place on the Neurosurgical Ward either by consultants or Specialty Trainees and supported by middle-grade and foundation doctors [NHST-04440].
- 19(g).2 A 2012 weekly schedule [NHST-01547] illustrates this pattern and highlights joint ward rounds, showing:
- Monday: Joint consultant ward round with Physiotherapy and Occupational Therapy.

- Wednesday: Joint consultant teaching round with the ANP.
- Friday: Joint consultant ward round involving multiple MDT members.

19(g).3 In addition to scheduled rounds, further reviews were carried out following emergency admissions or in response to significant post-operative developments.

19(g).4 Consultants covering the Friday to Sunday on-call period routinely attended the ward for daily rounds on Saturday, Sunday and bank holidays. They also attended as required to review neurosurgical patients in the ward, Emergency Department or other inpatient areas within Ninewells.

h) Clinics;

19(h).1 During the relevant period, consultants delivered a range of outpatient activity, including new patient clinics, return (review) clinics, specialist clinics and joint multidisciplinary clinics. Clinics were supported by middle grade doctors and, where available, ANPs. Joint clinics were typically run by two consultants alongside relevant specialty colleagues.

19(h).2 Outpatient clinics were consultant-led. Clinic bookings did not normally exceed numbers set out on the clinic template unless this was specifically agreed by the relevant consultant. NHS Tayside has found no evidence to suggest that there were inadequate consultant sessions for outpatient clinics to maintain waiting time guarantees [NHST-01547; NHST-01546].

19(h).3 Examples of specialist joint multidisciplinary clinics included:

- Neuro-oncology clinics with oncology consultants.
- Functional neurosurgery clinics with neurologists and other specialists.
- Pituitary clinics.
- Skull base clinics.
- Deep Brain Stimulation (DBS) clinics (which ceased upon Mr Eljamel's departure).

- 19(h).4 Consultants also undertook clinic-related administrative work (dictation of letters, review of results, communication with GPs and other clinicians) within their agreed sessions.

i) Pre-operative consultations with patients;

- 19(i).1 For the relevant period, pre-operative assessment typically included a full history, examination, discussion of the planned procedure, explanation of risks and benefits, and confirmation of the operative plan. Consent for surgery included completion of the appropriate consent or incapacity documentation. These reviews were carried out by the named consultant for elective cases, and by the on-call consultant for emergency admissions. Senior registrars also contributed to assessments and routinely supported communication with patients and their families. UK training standards and GMC guidance make clear that taking consent is a core clinical responsibility for doctors involved in patient care. The GMC's consent guidance states that doctors must ensure patients have given valid consent before examination or treatment, and this requirement applies across training grades, including junior and middle-grade doctors [NHST-04471].
- 19(i).2 Consultants had dedicated time within their job plans to complete pre-operative reviews, consent discussions, and the associated administrative work.

j) The role and engagement of honorary fellows/research fellows attached to the unit;

- 19(j).1 Honorary fellows and research fellows were involved in the academic and clinical activity of the unit. They participated in departmental research programmes and supported ongoing clinical studies. They were expected to participate in the running of single centre and multicentre trials, encouraged to pursue their own research and explore the possibility of a higher degree at the University of Dundee. They also were expected to perform clinical activities under supervision, participate in the on-call rota, in teaching activities, and in regular meetings and audits [NHST-04444].
- 19(j).2 Consultant surgeons involved in a research project would normally have a supervisory role over the honorary or research fellows who are undertaking or supporting that research activity. This supervision relates to the design, contribution, governance and participation in the research project. As outlined in the 2010 clinical

research fellow job description, [NHST-04444_2], the post holder was expected to participate in the running of research trials with Mr Eljamel. This would normally indicate that Mr Eljamel, as the lead consultant overseeing the research projects outlined in the job description, has an academic and supervisory role over the research fellow. This is standard of research supervision arrangements, which is usually provided by the principal investigator or supervising consultant responsible for the research project. Clinical supervision operates separately. The day-to-day supervision of clinical work undertaken by a fellow or trainee is the responsibility of the consultant responsible for the patient's care, typically the consultant on call or the supervising consultant in an elective setting. This reflects standard NHS clinical governance arrangements where the consultant with responsibility for the patient provides clinical oversight and decision making support – as outlined in all the job descriptions and job plans previously referenced.

k) The mechanisms for providing information to patients, including the use of leaflets or other standard form information sharing media;

- 19(k).1 During the relevant period, from employee recollection, organisational memory and clinical knowledge, patients received information through a combination of face-to-face consultations, written clinic letters, and standardised patient information leaflets. Consultants and senior registrars routinely discussed diagnosis, treatment options and operative plans with patients and their families. This was corroborated in the MSN audit local report in 2011 [NHST-01519; NHST-01520].
- 19(k).2 Written information leaflets were available for common neurosurgical procedures, outlining expected outcomes and post-operative care, and were given to patients if required by NHS Tayside employees. Communication was reinforced through discharge summaries and correspondence sent directly to GPs. Consultants also had dedicated flexible time within their job plans for preparing discharge letters, communicating results, responding to queries from GPs and patients, and liaising with other specialties [NHST-01519].
- 19(k).3 In Mr Eljamel's job plan dated 2012 [NHST-01546], one hour per week was specifically allocated to meeting with relatives to provide progress updates, answer concerns and discuss ongoing plans of care.

19(k).4 NHS Tayside has been unable to locate documents, or job plans, for other surgeons during the relevant period and therefore cannot compare between individuals. However, NHS consultant job planning is governed by national contractual and guidance frameworks and therefore expected to include time allocated to both direct clinical care - which includes clinical work as well as patient care administrative duties - and to Supporting Professional Activities (SPA) - which underpin clinical care (for example, audit, governance, appraisal/revalidation, continuing professional development, teaching/training and job planning) [NHST-01624]. Therefore, while we cannot evidence this through individual surgeons' job plans, NHS Tayside has found no evidence to suggest that job plans varied widely between consultants.

I) Morbidity and mortality meetings within the unit or jointly with other units; and

19(l).1 In the NHS Tayside Due Diligence Review of Documentation Held Relating to Mr Eljamel dated 25th August 2023, it was mentioned that a dedicated neurosurgery M&M forum was established in 2000: *"Mortality and Morbidity Meetings were held within Neurosurgery since 2000 and these had the potential to signal concerns relating to a service or individual. However, it should be noted that these relied on the individual members of staff bringing a case to the meeting and reflecting on their own practice"* [NHST-00076_7]. These meetings provided a structured setting in which clinical cases and post-operative complications were presented and discussed. The process relied on consultants identifying relevant cases. During the relevant period, M&M meetings took place within the Neurosurgical unit [NHST-01524]. This was corroborated in the Royal College of Surgeons Review [NHST-00072] which found that Morbidity and Mortality meetings were held monthly during hospital Clinical Effectiveness half days. Complex or shared cases were also discussed jointly with Neurology, Neuroradiology or Anaesthesia when appropriate. Attendance at M&M meetings included consultants, trainees, nursing representatives and allied health professionals. Juniors and SpRs in Neurology and Neurosurgery took turns weekly to present patients' cases. Information recorded in the M&M blue folder was typically used by the SpRs for their presentation [NHST-04440; NHST-04636; NHST-04647; NHST-04648].

m) Any other key aspects of the working arrangements within the unit.

19(m).1 The department undertook a wide range of additional clinical, academic and governance activities that supported the functioning of the Neurosurgical service.

19(m).2 There was an active undergraduate and postgraduate teaching programme, with regular teaching delivered to medical students, trainees and fellows throughout the year. This included:

- Mr Eljamel's job plans provide details of the proportion of his time dedicated to teaching which was a daily requirement for his role and delivered also as part of his clinical responsibilities [NHST-01542; NHST-01543; NHST-01547; NHST-01640; NHST-04518; NHST-04600; NHST-04788; NHST-04628; NHST-04629; NHST-04642; NHST-04644]. There was 3 hours ringfenced a week for this purpose in his 2008/2009 job plan. Earlier job plans such as 1997 referenced teaching as 20 hours a week which likely reflects the 'on the job' teaching which would happen in theatre, clinic and on the ward.
- Additionally, handover documents for doctors rotating into neurosurgery mention the teaching programmes that they are expected to attend and contribute to [NHST-04440]; [NHST-04698 - NHST-04699].

Block teachings and student selected components teaching;

- regular bedside and seminars;
- participation of consultants, trainees or fellows in local, national and international educational meetings, workshops and professional development events; and
- reading, reviewing and writing academic articles (in 1995, newly appointed consultants were expected to be offered an Honorary Senior lectureship).

19(m).3 In 2005 Mr Eljamel was offered an honorary readership in surgical neurology [NHST-04684]. On 22 September 2009 the University of Dundee made Mr Eljamel an Honorary Professor [NHST-04685_2].

19(m).4 In April 2014, the University of Dundee queried NHS Tayside as to whether Mr Eljamel had sought early retirement, with the intent of terminating his concurrent honorary appointment with the University [NHST-04686].

19(m).5 The Inquiry would be required to engage with the University of Dundee for details on how the role was obtained and what it involved.

19(m).6 Job plans referenced earlier in the document, consistently outline delivery of research as part of the role, varying by the year but from an illustrative basis he held 4 hours a week within his job plan 2008/2009.

19(m).7 Consultants, as well as trainees, participated in audit and clinical governance structures and hospital service development committees. They were also active in multiple research programmes, including writing protocols, preparing ethics applications, shortlisting and interviewing. Activities also included writing references, supervising departmental processes, and attending governance and planning meetings. Where national audits took place, the unit participated fully [NHST-01546; NHST-01524].

20. What questions, if any, were raised about the viability of maintaining a neurosurgical unit within NHS Tayside in the context of a re-structuring of neurosurgical services in Scotland over the relevant period?

20.1 NHS Tayside does not have any organisational memory, evidence or documentation to provide a response to the above question. However, NHS Tayside are aware of a report titled “Final Report of the Neuroscience Implementation Group” authored by the Neuroscience Implementation Group, which was chaired by Mr John Glennie, Chief Executive, NHS Borders (as at the time of the report’s publication in around 2008). The Inquiry may wish to consider this report and its findings in relation to this question [NHST-04433].

The work of Mr Eljamel

21. Please explain the broad trajectory of the career of Mr Eljamel, including his work in NHST between 1995 and 2014 and, to the extent that you are able, in the private sphere over that period, including the nature of the roles he held, the terms and conditions of his employment and the nature of the practising privileged (*sic*) he enjoyed.

21.1 Based on information from Mr Eljamel's original application for the role of consultant neurosurgeon [NHST-01544] with Dundee Teaching Hospitals NHS Trust, and other information available in Mr Eljamel's HR file, Mr Eljamel's career history is as follows:

- January 1983 – December 1983: Pre-registration Training in Libya
- January 1984 – August 1985: General Professional Training in Tripoli, Libya
- September 1985 – August 1987: General Professional Training, Dublin and Airdrie
- Sept 1987 – Sept 1991: Senior House Officer/Registrar, Walton Centre for Neurology and Neurosurgery, Liverpool
- Oct 1991 – Sept 1994: Senior Registrar, Beaumont Hospital, Dublin
- December 1994 – Sept 1995: Clinical Neurosurgical Fellow, University of Connecticut *
- October 1995 – May 2014: Consultant Neurosurgeon, NHS Tayside

*This information is from a handwritten annotation within document *NHST-01544_8*.

Mr Eljamel's employment from September 1987 to September 1994 was verified by references.

21.2 According to Mr Eljamel's offer of appointment letter [NHST-01540], he was offered the position of Consultant Neurosurgeon with Dundee Teaching Hospitals NHS Trust, with a start date of 9 October 1995. The terms and conditions of his appointment were those as applied to Hospital Medical and Dental Staff in the NHS in Scotland, as determined by the Secretary of State for Scotland and the General Whitley Council conditions of service. NHS Tayside does not hold a copy of the terms and conditions that would have been applied at the time of Mr Eljamel's appointment. The Inquiry may wish to direct this question towards the Scottish Government.

21.3 The offer of appointment letter [NHST-01540] laid out the duties assigned to Mr Eljamel for the purpose of providing health services under the National Health Service Acts as being the following:

- a) Diagnosis and treatment of patients in the Directorate of Neurosciences, Dundee Royal Infirmary.*
- b) Such clinical teaching duties as may be determined from time to time by the University of Dundee and the Trust.*
- c) Domiciliary consultations as may be required from time to time.*
- d) The diagnosis and treatment of patients occupying accommodation made available under sections 57(1), 57(2) and 58 of the National Health Service (Scotland) Act 1978 [NHST-04332], insofar as patients have not made private arrangements for such treatment.*
- e) Continuing clinical responsibility for the patients in your charge, allowing for all proper delegation to, and training of, your staff.*

21.4 After taking up his appointment in October 1995, Mr Eljamel worked within DRI until the Neurosurgery service was transferred to Ninewells Hospital on around 16 November 1998. After appointment to NHS Tayside as a Consultant, Mr Eljamel took on the role of Clinical Lead, and this is described in Question 8(j)2.

21.5 NHS Tayside also has evidence of Mr Eljamel submitting his interest, via letter to the Medical Director Mr Lyall, in the post of Clinical Group Director of Specialist Services on 02 November 2004 [NHST-04726_3]. NHS Tayside holds no documentation in relation to the outcome of this process, however it should be noted that Dr Richard Roberts, who was also scheduled to interview for the post alongside Mr Eljamel [NHST-04726_1], subsequently became the Clinical Director of Specialist Services in 2005, as outlined in response to Question 8(d).

21.6 There is no documentation regarding private work contained within Mr Eljamel's HR file. The response to Question 10(b) provides information in relation to guidance around private practice, and the response to Question 39 provides further information regarding practicing privileges Mr Eljamel held.

22. What products or devices were regularly used in in (sic) surgery on Mr Eljamel's NHS patients, in particular any products which were unlicensed or where their use was experimental?

22.1 It is accepted practice to record implants, products or devices used in the operation theatre record and/or in patient notes.

- 22.2 A summary of products and devices, which are generally used within neurosurgical theatres, are as follows; shunts, extra-ventricular drains, subdural drains/catheters, lumbar drains, neuroballoon catheters, brain lab, ultrasound, embolectomy catheters, cranial bolts, mayfield clamps, sonopet, mallis, vagal nerve stimulators, spinal fixation screws and rods, anterior cervical discectomy and fusion, dogbone plates and screws, burrhole covers and screws, dural grafts, haemostatic agents, felt, vitoss, dural sealant, goretex sutures, aneurysm clips and nerve monitors.
- 22.3 To identify all products or devices that Mr Eljamel used in surgery on his NHS patients, NHS Tayside would require to undertake a review of approximately 4,000 operation notes and collate these to identify what products or devices were used. During this review, NHS Tayside would also require to examine any available patient's medical records for further information on whether the product or device was unlicensed and/or experimental at the time of use. It is estimated that this work would take around six months to complete. Should the Inquiry require NHS Tayside to undertake this piece of work, please inform us.
- 23. In particular, please explain how Mr Eljamel's NHS commitments were split between Dundee Royal Infirmary (see NHST-00245) and Ninewells Hospital, with reference to timescales over the relevant period.**
- 23.1 Mr Eljamel's base was in DRI from 1995 – 1998. During this period his work would have been undertaken in DRI. The neurosurgical unit moved from DRI to Ninewells Hospital in 1998. From 1998 to 2014 Mr Eljamel's commitments would have been at Ninewells Hospital.
- 24. Please explain broad nature, conditions and commitments to his teaching and research commitments, including the nature and content of Mr Eljamel's publications (ToR 2).**
- 24.1 The clinical research trials undertaken by Mr Eljamel in the period 1995 to 2014 in NHS Tayside are provided [NHST-01514]. This information has been extracted from Tayside Medical Science Centre (referred to as TASC) ReDA database, which is a cloud-based Clinical Trial Management System (ReDA is the name of the database,

it is not an acronym). Included are studies where Mr Eljamel was either Chief Investigator or Principal Investigator and is listed on the CI-Eljamel and PI-Eljamel tabs in the provided file. As detailed in the UK Policy Framework for Health and Social Care Research [NHST-04445], a Chief Investigator (CI) is the overall lead researcher for a research project, and a Principal Investigator (PI) is an individual responsible for the conduct of the research at a particular research site such as NHS Tayside. The CI and PI may be the same person in the case of a clinical trial being undertaken at a single site, or if the individual is the CI of a multi-site trial and acts as a PI with responsibility for conduct of the trial at a particular site. Trials where Mr Eljamel was CI and PI are highlighted in the evidence provided [NHST-01514]. The study details are provided in this file. Those studies indicated as withdrawn were proposed trials that did not start due to unsuccessful funding applications for grants.

24.2 A list of Mr Eljamel's publications has also been provided along with this submission [NHST-01515].

25. Please set out a statistical breakdown of the work undertaken by Mr Eljamel and the other consultants in the Ninewells neurosurgery unit, including the nature and types of surgery which he/ they. (sic) they undertook, both in the NHS and, to the extent that you are able, in the private sphere. In particular, please provide this detail relating to the work of Mr Eljamel over the relevant period, broken down into:

25.1 NHS Tayside's historical clinical activity data is held across a series of legacy and current digital systems, with availability determined by the date of system implementation, subsequent migrations and Health Records Retention policies [NHST-00050 - NHST-00063].

25.2 The Out-Patient Appointment System (TOPAS), which remained in operational use by Health Records until recently, was the primary source of inpatient and day case admissions from June 2011 onwards, and outpatient activity from April 2013.

25.3 Theatre procedure data is available from the electronic recording system OPERA from April 2011. All digital records are subject to minimum Health Records retention and destruction policies.

- 25.4 TOPAS itself was populated through multiple earlier systems, and data, where retained, was migrated through defined digital pathways. The reporting system available to the Business Unit only goes as far back as 2011, therefore NHS Tayside is unable to report on any activity prior to this date. Prior to the implementation of electronic systems, some clinical activity was recorded manually using paper-based systems. It is the recollection of current employees that outpatient attendances were logged in books maintained by administrative staff. Separate books were used to record referrals to inpatient wards. All these records were subsequently destroyed in accordance with the Health Records Retention Policy [NHST-00050 - NHST-00063].
- 25.5 NHS Tayside does not hold data for private hospitals and therefore cannot provide a statistical breakdown of the work undertaken by Mr Eljamel and/or others.
- 25.6 Answers to all data related questions extracted from NHS Tayside Business Unit systems will refer to 2011 onwards, unless sourced from other repositories (e.g., national datasets or RCS report [NHST-00072]).
- 25.7 In response to Questions 25(a-f), and following the explanation in 25.1, data has been extracted from the OPERA electronic system for the time period April 2011 – December 2013 inclusive and focuses on the four neurosurgical consultants operating in Tayside at this time. This data is included in Appendix 5, table 1 [NHST-04945]. This time period has been provided as the reporting system available to NHS Tayside only goes as far back as April 2011 and includes Mr Eljamel's last operating date in December 2013. There are cases that do not have a clear consultant listed from the data available, which have been marked as "unknown". Cases recorded with an 'Unknown' consultant indicate that no consultant name was entered in the original data entry source system (e.g., OPERA). Unlike datasets submitted nationally (e.g. TrakCare). OPERA data has fewer validation checks, so missing fields are more likely to reflect omissions at the point of entry. Any cases that appear to have been undertaken by a trainee under a consultant (usually under direct supervision of the consultant or while the consultant is available but not present in theatre) have been counted under that consultant's name.

25.8 During the 2011-2013 period references are likely to be to the older Operation Procedural Codes (OPCS) manuals (which is a statistical classification for clinical coding of hospital interventions and procedures undertaken by the NHS); possibly version 4.5 or 4.6. The oldest version that is publicly accessible is OPCS-4.8, which was published in 2017. The OPCS manuals from 2017 onwards are held electronically, on the NHS Classifications Browser website, and there is no option to download this into a document format. This information is publicly available to anyone. It is understood that for the most part, each version of OPCS-4 carries over information from the previous version, so this should be relevant for the time period from April 2011.

25.9 Using a section within OPCS-4.8 (Volume 1, Part 1 – Tabular List of Three Digit Categories), the primary OPCS codes recorded for each case on OPERA has been summarised into headings (see Appendix 5, table 1) [NHST-04945].

- a) **Spinal cases, broken down by type of surgery including degenerative spinal cases;**
- b) **Skull base work;**
- c) **Neuro-oncology;**
- d) **Neuro-radiology;**
- e) **Deep brain stimulation work for movement and other functional disorders including OCD; and**
- f) **Other types of work undertaken by Mr Eljamel.**

For 25(a-f) please see response in paragraphs 25.1, 25.2 and 25.3. The available data is presented in Appendix 5, Table 1 [NHST-04945].

26. How complex were the medical issues with which Mr Eljamel's patients presented for treatment/ care?

26.1 The types of surgery that Mr Eljamel performed has been provided in response to Question 28 at Table 5 in Appendix 5 [NHST-04945]. This demonstrates the variety and broad categories of surgeries that Mr Eljamel performed.

26.2 The patients that were managed by Mr Eljamel would have covered a spectrum of simple to complex cases. It is difficult to quantify this in any meaningful way. Neurosurgery in itself is a complex specialty.

27. Please set out the surgical (a) re-admission data and rates (b) return to theatre data (c) patient fatality data and (d) waiting times relating to Mr Eljamel's patients, compared to those of his neurosurgical consultant colleagues. How did NHST monitor and manage these aspects of the work of its neurosurgical service?

27(a) Readmission data?

27(a).1 NHS Tayside undertook an exercise to extract and review the relevant information using TOPAS data. The review aimed to replicate, as far as possible, the time period previously referenced (April 2011 to March 2013 inclusive, within the 2013 RCS Review [NHST-01587]). However, the earliest data available to us within TOPAS (which is the system used to hold data related to theatres) begins in June 2011, and therefore data from April–May 2011 could not be included in this analysis. As such, the dataset reviewed covers the period June 2011 to March 2013. There are many ways to calculate readmission. For the purposes of this exercise, the analysis was conducted using TOPAS data available at the time and applying the following criteria:

- Stay-level Neurosurgery discharges Apr'11-Mar'13 inclusive.
- Cross-referenced with emergency episode admissions within 28 days of previous discharge, where specialty of episode is Neurosurgery, and
 - CHI matches
 - Date/time of episode admission is greater than previous discharge date/time
- Date of episode admission is <29 days after previous discharge date
- Episode level admissions used to ensure that any Neurosurgery patients admitted initially through other specialties would be captured. **NOTE:** this was chosen for accuracy and to capture all episodes as much as possible but may not be standard process in other data capturing methodologies.
- Counted by parent discharge month and parent discharge consultant.

27(a).2 Readmissions within 28 days, by month of parent discharge

Row Labels	C Lim	D Mowle	E Ballantyne	S Eljamel	Grand Total
Jun 2011				1	1
Jul 2011		4	1	1	6
Aug 2011		1		4	5
Sep 2011		1	1		2
Oct 2011			1		1
Nov 2011		1	3	2	6
Dec 2011		3	1	1	5
Jan 2012	1	1	3		5
Feb 2012		2	3		5
Mar 2012			2		2
2011-12	1	13	15	9	38
Apr 2012		3		2	5
Jun 2012			1	2	3
Jul 2012	1	2	1	2	6
Aug 2012	1	1			2
Sep 2012		3		2	5
Oct 2012	1	1	1	1	4
Nov 2012	1		1	1	3
Dec 2012		1	2	3	6
Jan 2013				1	1
Feb 2013	2	2		3	7
Mar 2013		2		2	4
2012-13	6	15	6	19	46
Total	7	28	21	28	84

27(a).3 Readmission Rates from above table

Row Labels	C Lim	D Mowle	E Ballantyne	S Eljamel
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2011-12	2%	4%	6%	2%
2012-13	2%	5%	3%	5%

- 27(a).4 At present, NHS Tayside is unable to comment on the data previously reported by the Royal College of Surgeons, as there has not been an opportunity to engage with them directly to understand the methodology used in their analysis. The documentation currently available does not provide sufficient detail regarding the definitions, inclusion criteria, or data extraction approach applied. However, the readmission data and results they presented are highlighted in *NHST-01587* and the RCS report [*NHST-00072*].
- 27(a).5 Readmission is defined as an emergency admission within 28 days of discharge and are counted against the original discharging consultant.
- 27(a).6 The table below is an extract from the RCS Review [*NHST-01587_6*] and contains the comparative readmission rates for emergency and elective readmissions combined for FY11/12 and FY12/13. It is not possible to secure earlier data as is explained in section 25.1.

Year	Consultant	Readmission Rate
FY 2011/12	Ballantyne	6%
	Eljamel	3%
	Lim	3%
	Mowle	6%
FY12/13	Ballantyne	4%
	Eljamel	7%
	Lim	4%
	Mowle	6%

27(b) Return to theatre data

- 27(b).1 NHS Tayside's electronic systems with return to theatre data date back only as far as April 2011 (see response to Question 25). Any return to theatre data prior to April 2011 would require a manual review of available paper records, and would take approximately six months to compile, as no reliable electronic data exists for that period. Should the Inquiry require NHS Tayside to undertake this piece of work, please inform us. The return to theatre data was extracted digitally from the OPERA system and is included in Appendix 5, Tables 2 and 3 [*NHST-04945*].

27(b).2 Return to Theatre is defined as any subsequent episode in which a patient returns to an operating theatre within 30 days of an index operative procedure, as recorded in the OPERA system. The data presented has been extracted directly from the OPERA system. The dataset does not differentiate between:

- planned versus unplanned returns to theatre.
- returns related to complications vs non-complication return.
- staged or planned multi-procedure pathways.
- returns for the same procedure versus a different procedure.

27(b).3 It is important to note that where a patient returns to theatre under the care of a different operating surgeon, the return episode is still be recorded against the original (index) operating surgeon.

27(c) Patient fatality data

27(c).1 Extracted data from NHS Scotland surgeon mortality records (2007–2013) [*NHST-04703*] provides an overview of patient mortality rates across all surgeons in the unit for each year. However, the figures are based on episodes of care rather than individual patients (e.g., continuation episodes). By episodes of care, the information presented does not count individual patients seen by consultant surgeons but episodes of care of continuous period in hospital under a particular consultant. One patient can have many episodes of care over a time period, and as a result there is an element of duplication in the figures, i.e. a patient could be admitted to one consultant and transferred to another. In this instance the patient is counted in the activity levels of both consultants. The death is assigned to the consultant who was responsible for the patient in the episode of care where the death occurred. This audit reviewed and registered all deaths that occurred in hospital under the care of a consultant surgeon, whether an operation has taken place or not. This information is included in Appendix 5, Table 4 [*NHST-04945*].

27(c).2 In addition to the information in Appendix 5, Table 4 [*NHST-04945*], as part of the work for the 2013 RCS Review, data was collated which measured patient stays for Neurosurgery consultants including deaths for 2011-2012 and 2012-2013 [*NHST-01587_7*].

27(c).3 No patients in this cohort (April 2011 - December 2013) who were returned to theatre died intra-operatively. However, mortality data cannot be reliably extracted from the current electronic system. The platform records whether a patient is alive or deceased at present but does not provide the date of death.

27(c).4 To compile further patient fatality data would take approximately 6 months and would involve a manual review of available paper records to create the data set requested. Should the Inquiry require NHS Tayside to undertake this piece of work, please inform us.

27(d) Waiting times relating to Mr Eljamel's patients, compared to those of his neurosurgical consultant colleagues

27(d).1 NHS Tayside's electronic systems which hold this type of data date back only as far as April 2011. Please refer to the answer in Question 25.

27(d).2 An answer in part to this question was provided from the RCS Report [NHST-00075] and the data presented to the RCS for that report [NHST-01587_3] which measured neurosurgery inpatient and day case waiting lists as recorded at the end of 2013. This is not comprehensive and does not represent a full longitudinal dataset but provides a reliable snapshot of the total waiting list at that point in time. The 2013 RCS Report categorised waiting lists by spine subspecialty, Inpatient (IP) activity and Outpatient Planned Procedures (OPPS) broken down by consultant. The Report found that *"the waiting list data [...] shows that the number of patients on Professor Eljamel's waiting list, 46, was slightly higher than his colleagues who had between 15 and 40 patients on their lists. One notable factor was however that on average Professor Eljamel's patients had waited a lot longer for their procedures. Of the 27 neurosurgery patients who had waited more than 84 days 24 were patients of Professor Eljamel."* [NHST-00075_11]

27(d).3 Treatment Time Guarantee (TTG) Waiting Lists

The data below captures the average waiting time for each neurosurgeon consultant from April 2011 to December 2013. To capture waiting times from earlier data would require a manual review of paper records.

Admitting Consultant	Average Wait by Consultant
C Lim	6 weeks
D Mowle	5 weeks
E Ballantyne	3 weeks
S Eljamel	7 weeks

(Covers data where admission is coded as admitted from waiting list and is not a repeat waiting list admission)

27(d).4 Prior to 2011 as digitally held records are not available, NHS Tayside has been unable to locate available waiting times data at a surgeon level within Neurosurgery.

28. How many patients were under Mr Eljamel's care over that period, divided over time periods and by type of medical issue being treated?

28.1 In addition to the response to Question 29 which lists the categories of care and breaks down the activity (including number of patient) under Mr Eljamel's care, Table 5 in Appendix 5 [NHST-04945] shows the number of inpatient stays where the admitting consultant is recorded as "S Eljamel" by the recorded procedure. The breakdown is provided by surgical procedure category. The 981 inpatient stays relate to 807 individual patients. Where the total in the OPCS grouping is <5, this has been combined into "Other". Where figures are less than 5, this has been converted to "<5" to avoid the potential for patient identification. The data runs from April 2011 - December 2013.

28.2 Please refer to answer at paragraph 27(d).4 as an explanation for the time period provided.

29. How did the numbers under his care over that period compare with averages for patient numbers under the care of neurosurgeons at his various levels of seniority?

29.1 We defined "care" as encompassing three main categories:

- Inpatient activity.
- Outpatient activity (clinics).
- Surgical activity (including inpatient and day cases).

- 29.2 These categories represent the standard ways in which patients are typically recorded under a consultant's name. We refer to these as activity and provide a detailed breakdown for Mr Eljamel and his consultant colleagues across each category, between April 2011 and December 2013. The reason for this timeframe is explained in answer at paragraph 25.1.
- 29.3 The table included below captures the caseload of each neurosurgeon in the Neurosurgery department from April 2011 to December 2013. The information below relates to patients who had surgery. Mr Eljamel routinely had a higher caseload than his colleagues, albeit not significantly higher than the second most active neurosurgeon in the department.
- 29.4 NHS Tayside has not identified a single document or record that explains why Mr Eljamel routinely had higher caseloads than his colleagues. This is likely due to a combination of factors rather than a single explanation. Based on the evidence available, a number of points may have contributed to the higher workload. In the earlier period, there is evidence that the service was experiencing a shortage of consultants with Mr Varma's retirement, as explained in an email from Mr Eljamel in 1998 requesting to carry over some of the annual leave he was not able to take *[NHST-04719]*.
- 29.5 In later years, there is documentation indicating that Mr Eljamel undertook additional clinical activity including work associated with waiting times guarantees *[NHST-01518]*. The increased throughput of patients and pressures of waiting times guarantees on Mr Eljamel (as well as other colleagues) was acknowledged by David Mowle, Consultant Neurosurgeon in an email to Mr McLoughlin, Clinical Director of Specialist Services *[NHST-01517]*.
- 29.6 It is also possible that individual clinical practice patterns, including differing thresholds for undertaking surgical intervention or accepting complex cases, may have contributed to variations in caseload between consultants. Some of the interviewees in the Royal College of Surgeons' report *[NHST-00072]* stated that

“they referred patients to Professor Eljamel at least as often as they did to his colleagues, if not more so. One also stated “If you want something done, go to Sam. If you want more conservative management go to one of the others” [NHST-00072_10].

29.7 Overall, the available records do not provide a comprehensive account of how caseloads were distributed between consultants during the relevant period. As such, while the above factors may have contributed, it is not possible to determine definitively why Mr Eljamel had a higher caseload than that of his colleagues.

29.8 Please refer to the answer at paragraph 27(d)4 as an explanation to the time period provided and limitations of the electronic recording systems.

29.9 Inpatient Surgical Admissions by Consultant Neurosurgeon and Year, Broken Down by Daycase (discharged home within the same day) or Inpatient Stay, Extracted from TOPAS, June 2011 to December 2013 Inclusive

Inpatient Admission By Consultant	(June) 2011		2011 Total	2012		2012 Total	2013		2013 Total	Total
Row Labels	Day-case	Inpatient		Day case	Inpatient		Day case	Inpatient		
S Eljamel	30	245	275	37	325	362	43	301	344	981
D Mowle	25	201	226	34	288	322	18	318	336	884
E Ballantyne	28	144	172	32	221	253	24	222	246	671
C Lim		9	9	10	255	265	18	276	294	568
Grand Total	83	599	682	113	1089	1202	103	1118	1221	3105

*Please note, the number of Inpatient Stays for Mr Eljamel broken down by Procedure Code (explanation of OPCS 4.8 Grouping Codes provided in answers at paragraphs 25.8 and 25.9) is provided in Appendix 5 Table 5 [NHST-04945].

29.10 Surgical (Theatre Operations) Cases by Consultant Neurosurgeon and Year, Extracted from OPERA, April 2011 to December 2013 Inclusive

	Year			
Consultant	2011	2012	2013	Total
Ballantyne, Eric	174	218	225	617
Eljamel, Prof S	272	321	273	866
Lim, Chris	18	243	280	541
Mowle, David	223	262	283	768
Unknown	5	25	7	37
Grand Total	692	1069	1068	2829

Please note: *There are a handful of cases that do not have a clear consultant listed from the data held, which have been marked as “unknown”.

** Any cases that appear to have been undertaken by a trainee under a consultant have been counted under that consultant’s name, as accepted practice.

29.11 TOPAS outpatient attendances under the specialty of Neurosurgery April 2013 to December 2013 inclusive.

Row Labels	New	Return	Total
C Lim	293	473	766
D Mowle	344	563	907
E Ballantyne	296	316	612
S Eljamel	387	650	1037
Grand Total	1320	2002	3322

Please note, the information is shown by ‘attending clinician’. In 105 of these attendances, ‘attending clinician’ was information was missing. These have been replaced by ‘responsible clinician’.

29.12 In addition to the above, data was provided for the 2013 RCS Review which measured the number of patients on the New and Return waiting lists, broken down by neurosurgeon, over a two-year period [NHST-01587_4]. It also presented the percentage of outpatient activity under each neurosurgical consultant as a percentage of the total activity.

30. Please set out the broad systems for how Mr Eljamel's work was undertaken, including the broad roles of other members of his team and associated professional colleagues at NHST, including how these evolved over time.

30.1 Mr Eljamel's work involved managing scheduled (elective) and unscheduled (urgent) work. Both scheduled and unscheduled work included examining patients, deciding on treatment plans and executing the treatment, including both surgical and non-surgical treatment.

30.2 Mr Eljamel would be supported in the above tasks by Foundation year doctors (see paragraph 19(b).9 for definition and overview of roles), middle grade doctors (see paragraphs 19(b).6 and 19(b).7 for definition and overview of roles), nursing staff theatres and allied health professionals. Further information relating to these roles can be found as follows:

- Foundation and middle grade doctors please see paragraphs 14.9, 19(a).4, 19(b).6, 19(b).7, 19(b).9 19(d).6 and 19(d).7
- Nursing staff please see paragraphs 19(a).3, 19(b).10, 19(d).8 and 19(d).9.
- Information on wider staff groups that Mr Eljamel worked with can be found in Questions 18 and 19.

30.3 Mr Eljamel was also supported by a multidisciplinary team comprising of radiologists and neurologists to manage complex elective cases.

30.4 An explanation of the evolution of the members of the team over time is provided in response to Question 14(b), paragraph 14.8.

31. In particular, please explain Mr Eljamel's responsibilities for the training and supervision of junior professional colleagues, including how these evolved over time.

31.1 Within Mr Eljamel's HR file there is a job plan signed by him in August 1996 [NHST-01542] which further details his responsibilities, which were:

- a) Professional supervision and management of junior medical staff attached to the unit.*
- b) Teaching, accreditation and examination duties as activity, locally and nationally.*

31.2 In general terms these would have involved his delivering practical training to enable trainee doctors to perform procedures and to manage patients in the ward to the level of their training requirement. The trainee doctors would then be assessed and supported to achieve the required capabilities, by their supervising consultant. Further information can be found in response to Question 8(x). Between 1995 and 2014, the supervision of trainee doctors in NHS Scotland progressed from largely informal, mentorship-based arrangements to formal, competency-driven system aligned with GMC standards. Over this period, structured educational and clinical supervision roles became established. Relevant policies were held by NHS Education for Scotland or its predecessor organisations.

32. Over what period did Mr Eljamel run a pain clinic within NHST. What was his role in that service?

32.1 No evidence has been found that Mr Eljamel ran a dedicated pain clinic within NHS Tayside. He did, however, lead/run a neuromodulation clinic/service which traditionally manages a cohort of patients with chronic pain. Please refer to paragraph 18(h).1 for further information, including the date period Mr Eljamel held this clinic. Following consultation with staff (Dr Gail Gillespie Consultant Anaesthetist and Current Pain Service Clinical Lead, neurosurgical ANPs and medical secretaries, Neurosurgery), employee recollection and organisational memory, it is believed that any reference to pain clinic in any report is in fact referencing the neuromodulation clinic, where he worked as a consultant with an Operating Department Practitioner (ODP) or ANP support.

33. What proportion of professional responsibilities in the care and treatment of Mr Eljamel's patients was undertaken by him and what proportion was undertaken by junior colleagues in training?

- 33.1 Mr Eljamel was responsible for the care and treatment of all patients for whom he was the named consultant, whether he treated the patient directly or was the supervising consultant.
- 33.2 Middle grade (specialty) doctors in Neurosurgery are responsible for the day-to-day clinical care of patients under the Neurosurgical service, acting under the supervision of the consultant neurosurgeons within a consultant-based service model. Duties include assessment and ongoing management of in-patients, participation in ward rounds and outpatient clinics, assisting in operative procedures under consultant supervision, and supporting the care of critically unwell patients, including those requiring ventilation and invasive monitoring. When on call, the specialty doctor receives and undertakes the initial assessment of emergency neurosurgical referrals, reporting directly to and escalating appropriately to the Duty Consultant Neurosurgeon, and following local departmental procedures for admission, investigation, referral and discharge. The role also involves supervision and support of more junior medical staff, be it foundation year doctors or more junior middle grade doctors, participation in multidisciplinary working, and engagement in professional development through structured time working with individual consultants, all in accordance with local policies, national standards and professional obligations. This is standard practice and NHS Tayside has no evidence to suggest the practice was different in the neurosurgical unit at any time across the period in question. A neurosurgery specialty doctor job description from 2009 outlines the above responsibilities [NHST-04442].
- 33.3 An overview of the roles and responsibility of medical staff can be found in paragraphs: 14.9, 19(a).4, 19(b).6, 19(b).7, 19(b).8, 19(b).9 19(d).6 and 19(b).7.
- 34. What systems existed for NHST's supervision or control of work done by Mr Eljamel within the University of Dundee in the period between 1995 and 2014, both in terms of workload and the nature of the work being undertaken?**
- 34.1 The University of Dundee would be solely responsible for the supervision and control of work undertaken by Mr Eljamel within the University of Dundee during the period of 1995 to 2014.

35. Please explain the broad timing, reasons for and conditions of Mr Eljamel's clinical supervision (ToR 8).

- 35.1 Based on documentation within Mr Eljamel's HR file, Mr Eljamel attended a meeting held on 3 June 2013 with the Clinical Director and the Neurosurgery Clinical Lead [NHST-01549]. Based on a note of that meeting [NHST-01550], it appears to have been held to discuss performance, specifically the escalating number of complaints involving Mr Eljamel ultimately resulting in a Significant Critical Event Analysis (SCEA) [NHST-01506]. It is noted that personal communication was also discussed as a performance issue. It was agreed at the meeting that these issues would be managed at Clinical Director level in the first instance. It was accepted by the attendees of the meeting that Mr Eljamel had been under a significant amount of pressure in recent years with his clinical practice. It is noted that Mr Eljamel had reflected and agreed to alter his practice significantly. It was agreed that any further issues would be raised and managed through the appraisal process [NHST-04637; NHST-04638; NHST-04409; NHST-04725].
- 35.2 The additional options available at this stage would have been those laid out in the formal Standards of Behaviour and Disciplinary Procedure [NHST-01579], involving an investigation with options including supervision or suspension on an interim basis pending outcomes of the investigation.
- 35.3 In a summary letter from the Medical Director to the Clinical Director [NHST-01555] and the General Manager for Specialist Services, which detailed the discussions that took place at a meeting held on 20 June 2013 [NHST-01555] between the Medical Director, the General Manager, and the Clinical Director for Specialist Services. There is no evidence that a formal meeting note was taken during this meeting. The meeting was as a result of letter dated 6 June 2013 from the patient involved in the above mentioned SCEA to the Medical Director. The letter raised concerns about another patient who had undergone wrong level surgery under Mr Eljamel's care. The patient asked for a full audit of patients who had undergone spinal surgery in the period 2010-2013 [NHST-04446].
- 35.4 It is noted within the summary letter that during the meeting on 20 June 2013 [NHST-01555], a further case was brought to the attention of the Medical Director that a second opinion from an external neurosurgeon (the identity of whom is unknown to NHS Tayside) suggested there were significant concerns with Mr Eljamel's surgical

practice. An itemised list of complaints focusing on poor communication between Mr Eljamel, his patients and colleagues was also shared with the Medical Director at that meeting. NHS Tayside does not hold this list; it is aware of this from the summary letter sent following the meeting [NHST-01555]. No concern was expressed in relation to current patient safety issues but there were clear concerns about a pattern of practice and behaviour resulting in significant concern being raised by patients and colleagues [NHST-01555].

- 35.5 It is noted within the summary letter that as a result of this meeting [NHST-01555], the decision was made to commission an independent review of Mr Eljamel's practice. The General Manager and the Clinical Director were asked to discuss this decision with Mr Eljamel and to determine the range of restrictions that should be put in place on his clinical practice.
- 35.6 In a letter from the Clinical Director, Specialist Services, dated 21 June 2013 [NHST-01556], a meeting was held with Mr Eljamel on that date, attended by the Clinical Director, and accompanied by the HR Business Lead. During that meeting the Clinical Director shared that a further two complaints had been received, hence the need to meet to discuss formal provisions to manage the clinical and individual/professional risks. It is noted that Mr Eljamel was advised that the Medical Director had decided to commission an external review, the scope of which would encompass the issues raised previously along with the more recent complaints.
- 35.7 It is noted that Mr Eljamel was further advised during the meeting on 21 June 2013 [NHST-01556] that it had been determined by the Medical Director to implement measures to support him to continue in his role on a basis that ensured neither patients nor himself were at risk. It was proposed that until the review had been completed, Mr Eljamel's clinical practice would be supervised by the Clinical Lead. The detail of how that would work in practice was to be agreed between the Clinical Lead and Mr Eljamel [NHST-01517]. Immediately, however, Mr Eljamel was to be removed from the on-call rota, and he was not allowed to supervise junior staff undertaking cases on his behalf.
- 35.8 A timeline held within Mr Eljamel's HR file [NHST-01549] suggests the supervision would involve reflective discussions. An email dated 25 June 2013 [NHST-01557], received by the Clinical Director, from the Clinical Lead confirmed the supervision would comprise joint ward rounds on post-operative days and would be followed

with a detailed case-based discussion. It was also agreed that the Clinical Lead and Mr Eljamel would discuss the cases that were subject to complaints. The Clinical Lead would take clinical responsibility for the patients under Mr Eljamel's care. The level of supervision would have been determined by the underlying concerns and risk assessment. This could have ranged from direct supervision of all aspects of practice or target elements of practice.

36. Please explain the broad timing, reasons for and conditions of Mr Eljamel's suspension from practice (ToR 9).

36.1 Documentation within Mr Eljamel's HR file outlines that following receipt of the 2013 RCS report [NHST-00072; NHST-01581], a meeting was held at 11:30 on 10 December 2013 [NHST-01568], attended by the Medical Director, Associate Medical Director Surgery, Operational Medical Director and General Manager. The documentation indicated that the RCS report had been shared with all attendees prior to the meeting. The attendees at the meeting discussed the contents of the 2013 RCS report [NHST-01581], and it was agreed to action the report's recommendations regarding Mr Eljamel's practice.

36.2 Those recommendations were that:

1. *"The GMC liaison officer should be made aware as there was a need to investigate with a view to considering Mr Eljamel's fitness to practice."*
2. *"Mr Eljamel should not be allowed to undertake any spinal surgery meantime."*
3. *"There were some concerns with regard to the probity of some of Mr Eljamel's activities."*

36.3 It is noted that attendees at the meeting agreed that, given the scale and level of concern expressed by the external neurological opinion, it was felt inappropriate to allow Mr Eljamel to continue working. The decision was therefore taken to suspend him from duties that day, 10 December 2013 [NHST-01568].

36.4 The Standards of Behaviour and Disciplinary Policy [NHST-01579] outline the procedures to be followed, and section 7 refers to Suspension [NHST-01579_12]. The decision to suspend is based on the perceived seriousness of the events in question. The alternative at this stage would have been not to suspend and continue

with alternative supervision arrangements, in which case Mr Eljamel would have continued working in some capacity with potential ongoing risk to patients.

- 36.5 Mr Eljamel was suspended in person by the Associate Medical Director (Surgery), accompanied by the Associate HR Business lead, at around 14:30 the same day, 10 December 2013. A letter dated 10 December 2013 from the Associate Medical Director Surgery [NHST-01558] was sent to Mr Eljamel confirming his suspension on full pay and noting that Mr Eljamel had been asked to leave the building immediately after the meeting that day. The letter further notes that Mr Eljamel would be called to an investigatory meeting to discuss the contents of the report and was asked to provide the name of a representative to the Operational Medical Director.
- 36.6 An email was sent to the Chief Medical Officer on 19 December 2013 [NHST-04499] advising of Mr Eljamel's suspension, as is required according to the suspension guidelines within the Standards of Behaviour and Disciplinary policy [NHST-01579]. NHST-04499 is a document which has been obtained from a Scottish Government FOI request. NHS Tayside would direct the Inquiry to the Scottish Government for the unredacted version.
- 36.7 Letters confirming that Mr Eljamel's suspension remained in place following the required four weekly suspension review by the Associate Medical Director, Surgical, per the suspension guidelines within the Standards of Behaviour and Disciplinary policy [NHST-01579], were sent to Mr Eljamel by the Associate Medical Director on 7 January 2014 [NHST-01559] and 3 February 2014 [NHST-01560].
- 36.8 On 13 February 2014 a letter [NHST-01561] was sent to Mr Eljamel by the Associate Medical Director confirming that the internal investigation would not proceed following Mr Eljamel's application to retire from NHS Tayside, effective 31 May 2014.
- 36.9 Two papers [NHST-04730; NHST-04731] were presented to the NHS Tayside Board meeting held on 27 February 2014 to inform the Board that Mr Eljamel had been suspended following receipt of the 2013 RCS Report [NHST-00072].

37. Please explain the broad circumstances and conditions of Mr Eljamel's resignation from his role at NHST (ToR 10).

37.1 Mr Eljamel gave notice of his intention to take voluntary early retirement by letter to the NHS Tayside HR department dated 27 December 2013 [NHST-01562]. The NHS Tayside HR department received Mr Eljamel's formal Voluntary Early Retirement application, for onward submission to the Scottish Public Pensions Agency (SPPA), on 10 February 2014, with an intended leaving date of 31 May 2014.

37.2 A letter dated 13 February 2014 [NHST-01561] from the Associate Medical Director to Mr Eljamel noted that Mr Eljamel had indicated his intention to retire on 31 May 2014. It noted that, following consideration of this intention, the Associate Medical Director had agreed with the Medical Director not to proceed with the internal investigation. The letter further notes the outcome of the GMC enquiry remained outstanding and arrangements would be put in place to extend his suspension from duty. It also notes that Mr Eljamel's suspension would be amended to enable remaining annual leave entitlement to be taken.

37.3 There is no available documentation or organisational memory that explains the reason for the decision not to continue with the internal investigation following Mr Eljamel's communication of his intention to retire. The Medical Director in post at the time may be able to assist the Inquiry further in this regard.

37.4 Mr Eljamel's last day of service was 31 May 2014 [NHST-01567], although he had been suspended from duties since 10 December 2013, and had not been treating patients since his suspension.

38. Please explain the broad circumstances and conditions of the removal of Mr Eljamel's name from the GMC medical register, including the role which NHST played in that event (ToR 11).

38.1 According to a letter from the Medical Director to the GMC dated 20 December 2013 [NHST-01566], a conversation regarding Mr Eljamel took place between the Medical Director and Mr William Paxton, Employer Liaison Advisor, of the GMC. There is no file record of this conversation, however the letter confirms to the GMC that Mr

Eljamel had been suspended within the last two weeks and that this had been the result of an external review by the RCS. A copy of the RCS report was enclosed [NHST-00072].

38.2 The letter from the Medical Director to the GMC [NHST-01566] advised that NHS Tayside was in the process of reviewing Mr Eljamel's cases and this would be concluded early in the new year (2014), at which point the GMC would be provided with an update on the outcome.

38.3 A further letter to the GMC (noted as draft in the file) dated 13 February 2014 [NHST-01565] advised the GMC that Mr Eljamel had given notification of early retiral and that as a result, the internal investigation would no longer be pursued.

38.4 An email dated 28 February 2014 from the GMC into a generic mailbox called "Tayside GMC" [NHST-01564] notified NHS Tayside of fitness to practice restrictions placed on Mr Eljamel. These were as follows:

1. *He must notify the GMC of any professional appointment he accepts for which GMC registration is required and provide the contact details for the employer.*
2. *He must allow the GMC to exchange information with his employer or any contracting body for which he provides medical services.*
3. *He must inform the GMC of any formal disciplinary proceedings taken against him.*
4. *He must inform the GMC if he applies for medical employment outside the UK.*
5. *He must confine his medical practice to posts within the NHS and not undertake private practice.*
6. *He must not carry out any spinal surgery.*
7. *He must inform any employers that his registration is subject to conditions.*

38.5 NHS Tayside was further notified by the GMC on 7 August 2015 that they would grant Mr Eljamel's application for voluntary erasure, and that his name would now be removed from Medical Register. The letter stated Mr Eljamel's licence to practise would be withdrawn, and he could not practise in the UK [NHST-01538]. A further check of the GMC register undertaken on 8 September 2016 showed that Mr Eljamel's registration with the GMC was noted as relinquished from 10 August 2015 [NHST-01563].

Appendix B - Part D – Mr Eljamel’s appointments

Under Term of Reference 1, the Inquiry is charged with the investigation the processes leading to the appointment of Mr Eljamel to key positions he held in his professional capacity in Scotland, including (a) Consultant Neurosurgeon, Ninewells Hospital, Dundee on around 9 October 1995 (b) Head of Department /Section for Surgical Neurology, University of Dundee in around 1996 and (c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee in around 1998, including any induction he may or may not have received upon assuming such roles and the adequacy of the systems in place in that regard within NHS Tayside and the University of Dundee.

Mr Eljamel’s employments with NHS Tayside

With regard to the following roles, held by Mr Eljamel over the relevant period:

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee from around 9 October 1995;

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

39. What were the terms upon which Mr Eljamel conducted each of these roles? What practising privileges did he enjoy?

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee, from around 9 October 1995;

39(a).1 As outlined in Mr Eljamel’s offer of appointment letter [NHST-01540], he was offered the position of Consultant Neurosurgeon with Dundee Teaching Hospitals Trust, with a start date of 9 October 1995. The terms and conditions of his appointment were those as applied to Hospital Medical and Dental Staff in the NHS in Scotland, as determined by the Secretary of State for Scotland and the General Whitley Council conditions of service.

39(a).2 As noted in paragraph 21.3, the offer of appointment letter [NHST-01540] laid out the duties assigned to Mr Eljamel for the purpose of providing health services under the National Health Service Acts [NHST-04332; NHST-04333].

39(a).3 The appointment letter [NHST-01540] noted that Mr Eljamel was also required to be fully registered with the GMC. The letter outlined that in matters of personal conduct, he was subject to the Dundee Teaching Hospitals NHS Trust's "disciplinary and dismissal procedures" (formally the Disciplinary Procedures for Hospital Medical and Dental Staff) [NHST-01579].

39(a).4 A draft job plan, issued with the job description [NHST-01504] at advertisement stage, indicated two sessions a week for outpatient clinics and ten sessions shared between the three consultants of fixed theatre time. The rest of the sessions were flexible and would be agreed with the appointee. In job planning terms, a full-time consultant working a 40-hour week would have 10 sessions in their job plan, each of which would be four hours long.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

39(b).1 There is no information within Mr Eljamel's HR file held by NHS Tayside regarding this appointment. The Inquiry may wish to direct this question to the University of Dundee.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

39(c).1 There is no information within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside regarding his appointment to this role. It is not clear how this appointment occurred. The duties of the Clinical Lead are noted in the response to question 8(j).2.

39(c).2 NHS Tayside is aware that Mr Eljamel held the role of Clinical Lead, Neurosurgery, NHS Tayside from 1998 to 2009.

39(c).3 "Lead Clinician" and "Clinical Lead" are one and the same role. Please see the answer to Question 17.4 for details on the Clinical Lead/Lead Clinician role.

40. What were his responsibilities in each of these roles, including which hospitals these responsibilities covered?

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee from around 9 October 1995;

40(a).1 Within Mr Eljamel's HR file there are job plans signed by him in 1996 and 1997 [NHST-01542; NHST-01640], which further detail his responsibilities, as follows:

- a) The provision, with consultant colleagues, of a Neurosurgical Service to the DTHT with responsibility for the prevention, diagnosis and treatment of illness and for the proper functioning of the unit.*
- b) Out of hours responsibility for the provision of an emergency Neurological Service.*
- c) Provision of cover for consultant colleagues where appropriate.*
- d) Professional supervision and management of junior medical staff attached to the unit.*
- e) Teaching, accreditation and examination duties as activity (locally and nationally).*
- f) Participation in continuing medical education and in medical audit in conjunction with the audit sub-committee of the Directorate of Neurosciences.*
- g) Involvement as appropriate in research and development which would be of benefit to the care of patients.*
- h) Managerial - including budgetary - responsibilities by agreement with the clinical director.*

40(a).2 In relation to the 1996 job plan, Mr Eljamel's responsibilities were supported by a work programme [NHST-01542]. This outlined a weekly timetable showing fixed commitments, the hospital or other work locations where each commitment would be undertaken, and the type of work involved. The weekly timetable showed a fixed weekly theatre on Thursdays (both morning and afternoon); outpatient clinics on a Tuesday afternoon; new patient clinics on a Wednesday morning; teaching commitments on Tuesday morning; ward and audit commitments on Wednesday afternoons; and theatre commitments every third Monday and Friday (all day). There was a similar work programme in relation to Mr Eljamel's 1997 job plan

[NHST-01640]. NHS Tayside holds job plans for years, 1996 [NHST-01542], 1997 [NHST-01640], 2003 [NHST-04642], 2005 [NHST-04629], 2008 [NHST-04600], 2008-2009 [NHST-04518], 2010 [NHST-04788], 2011 [NHST-04628], 2012 [NHST-04644], and 2013 [NHST-01543]. NHS Tayside does not hold job plans for years 1995, 1998, 1999, 2000, 2001, 2002, 2004, 2006 or 2007.

40(a).3 A job plan agreed for the year 2012/13 [NHST-01543] confirmed a fixed theatre day on a weekly basis; half day new and returning outpatient clinics on weekly basis; and a 1 in 4 on-call arrangement. The on-call pattern is as explained in Question 43, paragraph 43(a).1. The job plan had a more detailed list of non-fixed duties which included:

- *Prioritising GP referrals using the paper and electronic referral system.*
- *Interviewing patients and families for consenting, breaking bad news and relaying results.*
- *Arranging admissions, clinics and operation lists.*
- *Dictating letters to GPs and discharge summaries and checking letters.*
- *Coding discharges and reviewing letters dictated by juniors.*
- *Discussing results and arranging tests with radiology colleagues.*
- *Attending for consultation from juniors or other specialists or GPs.*
- *Teaching undergraduate students, and teaching and training of juniors attached to the unit.*
- *Running the department with colleagues, with responsibilities to maintain standards.*
- *Short-listing, arranging and interviewing potential candidates.*
- *Committees: Clinical Governance, Chairs of Clinical Governance, Clinical Governance and Quality Forum, Ethics Committee, and examiners meetings.*
- *Interviewing potential medical students, vetting their applications.*
- *Attending other committee meetings, appraisals, assessments and teaching courses.*

40(a).4 Mr Eljamel initially worked mainly within DRI, then mainly within Ninewells Hospital following the transfer from DRI, and occasionally at other hospitals within NHS Tayside, including Perth Royal Infirmary.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

40(b).1 There is no information within Mr Eljamel's HR file held by NHS Tayside regarding his appointment to this role. The Inquiry may wish to direct this question to the University of Dundee.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

40(c).1 "Lead Clinician" and "Clinical Lead" are one and the same role. Please see response to Question 17.4 for details on the Clinical Lead/Lead Clinician.

41. What standards was he expected to adhere to in these roles under (i) the terms of his employment and (ii) his professional obligations?

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee, from around 9 October 1995;

41(a).1 In Mr Eljamel's appointment letter, dated 9 October 1995 [NHST-01540], it states that in matters of personal conduct, Mr Eljamel was subject to the Dundee Teaching Hospitals NHS Trust's disciplinary and dismissal procedures [NHST-01579].

41(a).2 Those procedures would have been based on Scottish Executive circulars PCS-1990-08 [NHST-00242] and PCS 1994-dd-11 [NHST-00243].

41(a).3 NHS Tayside Standards of Behaviour and Disciplinary Policy [NHST-01579], undated but also based on the above noted circulars, notes that it applies to all Medical and Dental Employees of NHS Tayside. It also notes that each employee has a responsibility to achieve acceptable standards of personal conduct and where there is cause for dissatisfaction that the employee is given the opportunity to improve. It does not define what acceptable standards of personal conduct are.

41(a).4 Mr Eljamel would have been expected to work to the GMC's Code of Conduct in place at the time. NHS Tayside would refer the Inquiry to the GMC for that information for the period in question.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

41(b).1 There is no information within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside regarding his appointment to this role. The Inquiry may wish to direct this question to the University of Dundee.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

41(c).1 Please see the response to Question 41(a).1.

42. What restrictions, if any, applied to his ability to undertake private work in addition to his NHS responsibilities during the period he held these roles?

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee, from around 9 October 1995;

42(a).1 The national consultant terms and conditions handbook in place at the time of Mr Eljamel's appointment is not available as they have been replaced by more recent versions of the terms and conditions handbooks. Further information about this is included in response to Question 10(b). However, the Hospital Medical and Dental Staff Terms and Conditions of Service Handbook, published by the Scottish Executive in April 2003 [NHST-01574], confirms that consultants were able to undertake private practice provided that their gross income from such work did not exceed 10% of their gross salary. There was a requirement for the employee to certify annually that private practice income did not exceed 10% of their gross salary. This process would have applied to all consultants. NHS Tayside hold no records in relation to private work and no evidence that Mr Eljamel provided certification of income related to such work.

42(a).2 The new consultant contract introduced in 2004, and updated handbook dated 2007 and extant [NHST-01575] does not have the same restriction on the volume of private practice. There remains a requirement for the consultant to notify their employer that they undertake private practice. For consultants transferring onto the

new contract this was to happen as part of the initial job planning process. There are no records within Mr Eljamel's HR file of him notifying NHS Tayside that he was undertaking private practice.

- 42(a).3 While there is no documentation regarding private work contained within Mr Eljamel's HR file [NHST-04741]. Organisational intelligence and current staff knowledge indicate it was widely known that Mr Eljamel did undertake private work at Fernbrae Hospital.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

- 42(b).1 There is no information within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside regarding his appointment to this role. The Inquiry may wish to direct this question to the University of Dundee.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

- 42(c).1 Please see the response to Question 42(a).

43. What shift patterns and on call obligations did he have in each of these roles?

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee from around 9 October 1995;

- 43(a).1 The job description for the post, Mr Eljamel's appointment letter, and his job plan from August 1996 [NHST-01540; NHST-01542] all outline a 1:3 emergency cover requirement (the 1:3 on-call ratio refers to having three neurosurgical consultants in the rota, each taking turn for being on call, therefore each consultant is on call one out of every three times - for example, one night, one day, or one weekend out of three). Please refer to paragraph 40(a).2 which details all job plans held by NHS Tayside, the shift patterns, and on-call obligations. Between 2003 and 2009 job plans were relatively static with clinical leadership activities not allocated at specific times or locations.

43(a).2 A set out in paragraph 40(a),2 above, NHS Tayside does not hold Job Plans for years 1995, 1998, 1999, 2000, 2001, 2002, 2004, 2006 or 2007. In instances where a job plan is not held, this may reflect that there were not changes to the previous job plan and/or these were held by individual clinicians.

43(a).3 There is a later job plan within Mr Eljamel's HR file [NHST-04741] from July 2013 [NHST-01543] indicating a 1:4 on-call arrangement was in place which aligns with the timing of the recruitment of a fourth neurosurgical consultant in 2011. Therefore, the assumption is that between 1995-2011, Mr Eljamel had 1:3 on-call duties, which decreased to 1:4 in 2011 [NHST-04628] following the recruitment of a fourth neurosurgical consultant.

43(a).4 Please see the response to Question 40(a).2 and Question 40(a).3.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

43(b).1 There is no information within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside regarding his appointment to this role. The Inquiry may wish to direct this question to the University of Dundee.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

43(c).1 Please see the response to Question 43(a).

44. What responsibility for the training and supervision of others did he have in each of these roles?

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee from around 9 October 1995;

44(a).1 Within Mr Eljamel's HR file [NHST-04741] there is a job plan signed by him in August 1996 [NHST-01542] which details his responsibilities for training and supervision, as follows:

- a) Professional supervision and management of junior medical staff attached to the unit.*
- b) Teaching, accreditation and examination duties as activity (locally and nationally).*

44(a).2 In general terms, training and supervision in a consultant role would have involved delivering practical training to enable trainee doctors to perform procedures and the management of patients in the ward to the level of their training requirement. The trainee doctor would then be assessed and supported to the required capabilities.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

44(b).1 There is no information within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside regarding his responsibility for the training and supervision of others in this role with the University of Dundee. The Inquiry may wish to direct this question to the University of Dundee.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

44(c).1 These responsibilities would have been the same as in Mr Eljamel's consultant role. Please refer to paragraph 44(a).1, and to the comments in paragraph 32.1 above, in relation to Mr Eljamel's responsibility for a pain clinic. This was a lead clinician role and would have included providing leadership to other clinicians who may have been involved in running a pain clinic.

45. How was responsibility for the allocation of work to junior colleagues arranged in each of these roles?

45.1 Please note that in response to Questions 45(a), (b) and (c), NHS Tayside has not found any evidence that outlines the process for allocation of work to junior colleagues during Mr Eljamel's tenure. Organisational intelligence and current staff knowledge and experience would suggest the allocation of trainees in all specialties at the time would have been decided internally by the consultants, in line with their individual training needs. In practice, the allocation of work to junior medical staff

happens largely as a function of established roles and responsibilities within each grade, rather than through formal task assignment. Day-to-day duties were undertaken in accordance with the doctor's role on the rota at that time, with responsibilities naturally aligning to the expectations of that grade and shift. Where necessary, work was agreed informally between colleagues and escalated appropriately, reflecting standard NHS working practices.

45.2 Additionally, as explained in paragraphs 19(a).4 19(b).6 19(b).7 and 33.2, the responsibilities of "junior doctors" (previously split into Foundation Year and middle grade doctors - see paragraph 14.9) are well established. Foundation year doctors' work is primarily ward based, including completion of routine clinical tasks, discharge planning, review and escalation of clinical deterioration, and support for middle-grade doctors, senior trainees, and consultants. Middle grade doctors are more involved in direct work with consultants, including clinics and theatre lists, to support their training. A detailed junior doctor handbook and handover document from 2017 sets out the 'junior doctors' work [NHST-04467]. There is no evidence to suggest that junior doctor allocation of work differed materially in earlier years.

(a) Consultant Neurosurgeon, Ninewells Hospital, Dundee from around 9 October 1995;

45(a).1 See answer to Question 45.

(b) Head of Department /Section for Surgical Neurology, University of Dundee from around 1996; and

45(b).1 See answer to Question 45.

(c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee from around 1998

45(c).1 See answer to Question 45.

Employment as a consultant neurosurgeon from 1995

46. What interview/ assessment process was undertaken in connection with Mr Eljamel's appointment to this role and by whom were these undertaken?

- 46.1 Mr Eljamel applied for the post of consultant neurosurgeon by submitting a curriculum vitae (CV) [NHST-01544] in response to the vacancy that was advertised [NHST-01504]. His application was considered by an Advisory Appointments Committee (AAC) comprising nine members variously representing Dundee Teaching Hospitals NHS Trust and the University of Dundee, alongside two members from a National Panel of Specialists. This was in alignment with the National Health Service (Appointment of Consultant) (Scotland) Regulations 1993 [NHST-01577] which laid out the requirements for the selection process for consultant appointments in Scotland. The Regulations also set out a requirement on the Secretary of State for Scotland to create a National Panel of Specialists for the purpose of providing members of AAC. According to the minute of the AAC held in Mr Eljamel's file [NHST-01653], the AAC shortlisted Mr Eljamel and two other candidates for interview by assessing the applications against a set of agreed criteria, the advertisement and a memorandum of information about the post.
- 46.2 There is no evidence in Mr Eljamel's HR file [NHST-04741] held by NHS Tayside of the memorandum of information about the post or the agreed set of criteria, as referenced in the minute of the AAC meeting.
- 46.3 There is evidence within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside of his GMC registration status [NHST-04447], and of his status with the Royal College of Surgeons (RCS) in Ireland [NHST-04448].

47. How many other candidates were interviewed?

- 47.1 Two other candidates were interviewed [NHST-01653].

48. What was the “*national guidance at that time*” in accordance with which the selection process was undertaken (NHST-00075, page 6) and included senior clinical representatives from the Scottish Government, University of Dundee and NHS Tayside

48.1 The National Health Service (Appointment of Consultant) (Scotland) Regulations 1993 [NHST-01577] laid out the requirements for the selection process for consultant appointments in Scotland. The Regulations also set out a requirement on the Secretary of State for Scotland to create a National Panel of Specialists for the purpose of providing members of AAC.

48.2 All Consultant appointments generally required, and continue to require, the constitution of an AAC.

48.3 The membership of an AAC must consist of four members from the appointing Trust, with one of these acting as Chair, and two members appointed from the National Panel of Specialists, at least one of which should not be employed by the appointing Trust. Where undergraduate teaching is involved or the teaching responsibilities are a major part of the role, between two and four members are nominated by the University concerned.

49. Why and by whom was the decision to award him this role arrived at? In particular, what “senior clinical representatives from the Scottish Government, University of Dundee and NHS Tayside” who were involved in the process (NHST-00075, page 6)?

49.1 In line with the Regulations laid down in 1993 [NHST-01577], an AAC was constituted for the appointment to the post of Consultant Neurosurgeon with Dundee Teaching Hospitals NHS Trust in 1995 [NHST-01653]. Members of that panel included four representatives from Dundee Teaching Hospitals NHS Trust, including the Clinical Lead, two independent members from the National Panel of Specialists, and three members representing the University of Dundee [NHST-01653]. The panel members representing Dundee Teaching Hospitals NHS Trust were Mrs M H Cane, Dr D Maclean, Mr T R K Varma and Mr D D Gentlemen. Dr D W L Davidson, Dr R C Roberts and Mr J W McNab represented the University of

Dundee and the National Panel of Specialists was represented by Mr R A Johnston and Mr A J Steers.

50. What qualifications and other experience did he present as part of his application?

50.1 Mr Eljamel presented his qualifications and experience in the form of a CV [NHST-01544] as requested in the job advertisement.

50.2 Within his CV [NHST-01544], Mr Eljamel described undergraduate qualifications in Basic and Clinical Sciences achieved in Libya, graduating in 1982. Following this, Mr Eljamel described entering a Pre-Registration Training year in Libya.

50.3 Mr Eljamel advised that he began General Professional training in Libya at the start of 1984 which continued through to August 1985.

50.4 Mr Eljamel concluded his General Professional training in Dublin then Airdrie between September 1985 and August 1987.

50.5 Mr Eljamel entered Higher neurosurgical training from September 1987 – 30 September 1991 at the Walton Hospital, Liverpool. Mr Eljamel also described spending time as a senior registrar in surgical neurology at the National Centre for Neurology and Neurosurgery in Dublin from October 1991 to September 1994.

50.6 It is recorded that Mr Eljamel obtained a certificate of completion of higher surgical training in May 1994.

50.7 NHS Tayside would like to draw the Inquiry's attention to paragraph 40 of NHS Tayside's opening statement which states, "As far as NHS Tayside is aware, Mr Eljamel did not practise in any other Health Board in Scotland". Following a thorough review of records, NHS Tayside has discovered that within Mr Eljamel's CV [NHST-01544], which was submitted as part of his recruitment process in 1995, it is noted that he undertook training in General Surgery, Vascular Surgery, and Urology between April 1986 and August 1987 in Dublin and Airdrie as a Junior Doctor. It should be noted that this was prior to Mr Eljamel undertaking Higher Specialist Neurosurgical training from September 1987.

50.8 Mr Eljamel provided a list of research, including his thesis, various research publications, and letters to a range of journals.

50.9 Mr Eljamel also noted that he had participated in the teaching programmes of nursing, undergraduate medical and dental students and postgraduate students from the University of Liverpool and the RCS.

51. What investigation was undertaken by NHST of the material presented in support of his application including, in particular, any concerns which had been raised about his professional practice before his time in Tayside?

51.1 There is evidence in Mr Eljamel's HR file [NHST-04741] held by NHS Tayside of the standard recruitment checks being carried out to verify the information contained within his CV. The file contains copies of relevant qualifications, registration with the GMC, and references from previous employers. The independent specialists in the AAC noted that all candidates were suitable for the role [NHST-01653]. The references [NHST-01570] obtained for Mr Eljamel confirmed his higher neurosurgical training and spoke highly of him. NHS Tayside has found no evidence of any concerns being raised at any point in the recruitment process in relation to Mr Eljamel's professional practice or suitability for the role.

52. In particular, what investigations were undertaken relating to/ with:

(a) Mr Eljamel's medical qualifications from Libya, in particular with Tripoli Medical School where he claimed to have qualified in 1982 (NHST-00075, page 6);

52(a).1 Established practice for recruitment to consultant posts is that evidence of registration with the GMC, coupled with evidence presented, would not require investigation of undergraduate qualifications. Therefore, no checks were made in relation to Mr Eljamel's medical qualifications from Libya.

- (b) The Royal College of Surgeons in Ireland, of which he claimed to have become a fellow in 1986 (NHST-00075, page 6);**

52(b).1 Evidence was provided of Mr Eljamel's Fellowship in the form of a Certificate [NHST-01545], a copy of which was held within his file. It would not be normal practice to investigate further.

- (c) The Walton Centre for Neurology and Neurosurgery, Walton Hospital, Liverpool, where he claimed to have been a Senior House Officer in Neurosurgery between 1987 and 1989 and a Senior Registrar (locum appointment for training) in neurosurgery between 1990 and 1991 (NHST-00075, page 6)**

52(c).1 Confirmation of Mr Eljamel's time and performance at the Walton Centre was obtained through references [NHST-01570_3-4]. He was described as "a very competent neurosurgeon who will provide a first-rate neurosurgical service."

- (d) The Beaumont Hospital in Dublin, Ireland where he claimed to have worked between 1991 and 1994 as a Senior Registrar (NHST-00075, page 6);**

52(d).1 Confirmation of Mr Eljamel's time at the Beaumont Hospital was obtained through references [NHST-01570_1-2]. He was described as an "... outstanding surgeon..." and was recommended most highly as consultant neurosurgeon.

- (e) Liverpool University where he claimed to have gained a Doctor of Medicine (MD with Distinction) in 1992 (NHST-00075, page 6);**

52(e).1 Evidence of Mr Eljamel's Doctor of Medicine degree was provided in the form of a certificate [NHST-01571], a copy of which was held in his file. It would not be normal practice to investigate further.

- (f) The Royal College of Surgeons from which he claimed to have received an Intercollegiate Fellowship in Neurosurgery in 1992 (NHST-00075, page 6); or**

52(f).1 There was no claim within Mr Eljamel's CV [NHST-01544] submitted as part of his application for the post of consultant neurosurgeon that he had received an Intercollegiate Fellowship in Neurosurgery.

- (g) Hartford Hospital in Connecticut, USA, at which he claimed to have undertaken a fellowship (NHST-00075, page 7)**

52(g).1 The CV submitted by Mr Eljamel in 1995 in application for the position of Consultant Neurosurgeon in Tayside [NHST-01544] did not claim that he had undertaken a fellowship at Hartford Hospital in Connecticut, USA. There is a handwritten annotation on the CV referencing a fellowship with the University of Connecticut. This note was not authored by Mr Eljamel and there is no evidence within Mr Eljamel's file as to when or why this annotation was added. It is notable that information relating to Mr Eljamel's fellowship in Connecticut, USA was included in the Staff Engagement Form [NHST-01593] signed by Mr Eljamel in October 1995 and within his visa application to the Overseas Labour Service in June 1995 [NHST-04449]. There is no evidence in Mr Eljamel's HR file [NHST-04741] held by NHS Tayside of further investigation into his time in Connecticut, USA. References were obtained from the three referees provided by Mr Eljamel in his application, all of which were very supportive [NHST-01570].

53. What was the outcome, if any, of those investigations?

53.1 Based on the information contained within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside, the standard recruitment checks were carried out to verify the information contained within Mr Eljamel's CV [NHST-01544] based on the requirements of the role. There is no evidence within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside that checks conducted uncovered any concerns about his professional practice or his qualifications.

54. What reliance was placed on the information presented in awarding him the role?

54.1 In general terms, in assessing a candidate's suitability for any post, the information presented is verified to the best of an employer's ability, in line with normal recruitment practices. This will include requesting references, confirming professional registration status, asking for proof of qualifications, and through

answers to questions during the interview. Decision making is reliant on the information presented by candidates but verified as far as possible.

54.2 The minute of the Appointments Advisory Committee (AAC) [NHST-01653] confirms that the committee considered the applications, read the reports of the referees and interviewed for the appointment of consultant neurosurgeon. The AAC was, therefore, reliant on the information provided by candidates and there is evidence in the file that this was verified, as noted in paragraph 54.1.

55. How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?

55.1 There is no evidence within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside relating to the recruitment process that any inaccuracies were brought to light. In general terms, if inaccuracies are identified during the recruitment process, the applicant would be asked to provide further verifiable information. Where they are unable to do so, consideration would be given to withdrawing the conditional offer of employment, based on the individual circumstances.

56. What assessment was undertaken by NHST of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?

56.1 The information held within Mr Eljamel's CV [NHST-01544] was verified by evidence of his qualifications, references from previous employers and answers provided to questions at interview. This will all have contributed towards the assessment of Mr Eljamel's capabilities and experience, as they pertained to the role he had applied for. The evidence within Mr Eljamel's HR file [NHST-04741] of the approach taken aligns with the National Health Service (Appointment of Consultants) (Scotland) Regulations 1993 [NHST-01577] which laid out the requirements for the selection process for consultant appointments in Scotland. The assessment was, and remains, the standard assessments used in recruiting to consultant posts across Scotland.

- 57. What assessment was undertaken by NHS Tayside of Mr Eljamel's (a) communication/ interpersonal engagement skills (internally and externally) and (b) ability to train others? Was that assessment adequate?**

57.1 See the response to Question 56.1.

2018 review

- 58. Why was a review into Mr Eljamel's appointment to Consultant Neurosurgeon conducted in August 2018 by the General Manager for Specialist Services after a website created by Mr Eljamel claimed that he undertook a fellowship at Hartford Hospital in Connecticut, USA, prior to his appointment as a Consultant Neurosurgeon in NHS Tayside (NHST-00075, page 7)?**

58.1 A review into Mr Eljamel's appointment as Consultant Neurosurgeon was conducted in August 2018 by the Audrey Warden, General Manager for Specialist Services because of concerns raised about his time in Connecticut.

- 59. What investigation was undertaken by that review in 2018?**

59.1 Based on a briefing document for the Chief Executive and Chair of the Board from August 2018 [NHST-01610_378-405] the General Manager for Specialist Services reviewed the documentation contained within Mr Eljamel's HR file [NHST-04741].

- 60. Upon what basis was it concluded that, at the time of his appointment to NHS Tayside, the relevant checks and verification of documents has (*sic*) been undertaken correctly (NHST-00075, page 7)?**

60.1 The briefing document [NHST-01610] notes that the appointment process is documented in Mr Eljamel's HR file [NHST-04741]. It concludes that the appointment process was conducted in line with national guidance at the time and that the relevant checks were carried out regarding Mr Eljamel's qualifications [NHST-01610_386]. The current Director of People and Culture, Elaine Watson, has reviewed the recruitment process undertaken, as part of the compiling of this

witness statement, and has not identified any concerns evident regarding the recruitment process that was undertaken.

61. In particular, what investigation was undertaken in 2018 of:

(a) Why and to whom Mr Eljamel had had such claims?

(b) What reliance had been placed on such claims by others?

61(a).1 In relation to Questions 61(a) and 61(b), please see response to Question 60.

(c) What “different implications” holding a clinical fellowship may have had in the USA, as compared to the role in the UK (see NHST-00075, page 7)?

61(c).1 From 1995 to date, it should be noted that the term “clinical fellowship” does not refer to a specific role. The term usually refers to a period of work in another institution within the UK or abroad to gain experience. This usually occurs towards the end of a training programme prior to a consultant appointment. There is usually no formal qualification associated with this role. Our interpretation of what was meant by the term “different implications” [NHST-00075_7] in the due diligence report refers to the inconsistent definition of clinical fellowship.

62. What knowledge did NHST have prior to 2018 of any claims made by Mr Eljamel that he held such a fellowship?

62.1 Please refer to the response provided to Question 52(g) for further detail on this matter.

Head of Department /Section for Surgical Neurology, University of Dundee in around 1996

63. What interview/ assessment process was undertaken in connection with Mr Eljamel’s appointment to this role and by whom were these undertaken?

64. Why and by whom was the decision to award him this role arrived at?

- 65. **What qualifications and other experience did he present as part of his application?**
- 66. **What investigation was undertaken by NHST of the material presented in support of his application including, in particular, any concerns which had been raised about his professional practice before his time in Tayside?**
- 67. **What was the outcome of those investigations?**
- 68. **What reliance was placed on the information presented in awarding him the role?**
- 69. **How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?**
- 70. **What assessment was undertaken by NHST of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?**
- 71. **What assessment was undertaken by NHS Tayside of Mr Eljamel's (a) communication. Interpersonal engagement skills (internally and externally) and (b) ability to train others? Was that assessment adequate?**
- 63.1 There is no information within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside regarding this appointment. NHS Tayside has assumed this was an appointment by the University of Dundee.

Lead Clinician for Neurosurgery and Pain, Ninewells Hospital Dundee from around 1998

- 72. **What interview/ assessment process was undertaken in connection with Mr Eljamel's appointment to this role and by whom were these undertaken?**
- 72.1 In general terms, there is no formal appointment process to Clinical Leader/Lead Clinician roles. The roles are usually rotated around the consultants in the department. No specific appointment process would normally be undertaken. Mr Eljamel was the most senior consultant in the department following retirements around 1998.
- 73. **Why and by whom was the decision to award him this role arrived at?**
- 74. **What qualifications and other experience did he present as part of his application?**

75. **What investigation was undertaken by NHST of the material presented in support of his application including, in particular, any concerns which had been raised about his professional practice before his time in Tayside?**
 76. **What was the outcome of those investigations?**
 77. **What reliance was placed on the information presented in awarding him the role?**
 78. **How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?**
 79. **What assessment was undertaken by NHST of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?**
 80. **What assessment was undertaken by NHS Tayside of Mr Eljamel's (a) communication/ interpersonal engagement skills (internally and externally) and (b) ability to train others? Was that assessment adequate?**
- 73.1 In relation to Questions 73-80, please see response to Question 72.

Inductions into the key roles assumed by Mr Eljamel

81. **What was the nature of the inductions which Mr Eljamel received for the roles listed in Term of Reference 1?**
- 81.1 There is no evidence within Mr Eljamel's HR file [NHST-04741] held by NHS Tayside of him having received formal induction for any of the roles he held.
 - 81.2 In general terms, however, consultants appointed would already have been assessed by the AAC independent specialists as having the necessary skills to perform their duties as a consultant. They would have been assessed as having undertaken appropriate training, as confirmed via the interview assessment process.
82. **In particular, what induction (if any) did he receive relating to systems and responsibilities relating to his duties of candour with patients and other relevant bodies?**

83. What induction (if any) did he receive relating to standards required of him in relation to (a) the training and supervision of his junior colleagues and (b) the importance of communication/ interpersonal engagement (both internally and externally)?
84. Were those inductions adequate, in light of the nature of the role and Mr Eljamel's particular qualifications and experience?
85. What measures were taken to ascertain whether the induction (if any) was adequate and that at the completion of it, Mr Eljamel was adequately informed and equipped to perform his duties in each of the roles?
- 82.1 In relation to Questions 82-85, please see answer to Question 81.

Other key roles

86. The Inquiry understands that Mr Eljamel was the clinical lead for the neurosurgical department in Ninewells Hospital. In this regard:
- (a) Over what period did he hold this position?
 - (b) On what basis was Mr Eljamel awarded this position?
 - (c) By whom was this awarded? What role did NHST play in the appointment?
 - (d) What assessment, if any was done of Mr Eljamel's suitability for this role/ title?
 - (e) What rights and responsibilities flowed from this appointment?
- 86(a).1 In relation to Questions 86(a)-(e), this relates to the same role as Lead Clinician. These questions are addressed in the response to Question 72. Please refer to this response for the relevant information.
87. The Inquiry understands that from a certain point until 2012, Mr Eljamel was a member of NHST's ethics committee. In this regard:
- (a) On what basis was Mr Eljamel awarded this position?
 - (b) By whom was this awarded? What role did NHST play in the appointment?
 - (c) What assessment, if any was done of Mr Eljamel's suitability for this role/ title?
 - (d) What rights and responsibilities flowed from this appointment?

87(a).1 In relation to Questions 87(a)-(d), there is no evidence held within Mr Eljamel's HR file [NHST-04741] of how Mr Eljamel was appointed to the Ethics Committee. In respect to Question 8(d), in general terms, a member of the Ethics Committee would be required to review applications, attend committee meetings and provide either an expert or lay opinion, dependent on their role.

88. The Inquiry understands that from 2012, Mr Eljamel held the role of lead surgeon on the Scottish Adult Neuro-oncology Network (SANON) board. In this regard:

- (a) On what basis was Mr Eljamel awarded this position?**
- (b) By whom was this awarded? What role did NHST play in the appointment?**
- (c) What assessment, if any was done of Mr Eljamel's suitability for this role/ title?**
- (d) What rights and responsibilities flowed from this appointment?**

88(a).1 In relation to Questions 88(a)-(d), this is not an NHS Tayside position, and we hold no evidence of how Mr Eljamel was awarded this position.

89. What other significant professional roles or positions did Mr Eljamel hold in his academia, in the NHS or associated with his NHS roles?

89.1 Within Mr Eljamel's CV from around 2013 [NHST-01572], it is noted that he was Clinical Director of the Scottish Photodynamic Centre from 2008 and Co-Director of the National Centre of Neurosurgery for Mental Disorders from 2007. There is no other evidence within his HR file [NHST-04741] in relation to these roles.

89.2 It is also noted within Mr Eljamel's CV from around 2013 [NHST-01572] that he was a member of the National Panel of Specialists. NHS Tayside holds no records of his acting in this capacity on AACs.

90. What assessments were done of his professional competency to perform these roles/ hold these positions? By whom were they undertaken?

90.1 The roles noted in paragraphs 89.1 and 89.2 were not NHS Tayside appointments, and NHS Tayside holds no records in relation to them.

91. What were the “many internal and external clinical committees and groups over the years” of which Mr Eljamel was a member (NHST-00075, page 7)? What was the role of these committees and groups? What role did he play on them?

91.1 The statement that Mr Eljamel was a member of “many internal and external clinical committees and groups over the years” is based on information recorded in Mr Eljamel’s CV as at approximately summer 2013 [NHST-01572]. The majority of these roles are external to NHS Tayside, and some are not related to his role as a Neurosurgeon. The formal roles identified in his CV that relate to his role as a Neurosurgeon within NHS Tayside are, Chairman Clinical Governance Committee Specialist Services Group from 2006 to 2010, Chairman of Malignant Spinal Compression Group from 2008 to 2012, Chairs of Clinical Governance Committee and the Committee of Quality and Clinical Governance of Secondary Care, NHS Tayside 2005-2009. Appendix 6 sets out Mr Eljamel’s Local and Regional, National and International Committee roles [NHST-04945].

92. In particular, what was NHST’s Specialist Services Group Clinical Governance Committee? What role did Mr Eljamel play on it? What assessment was done as to his professional competency to hold such a position?

92.1 NHS Tayside has been unable to locate specific records relating to NHS Tayside’s Specialist Services Clinical Governance Committee for the time period up to 2014.

92.2 NHS Tayside holds documents which record Mr Eljamel as being the Clinical Governance Chair for Specialist Services in 2007 [NHST-01703; NHST-01704; NHST-01705]. However, NHS Tayside has found no evidence beyond these documents of the specific role that Mr Eljamel played as the Clinical Governance Chair for Specialist Services. These roles followed the definition within MEL(1998)75 [NHST-00231].

92.3 It should be noted there are no formal selection processes or defined criteria for participation in clinical governance groups within NHS Tayside. Membership and involvement are generally determined through professional roles, responsibilities, and operational requirements rather than through a structured selection procedure.

93. What advisory role (if any) did Mr Eljamel hold with the Scottish Government? What were Mr Eljamel's responsibilities in that regard? What assessment was done as to his professional competency to hold such a position?

93.1 NHS Tayside does not hold any records of any advisory role that Mr Eljamel held with the Scottish Government, nor would it normally hold such record.

94. What professional affiliations did Mr Eljamel hold? What assessment was done as to his professional competency to hold such professional affiliations?

94.1 According to Mr Eljamel's CV submitted in relation to his 1995 appointment [NHST-01544], he was affiliated to the Society of British Neurological Surgeons; the Royal Academy of Medicine; the Irish Neurological Association; the International Association for the Study of Pain; the New York Academy of Sciences; and the American Biographical Institute.

94.2 According to Mr Eljamel's CV from around 2013 [NHST-01572], he was affiliated to an extensive list of bodies, both national and international. In addition to those mentioned in paragraph 94.1, these included the Congress of Neurological Surgeons, USA, the American Association of Neurosurgery, the European Association of Neurosurgery, the Scottish Association of Neurological Sciences, the International Society for Stereostatic Radiosurgery, the North American Base Skull Society, and the International Society for Computer Assisted Surgery.

94.3 Any assessment of Mr Eljamel's competence to be a member of these bodies would have been a matter for them, not NHS Tayside.

95. What assessment was done as to his professional competency to hold the position of “Honorary Professor” at the University of Dundee, to which position he was appointed on 22 September 2009?

95.1 This is not a position which Mr Eljamel held with NHS Tayside. NHS Tayside would direct the Inquiry to the University of Dundee to consider this question.

Conclusions and lessons learned

96. Please state what NHST considers the key challenges were, your understanding of the reason for those challenges, what went well and what did not (either as was apparent at the time or in hindsight), and whether you identified (at the time or subsequently) things that could or should have been done differently in the way that (a) Mr Eljamel came to be appointed to the positions referred to above or (b) inductions were provided by NHST in connection with those positions.

96.1 Based on the minute of the AAC, the references provided, along with copies of relevant certificates and registration checks - all contained within Mr Eljamel's HR file [NHST-04741] - the recruitment process was followed as laid out within the National Health Service (Appointment of Consultants) (Scotland) Regulations 1993 [NHST-04450].

96.2 The 2023 Due Diligence review [NHST-00075] identified a need for training for new clinicians taking on leadership roles to be further strengthened. The review noted that Clinical Leaders must have the knowledge and skills to create environments in their own areas which are person-centred and deliver safe care. This will ensure Clinical Leaders have the knowledge, skills and confidence to undertake their role.

96.3 In response to this, NHS Tayside has introduced a new Leadership programme aimed at providing new and experienced leaders with the knowledge and skills to lead their teams effectively. The programme's first two levels - Essentials of Leadership and Management, and Forging Influence and Responsibility - were delivered for the first time in 2025. The programme is open for registration to all consultants.

96.4 In addition to the above, all new consultants receive a handbook [*NHST-04733; NHST-04734*] that outlines their roles and responsibilities, as well as guidance on how to raise a concern.

97. What lessons, if any, has NHST learned from the way that (a) Mr Eljamel came to be appointed to the positions referred to above or (b) inductions were provided by NHST in connection with those positions.

97.1 See the response to Question 96.2 above.

98. Please identify any key areas/ systems/ practices which you consider worked well, and any key areas in which you consider there were issues, obstacles or missed opportunities the way that (a) Mr Eljamel came to be appointed to the positions referred to above or (b) inductions were provided by NHST in connection with those positions.

98.1 The information contained within Mr Eljamel's HR file [*NHST-04741*] held by NHS Tayside shows that the established processes and practices for recruiting to medical and dental positions were followed. NHS Tayside has found no evidence of any issues, obstacles or missed opportunities in this regard.

99. Please set out what, if anything, NHST considers can be done to improve systems used in (a) the appointment of surgeons to positions such as those referred to above or (b) inductions to such positions provided to successful candidates.

99.1 See the response to Question 98.1 and Question 96.2.

Appendix B - Part E – Document management with NHS Tayside

Under Term of Reference 14, the Inquiry is charged with the investigation of document management and retention systems within NHS Tayside relating to the professional practice of Mr Eljamel during the course of his employment there (for the avoidance of doubt including medical records and other documentation relating to his practice), including but not limited to the extent to which reviews or investigations into his professional practice during the course of that employment were to any extent undermined by lack of available documents.

In relation to systems governing document management generally, including (for the avoidance of doubt) corporate records as well as medical records:

Systems of document management within NHS Tayside

Management of records relating to Mr Eljamel's practice prior to 2014

100. What systems of document management existed within NHST (which were relevant to the neurosurgical patients of Mr Eljamel) in the period of his employment there between 1995 and 2014?

100.1 During the relevant period the following UK Government, Scottish Government, NHS Scotland and NHS Tayside legislation, policy and guidance documents were in place for managing records within NHS Scotland and in NHS Tayside.

100.2 The Scottish Executive Health Department established The Confidentiality & Security Advisory Group for Scotland (CSAGS) Framework (2000-2001) in September 2000 [NHST-04732] to provide authoritative, system-wide guidance on the confidentiality and security of health-related information. This framework was established to advise Scottish Ministers, NHS Scotland, clinicians, and the public on the confidentiality and security of patient-related information. Furthermore, it was formed in response to rapidly evolving legal, technical, and ethical contexts (e.g., Data Protection Act 1998, Human Rights Act 1998, growth of electronic information systems).

- 100.3 A major component of the CSAGS framework was establishing conditions for when consent is required. Its work represented Scotland's first coherent, national information-governance framework, bridging the gap between emerging legislation and modern digital healthcare. It directly shaped both the 2003 NHS Scotland Code of Practice on Protecting Patient Confidentiality, and the later Caldicott, IG, SIRO, and data-governance systems that followed.
- 100.4 UK Government, Scottish Government and NHS Scotland legislation and guidance documents:
- The Scottish Hospital Service: Destruction of Hospital Records - Memorandum SHM 58/60 was in place in 1995 [NHST-04474]
 - The Data Protection Act 1984 [NHST-04500]
 - The Code of Practice on the Confidentiality of Personal Health Information, issued in Scotland in 1990 (NHS Tayside does not have a copy of this document, however we do have a copy of the 2003 version [NHST-04729])
 - The Access to Health Care Records Act 1990 (in force from 13 July 1990 to present date) [NHST-04477]
 - Guidance for The Retention and Destruction of Health Records (MEL(1993)152) [NHST-00064]
 - Data Protection Act 1998 [NHST-04466]
 - Data Protection Act 1998 NHS MEL (2000) 17 [NHST-04483]
 - Freedom of Information (Scotland) Act 2002 [NHST-04484]
 - The Management, Retention and Disposal of Administrative Records (HDL (2006) 28) [NHST-04496; NHST-04479]
 - Scottish Government Records Management: NHS Code of Practice (Scotland) Version 1.0 2008 (CEL 28 (2008) [NHST-04475]
 - Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.0 2008 (CEL 31 (2010) [NHST-04476]
 - Public Records (Scotland) Act 2011 [NHST-04485]
 - Scottish Government Records Management: NHS Scotland Code of Practice [NHST-04486; NHST-04487]
 - NHS Scotland Protecting Patient Confidentiality – NHS Scotland Code of Practice 2012 [NHST-04488] – Staff booklet replacing NHS Code of Practice on Protecting Patient Confidentiality published in 2003 [NHST-04729]. (It should be noted that NHS Tayside does not hold the 1990 document)

100.5 NHS Tayside policy and guidance documents:

- NHS Tayside Information Management Handbook was developed in 2002 [NHST-01486]. This contained the Records Management Policy dated January 2003 which set out retention, storage and destruction of records. This was both for the management of clinical and non-clinical records. This policy is contained within the NHS Tayside Information Management Handbook [NHST-01486_226].
- The Records Management Policy dated January 2003 sets out retention, storage and destruction of records.
- NHS Tayside Data Protection Policy 2006 [NHST-01488]. The policy was further updated in 2009 [NHST-01489], 2011 [NHST-01490], 2013 [NHST-01491], 2015 [NHST-01492], 2019 [NHST-01493], 2024 [NHST-01494] and 2025 [NHST-01495].
- The NHS Tayside Information Governance Policy, established in 2007 [NHST-01487].
- The scope of the NHS Tayside Records Management Policy relates to all operational records. The policy was updated in 2009 [NHST-01589], 2011 [NHST-01590] and 2013 [NHST-01591].
- NHS Tayside Health Records Strategy and Management Policy was first published and implemented as a new policy in August 2011 [NHST-01457]. Prior to 2011, NHS Tayside would have followed The Retention and Destruction of Health Records (MEL(1993)152) [NHST-00064], Scottish Government Records Management: NHS Code of Practice (Scotland) Version 1.0 2008 (CEL28(2008)) [NHST-04475], Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.0 2008 (CEL31(2010)) [NHST-04476]. There may have been local policies in place prior to 2011, but NHS Tayside does not have any documentation of this.
- The Health Records Operational Guidance and Service Operating Procedures [NHST-01469-01483] were created as an annex of the Health Records Strategy in 2015. Between 2011 and 2015, the NHS Tayside Health Records Strategy and Management Policy referenced above [NHST-01457] was in use. In 2015 this was separated into two policies – The Health Records Strategy and Management Policy [NHST-01462] and The Health Records Operational Guidance and Service Operating Procedures [NHST-01469-01483].

- 100.6 The Scottish Government guidance as detailed in paragraph 100.2 provides a framework for NHS Tayside and across NHS Scotland to support the consistent approach to, and effective management of data, information and records.
- 100.7 The systems of document management that existed within NHS Tayside in relation to patient medical records over the relevant period are described below.
- 101. In particular, how were medical records organised, generated, stored and processed in or relating to the patients of Mr Eljamel over the relevant period? Why were they organised, generated, stored and processed in that way?**
- 101.1 NHS Tayside created and maintained a health record for every patient attending health services to provide a contemporaneous and chronological record. NHS Tayside patient health records were mainly paper based over the period of 1995-2015. These were created using standard paper case record folders, constructed of robust material to withstand handling and transport, with secure anchorage points to prevent loss or damage to documents. Patients may have multiple volumes of such case record folders. Over the period 1995-2015, the creation of the paper folder was registered on a digital system to ensure a health record inventory. The folders were stored across twelve different filing libraries within the Health Records Departments. Records were stored and organised by date of birth and then surname for that date.
- 101.2 During the relevant period of 1995-2015, patients had a paper acute medical record. Acute medical records contained documentation from care or treatment on a secondary care hospital site. If patients received care or treatment on multiple hospital sites, they would have a paper acute medical record created in each of the locality areas (e.g. Perth & Kinross, Dundee, Angus). Community, Mental Health, Dental, Allied Health Professional and Maternity records were held in a separate folder to the acute record. Patients also had medical records held electronically during 1995-2015, on digital clinical systems, and these are outlined in Appendix 7 [NHST-04945]. These systems were available to be viewed by clinical and administrative staff.
- 101.3 Paper acute medical records would be retrieved from the Health Records Libraries and provided to the clinician to support clinical care. Paper tracer cards were used

to record movements of the folders, such as being taken out of the Health Records Libraries for clinical or administrative purposes.

101.4 Medical records have a lifecycle, from creation, throughout the period of their active use, to a period of inactive retention and then finally to either confidential disposal or permanent preservation in an archival facility. The retention and disposal schedules of medical records is set out in the provided Codes of Practice covering the period 1995-2015 [NHST-01453-01456]. Health Records employees are responsible for making sure that all records are periodically and routinely reviewed to determine what can be disposed of or destroyed in light of local and national guidance. At the end of the relevant minimum retention period, one or more of the following listed actions applied in the period 1995-2015 and continues to apply:

1. Review. Records may need to be kept for longer than the minimum retention period due to ongoing administrative and/or clinical need. As part of the review, NHS Tayside has regard to the fifth principle of the Data Protection Act 1998 [NHST-04466], which requires that personal data is not kept longer than is necessary. If it is decided that the records should be retained for a period longer than the minimum, internal retention schedules need to be amended accordingly and a further review date set. Otherwise, one of the following actions applies.
2. Transfer to or consult an NHS Archivist or The National Records of Scotland. If the records have no ongoing administrative value but have, or may have, long-term historical or research value, NHS Tayside uses archival facilities provided by the University of Dundee for records identified as having long-term historical value.
3. Destroy. Where records no longer need to be kept due to statutory requirement or administrative or clinical need, and they have no long-term historical or research value, they should be destroyed. Records of destruction of health records are retained permanently. No surviving health record dated 1948 or earlier should be destroyed.

101.5 The NHS Tayside Archivist has confirmed the archives do not contain any patient records from 1995-2015 [NHST-01683].

102. What types of corporate or administrative records existed within NHST relating to the professional practice of Mr Eljamel? Why were the organised (sic) in that way?

102.1 The types of corporate or administrative records that existed that related directly to Mr Eljamel and his professional practice include the following:

102.2 Mr Eljamel's HR file [NHST-04741] (including his appointment, appraisals, and retiral files), complaints information, legal files, reviews and MDT records, reviews and reports relating to Mr Eljamel, reports to the Board's Standing Committees and to the Board, and any other information of relevance such as emails, internal memos, minutes of relevant meetings and Freedom of Information responses regarding Mr Eljamel, and some statistical data in relation to the surgeries that he performed.

102.3 The types of corporate or administrative records that NHS Tayside believes would have existed, based on documents that Consultants usually create/generate during the course of their employment, in relation to their professional practice include the following:

102.4 Business letters, reports, emails, meeting minutes, research proposals, Caldicott applications, research reports, diaries and equipment requests. These document types are subject to specific retention periods.

102.5 Records were organised in this way to comply with legislation, government policy and direction and to support the work of the organisation. Files were organised in the related function of the organisation, for example, HR files within the HR department. Neurosurgery corporate or administrative records would have been held within the Department / Directorate.

103. How were corporate/ administrative records generated, stored and processed within NHST, insofar as relevant to the practice of Mr Eljamel?

103.1 The Government guidance and NHS Scotland guidance in place over the relevant period is detailed in paragraph 100.2.

103.2 The local NHS Tayside guidance in place over the relevant period is detailed in paragraph 100.5.

104. What systems existed within NHST to ensure that such (a) medical records and (b) relevant corporate /administrative records were accurate?

104.1 Individual clinicians (doctor, nurses, other clinical staff), are primarily responsible for ensuring accurate recording of records as set out by the relevant regulators, i.e. the GMC and its Good Medical Practice guidance [NHST-04355; NHST-04356; NHST-04357; NHST-04358; NHST-04359].

104.2 All staff are required to comply with legislation, guidance and policy from the Government and NHS Scotland, including NHS Tayside. Local codes of practice and records management policies were in place over the relevant period.

104.3 The NHS organisations had a responsibility to train staff in records management and safe information handling. The initial training was delivered at induction with a requirement for all staff thereafter to complete national and local online mandatory training modules.

105. What systems existed within NHST to ensure that (a) medical records and (b) relevant corporate /administrative records were accessible and understandable to patients or their representatives?

105.1 Records were accessible and understandable to patients or their representatives through the application of the relevant provision within the Data Protection Acts of 1984 [NHST-04500] and 1998 [NHST-04466] and the Freedom of Information (Scotland) Act 2002 [NHST-04484]. Patients also had the right to have the information in their medical record explained to them by a clinician.

105.2 Records were understandable to patients or their representatives through the application of Data Protection Acts of 1984 [NHST-04500] and 1998 [NHST-04466].

Retention of records relating to Mr Eljamel's practice

106. What systems were in place in the period before May 2014 within NHST to ensure the retention of records relating to cases where there had been adverse outcomes or reports of sub-standard practice and how did they operate?

106.1 Paragraphs 100.2 and 100.3 set out the UK Government, Scottish Government, NHS Scotland and NHS Tayside guidance documents that were in place to ensure the appropriate retention of records.

106.2 Further information regarding the systems used to hold and retain information relating to adverse events and complaints is included in paragraphs 114.11 – 114.18.

107. What systems of document management and retention have been in place within NHST since Mr Eljamel's employment with NHST came to an end in May 2014 in connection with his neurosurgical practice?

107.1 Paragraphs 100.2 and 100.3 above provide the detail of UK Government, Scottish Government, NHS Scotland and NHS Tayside guidance documents that were in place in respect of the management and retention of documents.

107.2 Please also refer to paragraph 101.4 regarding the document management of medical records.

107.3 In 2016 NHS Tayside implemented an electronic paper medical record tracking system named iFIT. iFIT replaced the previous digital systems which had been in place since 1995 and the paper tracer cards, which recorded movements of the records (see the response to Question 101).

107.4 NHS Tayside has further developed the Electronic Patient Record (EPR), with the majority of patient health records now being created, processed and stored on electronic systems. While minimum patient information is now added to the paper health record, these are still retained. The NHS Tayside EPR is a combination of

multiple systems with different implementation dates. Further information on EPR systems in place from 1995 to date is provided in *NHST-04691*.

- 107.5 Retention of medical records: An NHS Tayside Do Not Destroy order was issued by the then NHS Tayside Medical Director of NHS Tayside on 26 April 2023 [*NHST-01485*], to instruct the Health Records department not to destroy any health records still in existence of patients who were seen or operated on by Mr Eljamel. The instruction was to retain these for a minimum of a further ten years. This order was communicated to all NHS Tayside Health Records Library locations on 26 April 2023 and actioned with immediate effect [*NHST-04687*].
- 107.6 The Eljamel Inquiry issued NHS Tayside with a Do Not Destroy (DND) Notice on Friday 11 October 2024 for information that may be of relevance to the work of the Inquiry. The DND Notice was shared with all Executive Directors on the 18 October 2024 [*NHST-04506*] to ensure that they were aware of their responsibilities.
- 107.7 A further communication was sent out on 8 November 2024 [*NHST-01592*] to all NHS Tayside staff with instructions to comply with the DND Notice.
- 107.8 In order to identify that a health record should not be destroyed in line with destruction schedules and instead needs to be retained, a label is added to the front of the paper folder which states “*Retain For Official Purposes from this date --/--/-- THB(MR)800*”.
- 108. What changes have there been to document management and technologies which are relevant to the retention of the records relating to the practice of Mr Eljamel over the period since Mr Eljamel commenced his employment with NHST in 1995?**
- 108.1 Please refer to the legislation and guidance detailed in paragraphs 100.2 and 100.3 and also to the paragraphs 107.1 to 107.8. The minimum retention periods are set out in *NHST-04474*, *NHST-00064*, *NHST-04475*, *NHST-04476*, *NHST-04486*, *NHST-04487* and *NHST-04479*. For Neurosurgery Health Records the retention periods have remained the same for adults from 1993 to date. Records should be retained for a minimum of six years following date of last entry or three years after death, if earlier. The retention of children’s records has remained the same from

1993-2024 – retain until the patient’s 25^h birthday or 26th if the young person was 17 at conclusion of treatment, or three years after death. In August 2024 the retention of children’s records changed to 25 years from the date of birth [NHST-04700_51]. Please also refer to paragraphs 107.3-107.8 which explain other changes.

109. In particular, what systems have been in place within NHST since May 2014 to ensure the retention of records relating to cases where there had been adverse outcomes or reports of sub-standard practice and how did they operate?

109.1 The Datix system was introduced in 2012/2013 and remains in place. All records regarding adverse event management and complaints are automatically retained within this system. The system used allows thorough and prompt reporting. The system in place prior to this was the Adverse Incident Management (AIM) system, which was decommissioned due to the introduction of Datix, further information can be found in paragraph 114.11. To support the introduction of the Datix system, staff communication was circulated across the organisation [NHST-04717; NHST-04718]. The Adverse Incident Policy (AIM) provided staff with information on how to record through AIM system [NHST-04354; NHST-04714; NHST-04715; NHST-04716].

109.2 The adverse event reporting system on Datix records the following as a minimum data set:

- The location of where the adverse event occurred (Where)
- The date and time of the adverse event (When)
- Brief description of the adverse event (What, Why and How)
- Any immediate action taken
- Personal details relating to the person/people involved in the adverse event (victim/injured party)
- The impact to the person/people or organisation (Injury/result)
- The likelihood of recurrence
- The immediate treatment given to the person/people involved
- Any remedial action taken to minimise risk of recurrence

- Others who were involved in observing or reporting the adverse event
- 109.3 In addition, progress notes can be logged and e-mails sent through the system. Documents can be uploaded, including final reports.
- 109.4 The complaints module in Datix records the following as a minimum data set:
- The complainant details
 - Date complaint received
 - Care Group/Team complaint relates to
 - Stage of complaint
 - Complaint Handler
 - Outcome
 - Date which record should be destroyed
 - Letters relating to file/response
- 109.5 For complaints, the data recorded includes any correspondence between NHS Tayside and the complainant, as well as internal correspondence regarding gathering evidence and responses to the complaint.
- 109.6 All Datix records (incidents and complaints) are retained on the Datix system according to the relevant retention policy for that type of record [*NHST-00054-00063; NHST-04493*].

Data protection systems

- 110. What systems have been in place within NHST since 1995 relating to how NHST has sought to ensure compliance with its data protection obligations (insofar as relevant to data held relating to the patients of Mr Eljamel) and how did they operate?**
- 110.1 Paragraphs 100.2 and 100.3 provide the detail of the UK Government, Scottish Government, NHS Scotland and NHS Tayside legislation, policy and guidance documents.

- 110.2 For the period during which Dundee Teaching Hospitals NHS Trust was in existence (1993-1999), NHS Tayside has not been able to find any documentary evidence of Dundee Teaching Hospitals NHS Trust organisational Policy or guidance applicable to data protection. NHS Tayside is unable to find relevant documents for the period above and given the period in question it is likely that during 1993-1999 there was not a Data Protection Policy for Dundee Teaching Hospitals NHS Trust.
- 110.3 Caldicott Guardians were introduced to NHS Trusts in Scotland by MEL(1999)19 Caldicott Guardians [NHST-04670]. The Caldicott Guardian for Tayside University Hospitals NHS Trust was the Trust Medical Director. In a report to Tayside University Hospitals NHS Trust in 1999 [NHST-04480], the following actions were agreed:
- A management audit of current practices and procedures.
 - Annual plans for improvement that will be monitored through Clinical Governance.
 - The development of clear protocols to govern the disclosure of patient information.
- 110.4 From 2002 until 2006, the data protection policy was included within the Information Management Handbook [NHST-01486]. NHS Tayside are unable to find relevant documents prior to 2002 and it is likely there was no Data Protection Policy for Dundee Teaching Hospitals NHS Trust. NHS Tayside created a standalone Data Protection Policy 2006 [NHST-01488] which was developed to ensure NHS Tayside complied with the Data Protection Act 1998 [NHST-04466]. The aim of the policy was to make staff aware of their obligations regarding the processing of personal data and the standards for using personal data, and to provide guidance on individuals' rights under data protection legislation. A revised Data Protection Policy was produced in 2009 [NHST-01489] (which superseded the Data Protection Policy 2006) and was further updated in 2011 [NHST-01490], 2013 [NHST-01491], 2015 [NHST-01492], 2019 [NHST-01493], 2024 [NHST-01494] and 2025 [NHST-01495].
- 110.5 The NHS Tayside Information Governance Policy, established in 2007, [NHST-01487], outlines NHS Tayside's framework for managing key information governance requirements, to ensure compliance with relevant data protection legislation.

- 110.6 In 2008 the Information Governance Committee replaced the NHS Tayside Area Information Security and Confidentiality Group. This Committee was chaired by the Director of Finance. A copy of the Terms of Reference is provided [NHST-01496], and the Remit of the Committee is included within this [NHST-01496_3-4].
- 110.7 Since May 2015, the Information Governance Committee has been chaired by NHS Tayside's Board Secretary. The Terms of Reference for the Information Governance Committee were updated in 2017 [NHST-01497].
- 110.8 The Information Governance Committee Terms of Reference were updated again in 2018 [NHST-01498] to reflect the changes in data protection legislation - in particular, the Data Protection Act 2018 [NHST-04481] and General Data Protection Regulation 2018 [NHST-04482].
- 110.9 The initial requirement for healthcare organisations to nominate a SIRO, assigning the role to executive level person, and putting the information risk high on the NHS Scotland agenda, was originally part of the NHS Scotland Information Security Policy Framework 2015 [NHST-04940]. This mandatory role is central to strategic information risk leadership and governance and should report to the Chief Executive. This post since 2018 has been held by the Board Secretary who also has the portfolio in NHS Tayside for Information Governance and Cyber Assurance. From 1 April 2026 this will move to the Director of Corporate Affairs portfolio.
- 110.10 In 2019 the Terms of Reference for the Information Governance Committee [NHST-01499] were reviewed and updated to align with changes in legislation, assurance reporting, and reporting structures.
- 110.11 The Information Governance Committee became the Information Governance and Cyber Assurance Committee (IG&CA) in 2019 to reflect its changing role regarding cyber compliance. The Committee continued to be chaired by NHS Tayside's Board Secretary. The Terms of Reference 2024-2025 v3.2, [NHST-01507] includes the version control for the IG&CA Committee over this period.
- 110.12 In 2025 the Information Governance and Cyber Assurance Committee changed its name to the Information Governance and Cyber Assurance Group. The Information Governance and Cyber Assurance Group reports to the Clinical Governance Committee. A copy of the Terms of Reference is included [NHST-01501].

110.13 In 2026 NHS Tayside has the following Information Governance Policies and guidance in place to ensure NHS Tayside can meet its data protection obligations as follows:

- Data Protection Policy [NHST-01495]
- Data Quality Policy [NHST-01601]
- Freedom of Information Policy [NHST-04489]
- Health Records Strategy and Health Records Policy [NHST-01539]
- Information Governance Policy [NHST-01487]
- Information Security Policy [NHST-04490]
- Records Creation and Registration Policy [NHST-04491]
- Records Management Policy [NHST-04492]
- Records Retention Schedule (Non Clinical /Administrative) [NHST-04493]
- System Access Policy [NHST-04494]

Subject access requests by or on behalf of former patients of Mr Eljamel

111. What systems have been in place within NHST since 1995 relating to how NHST has sought to ensure compliance with obligations relating to subject access requests made by or on behalf of the patients of Mr Eljamel and how did they operate?

111.1 Data Protection legislation underpins the data subject's rights to obtain a copy of their personal data through a subject access request. The legislative and Government Policy background had been described in the paragraphs 100.2 and 100.3 along with details of the policy and guidance developed in NHS Tayside over this period to ensure compliance with the relevant legislation and Government policy.

111.2 With regards to deceased patients, the Access to Health Records Act 1990 [NHST-04477] makes provision for the patient's personal representatives to access the relevant information within the patient's health record subject to certain exemptions.

- 111.3 NHS Tayside's policies are made available and communicated to staff across NHS Tayside. The policies have version controls applied, are regularly reviewed and updated to reflect legislative changes, and are approved through Tayside NHS Board's governance processes.
- 111.4 NHS Tayside has had a designated Data Protection Officer (DPO) and a Deputy Data Protection Officer since 2018. The DPO post was created to reflect the requirements of the Data Protection Act 2018. Prior to this date, data protection advice and guidance was provided by the Information Governance Team, however, there was no legally designated DPO.
- 111.5 Subject access requests made by former patients of Mr Eljamel that fall outside of the request process for health records and complaints records are handled by the Information Governance and Cyber Assurance Team. All requests received by the Information Governance and Cyber Assurance Team are logged, coordinated, managed and monitored for compliance. Subject Access Requests that fell outside the request process for health records were dealt with by the Information Governance Team, formerly the Information Security and Confidentiality Team.
- 111.6 Requests for data are sent by the Information Governance and Cyber Assurance Team to relevant services across NHS Tayside. The Information Governance and Cyber Assurance Team are responsible for collation of information, reviewing and applying any necessary redactions to the data, and applying appropriate exemptions in line with relevant legislation.
- 111.7 If a patient has asked to see their record during a consultation or treatment, and it is practical, the clinician should share this. This may include arranging a mutually suitable time. If it is not possible to reach agreement at that time, or if a patient decides later to request access, the application can be made in writing or verbally. The application process to request access is detailed in the Health Records Strategy and Management Policy [NHST-01457] and The Health Records Operational Guidance and Service Operating Procedures [NHST-01469-01483].

112. Please provide a breakdown of subject access request made by or on behalf of the patients of Mr Eljamel, including how many have been made, when they were made, when and how they were responded to.

- 112.1 In relation to Subject Access Requests received by the NHS Tayside Information Governance and Cyber Assurance Team, since 2017 there have been 18 requests from patients of Mr Eljamel for information that does not form part of the patients' medical record. Information prior to this date is not held. This is because the retention period for data subject access requests is three years after the closure of the request and where an appeal has been made, the retention period for the request is six years after the closure of the appeal. Appendix 8 contains specific details about the list of requests, dates and outcomes and includes several requests outside of the retention period that should have been destroyed [NHST-04945].
- 112.2 In relation to Subject Access Requests received by the NHS Tayside Health Records Department for patients' medical records, made by or on behalf of patients of Mr Eljamel from 1995 to date, NHS Tayside holds subject access requests made from 2015 onwards. Subject Access Requests made prior to 2015 were recorded in paper notebooks which, along with the paper subject access request application forms, have been destroyed in line with the retention period for data subject access requests. This retention period is a minimum of three years after the closure of the request, and where an appeal has been made the retention period for the request is a minimum of six years after the closure of the appeal.
- 112.3 A comparison of all patients on whom Mr Eljamel operated, against NHS Tayside medical record Subject Access Requests received from 2015 to date, was carried out. There were 455 Subject Access Requests received within the time period, the breakdown of when these were made, when they were responded to and the method of response is provided [NHST-04737].

Documents available relating to the professional practice of Mr Eljamel and relating to his patients

- 113. What broad categories of documents relating to the professional activities of Mr Eljamel in his work with NHST exist? Insofar as the answer to this question relates to the retention of medical records, please explain the proportion of records which are still available based on the total number of patients under Mr Eljamel's care during the period of his employment with NHST.**
- 113.1 The broad categories of documents relating to the professional activities of Mr Eljamel that exist are detailed in paragraphs 100.2 and 100.3, in addition to the information included below.
- 113.2 Information relating to Mr Eljamel's practice is also held in patients' medical records. This will include information such as clinical correspondence, operation notes, contemporaneous records and any results of tests or scans carried out, and nursing records.
- 113.3 Information related to Mr Eljamel's work would also be captured in the minutes of the NHS Tayside Neurosurgery MDT meetings which were held as subspecialties.
- 113.4 The subspecialties Neuro-oncology MDT records are held by NHS Tayside Cancer Team.
- 113.5 Neurosurgery Radiology MDT records are held informally and any notes necessary were documented by the clinician in the patient's medical record.
- 113.6 Spinal MDT records are held nationally by NHS Grampian.
- 113.7 NHS Tayside does not know the total number of patients under Mr Eljamel's care during the period of his employment with NHS Tayside. NHS Tayside does not hold a comprehensive list of all patients who Mr Eljamel treated from 1995 until his suspension in December 2013.
- 113.8 NHS Tayside holds approximately 4,000 operation notes for patients who were operated on, or on behalf of, Mr Eljamel. These relate to approximately 3,800 individual patients as some patients were operated on more than once. NHS Tayside can take steps to identify the medical records that still exist for these 3,800

patients, however this would take a further two months to carry out this work. Should the Inquiry require this piece of work to be undertaken, please inform NHS Tayside.

113.9 In January 2026 NHS Tayside advised the Eljamel Inquiry that NHS Tayside still retains 721 deceased patients' medical records from the 1,638 deceased patients.

114. To what extent are key documents missing from the records available relating to Mr Eljamel's professional practice in his work with NHST (including medical records)?

115. To what extent have key documents and/ or key information relating to the professional practice of Mr Eljamel in his work with NHST been lost or destroyed?

116. If so, what broad classes of documents were lost or destroyed? When and by whom were they lost or destroyed? What kinds of information might they have contained?

117. If documents were destroyed, on whose authority were they destroyed?

114.1 NHS Tayside has combined the response to Questions 114 – 117 listed above, to avoid duplication in its response. NHS Tayside has numbered the response paragraphs below under Question 114.

114.2 Due to the time that has elapsed since Mr Eljamel last worked for NHS Tayside (over ten years) and the preceding 18 year period in which he was employed as a surgeon in NHS Tayside, some records no longer exist. These records will have been disposed of in line with the records retention policies [NHST-00050-00063] which must be followed for data protection purposes. This includes both corporate, administrative records, and patients' medical records.

114.3 To find out if there is any information relating to the professional practice of Mr Eljamel missing from the patient medical record, NHS Tayside would be required to carry out a full note review of all known patients of Mr Eljamel.

114.4 Some information is no longer available due to the decommissioning of old data management systems and technologies. There is limited organisational and professional knowledge from the current operational, medical and corporate leadership teams, who were not in post in NHS Tayside at the relevant time

- 114.5 The key documents and/or key information relating to the professional practice of Mr Eljamel in his work with NHS Tayside that NHS Tayside is aware have been lost or destroyed are detailed below. The reason for destruction where known is also included.
- 114.6 Mortality and Morbidity (M&M) meetings
The 2023 Due Diligence Review [NHST-00075] found that there was a lack of documentation recording meetings involving Mr Eljamel. This included Mortality and Morbidity (M&M) meetings, and any other internal documents from internal monitoring meetings.
- 114.7 NHS Tayside holds minutes of M&M meetings from March 2013 to December 2013 [NHST-01534; NHST-01535; NHST-01536; NHST-01537].
- 114.8 Management of these records and documentation was the responsibility of the local department / service areas and given the retention policy for these types of records, most of the historic records would have been destroyed in accordance with the relevant retention policy prior to the Inquiry being announced in 2023. The retention policy for minutes would have been (and still is) six years from the date of creation, for the relevant period. If the records formed part of a clinical audit, then the retention period would have been five years from the completion of the audit.
- 114.9 Spinal MDT Meetings
A gap in documentation has been identified in relation to Spinal MDT records. Spinal MDT meetings were held in Grampian, and the records of these are held by NHS Grampian. NHS Tayside contacted NHS Grampian to ask if they hold records for specific NHS Tayside patients. NHS Grampian advised they did not hold records for these patients but also advised that the Eljamel Inquiry should make a specific request to NHS Grampian for any associated records.
- 114.10 Scan Images
Philips Electronics UK Limited informed NHS Tayside on 27 August 2025 that some scan images are unavailable on the Philips Vue Pacs system, due to data corruption, as part of the ingestion process, or as partial data loss, resulting from multiple migrations and data consolidation activities. A copy of the letter from Philips Electronics UK Limited has been shared with the Inquiry previously [NHST-04688].

114.11 Adverse Events

NHS Tayside is unable to determine if there were any adverse events in relation to Mr Eljamel prior to 2012 as adverse events were recorded on the AIM system which was decommissioned in 2012 / 2013, due to the introduction of Datix. Datix replaced this system as the database for adverse events, risks, and complaints.

114.12 On 21 January 2021 the AIM system, including all data it contained, was removed from the NHS Tayside Digital Network and no data was retained. This decision was made following the NHS Tayside Digital Directorate discussing this with the Complaints, Legal, and Clinical Governance and Risk Management Teams. However, one adverse event in 2012 that had been recorded in the AIM system [NHST-01685] has been retained because it was subject to a Significant Clinical Event Analysis (SCEA) [NHST-01506].

114.13 The records retention policies from 2013 to the present day [NHST-00054-00063] state that adverse event records, depending on the severity of the event, should be kept for ten years or permanently for Serious Adverse Events.

114.14 The information contained within an Adverse Event record would include the final report, as well as the initial Datix incident report, meeting minutes and action logs of any meeting that took place regarding the review itself, and any written statements or evidence gathered as part of the review.

114.15 It should be noted that there are three adverse events regarding wrong site surgeries reported in 2013 involving Mr Eljamel for which NHS Tayside does hold documentation that have been retained [NHST-01650; NHST-01685; NHST-01646].

114.16 Complaints

NHS Tayside holds limited complaint documentation in relation to Mr Eljamel prior to 2011, unless they have been retained for a specific legal purpose. Prior to 2011, complaints documentation was held in the CAMS system which was decommissioned in 2012 / 2013, due to the introduction of Datix. Datix replaced the CAMS system as the database for adverse events, risk, and complaints.

- 114.17 On 1 July 2021 the CAMS system including all data it contained was removed from the NHS Tayside Digital Network and no data was retained. As the records within the system were not accessible, in consultation with the Digital Directorate it was agreed this system should be removed from the NHS Tayside Digital Network. This decision was made following discussions with the Legal Team, and the Complaints Team to ensure that there was no relevant information held on the system that would need to be retained at that time. Legal claims information was not held on this system. The Legal Team were, however, consulted to ensure access to information involving legal claims was retained appropriately.
- 114.18 Further information regarding complaints is included in response to Question 224.
- 114.19 Formal Staff Complaints
The 2023 Due Diligence Review [NHST-00075] found that NHS Tayside held no records of any formal staff complaints against Mr Eljamel from 1995 to 2023. Furthermore, the Due Diligence Review found that Whistleblowing trackers held by NHS Tayside from this period do not record individual details of concerns. NHS Tayside has not been able to determine the source of the information which has been referred to as Whistle blowing trackers in the Due Diligence Review. NHS Tayside would direct the Inquiry to the commissioner and authors of the 2023 Due Diligence Review who would be best placed to provide clarification on the Whistleblowing trackers.
- 114.20 The 2023 Due Diligence Review [NHST-00075] identified that the Department of Medical Education held no staff complaints data prior to 2010 as this had been destroyed as per the data retention policies for NES.
- 114.21 Decision Making
The 2023 Due Diligence Review [NHST-00075] identified that there was limited documentation regarding the decisions made in relation to Mr Eljamel, in particular around decisions made to supervise and/or suspend his practice following concerns being raised. However, NHS Tayside notes that it may be that there was little or no documentation created about this. It is likely that decisions were made during informal meetings at senior and executive level and no record was created. The current Board members were not involved in the decision to supervise and suspend Mr Eljamel, so in this response NHS Tayside is dependent on the documentation available to it.

114.22 If documents around the decision making did exist, then they would be held by the decision makers at the time. Documents have been retained in Mr Eljamel's HR record [NHST-04741] for decisions made regarding his supervision, suspension, retiral and removal from the GMC register. It should, however, be noted that although there are records of the decisions made, NHS Tayside does not have the full reasoning behind why decisions were made at the time. Any information destroyed, should it have existed, would have been destroyed under the authority of the decision maker.

114.23 General Medical Council (GMC) – Mr Eljamel's Removal

The 2023 Due Diligence Review [NHST-00075] found that the GMC contacted NHS Tayside on the 7 August 2015 [NHST-01538] to inform NHS Tayside that Mr Eljamel had applied for voluntary erasure from the Medical Register. The GMC had granted Mr Eljamel's request, and this marked the conclusion of its investigations into him. The 2023 Due Diligence Review [NHST-00075] found that the usual process would be for the GMC to ask for the employing organisation to respond with any opposition to the voluntary erasure within ten days. If the GMC does not receive any communication raising any objections or concerns from the employing organisation within that time frame, the GMC will proceed to voluntary erasure.

114.24 The 2023 Due Diligence Review [NHST-00075] did not identify a documented response from NHS Tayside to the GMC to either note or oppose the application for voluntary erasure. NHS Tayside has no reason to believe that there are lost or destroyed documents in relation to this issue.

114.25 In this circumstance, it is reasonable to assume that NHS Tayside does not hold any documents for this, as none were created. NHS Tayside found no evidence to indicate that NHS Tayside raised any objections to Mr Eljamel's erasure from the GMC register. If there were no objections raised by NHS Tayside, then it is reasonable to assume that in this connection relevant documents are not missing or lost.

114.26 Destruction of Theatre Logbooks

On 28 August 2025, a verbal request was received into NHS Tayside Health Records Department from Police Scotland Operation Stringent (the police investigation into Mr Eljamel), to seize theatre logbooks containing information

regarding the surgical practice of Mr Eljamel dating from May 1995 to November 2014. This was followed up by Police Scotland with a formal request in writing from Operation Stringent on 24 September 2025 [NHST-04671].

- 114.27 It was identified by the Health Records Department that there were a number of logbooks over eight years old held in the theatre suite and pertaining to the theatre in which Mr Eljamel would usually operate.
- 114.28 On attempting to locate these following the verbal request from Police Scotland on 28 August 2025, it was discovered these logbooks had been removed from their location on 28 July 2025 and added to the confidential waste stream to be destroyed.
- 114.29 NHS Tayside still holds hard copy logbooks for the relevant theatre for the periods March 2000 to June 2007 [NHST-04695], 7 May 2013 to 21 October 2013 [NHST-04692], 21 October 2013 to 14 April 2014 [NHST-04693] and Theatre Registers for 27 November 2006 and 20 November 2007 [NHST-04694]. These documents have been provided to Police Scotland, in accordance with its request.
- 114.30 The destruction of some of the theatre logbooks was despite a DND Notice in place from The Eljamel Inquiry which had been received on around 11 October 2024. The DND Notice had been shared with all Executive Directors on 18 October 2024 [NHST-04506]. An all-staff communication was sent out on 8 November 2024 to the organisation regarding the Notice with instructions to comply [NHST-01592]. Thereafter, later in November and again in December 2024, the Notice was reiterated to key employees of NHS Tayside who it was thought may have relevant information [NHST-04495].
- 114.31 The incident was escalated to the Chief Officer, Acute Services on 9 September 2025. The Chief Executive and members of the executive team were also made aware, along with the Chair of NHS Tayside on the same day.
- 114.32 The DND Notice was immediately re-shared on 9 September 2025 [NHST-01697] with all members of staff across the organisation in a Vital Signs email communication.

- 114.33 A high level report commissioned by the Chief Officer, Acute Services, outlined the background and assessment of the circumstances of the destruction of the logbooks, and was provided to the NHS Tayside Eljamel Oversight Group on 12 September 2025 [NHST-04504] and discussed by the Chief Executive Team (CET) on 15 September 2025 [NHST-04724].
- 114.34 It was identified that the theatre logbooks contained high-level information of the types of operations performed including staff in attendance and equipment used. The information was recorded manually in hard copy books and held within the theatre suite for ease of access and review (this process was superseded by the introduction of the OPERA theatre management system, brought in by phased implementation in 2012).
- 114.35 The operation details that were captured within the logbook are as follows:
- Date
 - Ward
 - Patient name
 - CHI number
 - Surgeon
 - First Assistant
 - Anaesthetist
 - Anaesthetic Practitioner
 - Scrub Nurse
 - Floor Nurse
 - Operation
 - Time stamps (into anaesthetic, start op, finish op, into recovery)
 - Surgical tray and implant stickers
- 114.36 Through work led by NHS Tayside's Health Records and Theatres Departments, it has been determined that much of the information normally detailed in theatre logbooks is also normally contained in operation notes within patient records. It is understood, therefore, that much of the information lost when the theatre logbooks were destroyed should be available within operation notes. However, not all relevant patient records remain in existence.

- 114.37 Following a discussion on the circumstances of the loss of the theatre logbooks, led by the Senior Information Risk Owner (SIRO) at CET on 15 September 2025, [NHST-04724], initial actions were agreed to mitigate further risk.
- 114.38 It was agreed that a full investigation should be commissioned to establish more detailed facts of the incident. This was primarily an investigation into people and their actions, and therefore it was agreed that the NHS Scotland Workforce Policies Investigation Process was most appropriate applying a 'just culture' lens. The investigation was commissioned by the Chief Executive on 18 September 2025 [NHST-04697- NHST-04740]. It was completed on 30 October 2025.
- 114.39 Given the significance of the event, and the discussions at the Chief Executive Team meeting on 15 September, the Chief Executive directed a series of further actions including:
- The Chief Executive instructed the Executive Medical Director, as the Executive Lead for The Eljamel Inquiry and Caldicott Guardian, on his return from leave on 22 September 2025 to commission an external governance review. This would be undertaken by a recently retired auditor external to NHS Tayside, with recommendations for action on the governance and protocols for document management, information sharing and system-wide information governance in response to all investigatory matters relating to Mr Eljamel. The formal commission commenced on 4 November 2025. (Action currently in progress)
 - The Chief Executive issued formal correspondence [NHST-04673] to all their direct reports to request all members of the Executive Team seek assurance from their areas of responsibility that: the DND Notice has been shared and is fully understood and complied with; if any areas currently hold documentation in hard copy or electronically they should contact the Public Inquiry Programme Management Office who will make the necessary arrangements to collect/transfer any information.
 - Formal correspondences informing Police Scotland (14 November 2025) [NHST-04674] and The Eljamel Inquiry (17 November 2025) [NHST-04675] of the loss of the theatre logbooks
 - Tayside NHS Board members briefed on a confidential basis on 25 November 2025, the day before the Eljamel Inquiry's Opening Statements Hearing when the matter would be in the public domain.

- In NHS Tayside's Opening Statement to the Inquiry on 26 November 2025, an explanation was provided for the destruction of the theatre logbooks, and it was conveyed that the situation was deeply regrettable[NHST-04720].

114.40 The Operation Stringent Theatre Logbooks Investigation under NHS Scotland Workforce Policies Investigation Processes [NHST-04507].

The investigation was initiated to:

- *“Establish the detailed facts of what transpired that resulted in the decision to make arrangements for the destruction of the logbooks from the theatre in which Mr Eljamel would typically operate.*
- *Assess if there are any capability or conduct concerns on the part of the individuals involved, or any failure of responsibility on the part of senior staff, considering the “Do Not Destroy” notice and its implementation.*
- *Provide a comprehensive assessment of how information that would have been available through the provision of the logbooks can be provided from other documentation.*
- *Provide a detailed assessment of the preventability of the incident and detail all steps and mitigations which are required to ensure this does not happen in the future.*
- *Make any further necessary recommendations in response to learning from this incident.”*

114.41 The investigation disclosed that an unknown number of hard copy theatre logbooks, which would have contained certain information relating to Mr Eljamel's surgeries during the period 1995-2013, were destroyed on around 24 July 2025.

114.42 It has been ascertained that the theatre logbooks were placed in the confidential waste stream to be destroyed by members of the department in which they were held. This was part of a reorganisation of historical stores of information.

114.43 The individuals involved as witnesses in the investigation report were; Olivia Smallbone, Staff Nurse, Shauni Scott, Operating Department Practitioner, Sarah Kerr, Senior Charge Nurse, Michelle Kettles, Operational Theatre Manager, Angela Ogilvy, Staff Nurse, Heather Anderson, Head of Health Records, Jacqueline McDermott, Charge Nurse, Jenny Clarke, Senior Nurse, Stuart Davidson, Assistant

Health Records Manager (referenced in the report as “male supervisor”) and Kerry Reilly, Health Records Team Leader (referenced in the report as the “female medical records staff” [NHST-04507 4]. The individuals who destroyed the information were Olivia Smallbone, Staff Nurse and Shauni Scott, Operating Department Practitioner. These individuals were not aware of the connection between the theatre logbooks and Mr Eljamel for a variety of reasons, as set out in the investigation report NHST-04507. Given that Question 116 asks for information as to the identity of the individuals involved in the destruction of the Theatre Logbooks NHS Tayside has provided the names of individuals involved. In so doing NHS Tayside wishes to make clear that it accepts full corporate responsibility for this matter and by naming those individuals in response to the Inquiry’s question it does not seek to attribute any blame to them for their actions.

- 114.44 The individuals involved believed they had carried out the disposal and destruction of the logbooks in accordance with NHS Tayside’s Health Records Strategy and Management Policy [NHST-01539], its Health Records Operational Guidance & Service Operating Procedures [NHST-01483], and Scottish Government guidance [NHST-01484]. These indicate that documents such as the theatre logbooks are required to be retained for a minimum of eight years from the end of the year to which they related, at which time they are eligible for destruction.

- 114.45 Record classification is based on purpose and function; as such retention periods are therefore based on the content and purpose of the record, not purely whether it is labelled as clinical or corporate. Some corporate records contain personal information i.e. complaints files, Subject Access Request files and general correspondence. The presence of patient identifiable information affects how the record must be handled, but not the classification.

- 114.46 NHS Tayside guidance on the retention periods for clinical and non-clinical records, set out in the Records Management Code of Practice Scottish Government guidance [NHST-01484] which NHS Tayside adhere to.

- 114.47 NHS Tayside still holds hard copy logbooks for the relevant theatre for the periods March 2000 to June 2007 [NHST-04695], 7 May 2013 to 21 October 2013 [NHST-04692], 21 October 2013 to 14 April 2014 [NHST-04693] and Theatre Registers for 27 November 2006 and 20 November 2007 [NHST-04694]. These documents have been provided to Police Scotland, in accordance with its request.

114.48 The key conclusions of the investigation were that this had been an error in a department which was clearing out an office and carrying out general housekeeping of that area. The members of staff had sought advice from Health Records Department about retention periods of historical documentation. Based on the description, staff were provided with standard retention guidance. Staff had then inadvertently disposed of the theatre logbooks which had spanned back to the 1960s as they were not aware of the logbooks having any connection to Mr Eljamel [NHST-04507].

114.49 Key areas for action and learning were identified under the following key themes:

- Information Governance and Compliance - Targeted training with support from medical records and information governance team to all staff to reinforce data protection and record management compliance.
- Review of Clinical Record Storage - Conduct a comprehensive review across all clinical areas within NHS Tayside to confirm that patient identification records are securely stored and managed. Ensure storage practices align with statutory and organisational retention schedules and that the rationale for retention is clearly documented.
- Communication of Critical Information - Review and strengthen mechanisms for communicating urgent or critical information to all staff.

114.50 In light of the matters of serious concern raised in response to the information provided by NHS Tayside in relation to the destruction of the theatre logbooks at the Opening Hearings of The Eljamel Inquiry on 26 and 27 November 2025, and the significant impact the disclosures have had on those directly affected and their representatives, the following further actions have been initiated:

- The engagement of an external consultancy to investigate the loss of the theatre logbooks. The requirement to investigate this by an external body is recognised given the impact of the public disclosure on the former patients and their representatives. The Chief Executive has determined that an external investigation should be conducted to demonstrate independent assessment, objectivity and rigour in the organisation's response. It is hoped that by carrying out an external investigation into the destruction of the theatre logbooks, with an

independent assessment and recommendations to the Board, former patients of Mr Eljamel can have confidence in the process. As of 8 January 2026, an external company (AAB) has been commissioned [NHST-04723]. The investigation is due to be completed at the end of May 2026.

- The commencement of a Forensic Walk rounds process for walk-through of all relevant clinical areas (acute and community), and all relevant corporate areas, to conduct searches to identify if any further documentation relevant to the Inquiry is held in local areas. Forensic Walk rounds in clinical areas were completed by 8 January 2026. Any archived records or clinical information from the relevant period from any department have been retained and is to be catalogued. No material of note to the Inquiry has been identified to date. A further detailed clinical assessment of the material will be undertaken during January 2026. Corporate Area Walk rounds are under way and will complete by the end of January. The Patient Liaison Response Team (PLRT) has developed a list of the types of corporate documents which may have been created for patients of Mr Eljamel [NHST-04739] and this has been used as a checklist to support the Forensic Walk rounds in clinical and corporate areas. A mapping framework of all key document types and corporate information that could have been created for patients under Mr Eljamel's care is also being finalised, identifying typical storage locations across NHS Tayside systems, ensuring a comprehensive coverage of known document categories and systems. Further information about types of corporate records can be found in paragraphs 102.3 and 102.4 of this response.
- The Inquiry's DND Notice re-issued through clinical huddles and leadership communications at all levels of organisation.
- Further core messages for managers to use as basis of face-to-face discussions with teams about the Inquiry and the development of further communications tools for frontline staff groups.
- Induction for new starts to be further reviewed with The Eljamel Inquiry on key messages and significance of DND Notices.

114.51 These actions are being monitored by Tayside NHS Board.

114.52 Following the Opening Statements Hearings, the Cabinet Secretary for Health and Social Care has requested regular updates on the actions taken by NHS Tayside in response to the destruction of the theatre logbooks and has sought further assurances from NHS Tayside Chief Executive and Chair on the systems and processes in place. The NHS Tayside response was provided to the Cabinet Secretary on 28 November 2025, the Action Plan was shared on 8 December 2025 [NHST-04669] and a further update provided on 9 January 2026 [NHST-04382].

Appendix B - Part F – Previous investigations into Mr Eljamel

Under Term of Reference 12, the Inquiry is charged with investigating previous investigations into Mr Eljamel. The Inquiry is keen, in section 1 of its evidential investigations to understand the broad ambit, aims and findings of the investigations. It is intended that further, more detailed evidence about these investigations will be sought at a later stage in the work of the Inquiry.

Responsibilities

118. Please explain NHST’s legal, regulatory and any other responsibilities for investigating concerns about the practice of individual surgeons in the positions held by Mr Eljamel over the relevant period

118.1 NHS Tayside had statutory and policy responsibilities to receive, investigate and act on concerns about the practice of individual surgeons in the positions held by Mr Eljamel over the relevant period through complaints handling, incident reviews and employer-led investigations. Professional regulation regarding fitness to practice sat with the national professional regulators, and in relation to surgeons such as Mr Eljamel that regulator was the (GMC).

118.2 The National Health Service (Scotland) Act 1978 [NHST-04332] was amended but the Health Act 199, 51, Section 12H created the legal duty on Health Boards to “*put and keep in place arrangements for the purpose of monitoring and improving the quality of health care*”.

118.3 During the relevant period, clinical governance and local incident management frameworks were rolled out across NHS Scotland, including HDL guidance and national clinical governance work. Health Boards were therefore expected to investigate adverse events, review care and take learning/ action [NHST-04454].

118.4 The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012 [NHST-04455] set out to modernise the complaints framework in the NHS in Scotland, and to continue the requirement that Health Boards maintain a structured procedure capable of investigating complaints, responding within set timescales and offering review. Prior to 2011 guidance was

provided in the national 2005 document, the first edition of “Can I help you” which established early principles of complaints handling [NHST-04722; NHST 01684].

- 118.5 ‘Can I Help You?’ was published by the Scottish Government in 2012 [NHST-01645] to support the Patients Rights (Scotland) Act 2011 [NHST-04437].
- 118.6 Following this was the publication Scottish Public Services Ombudsman (SPSO) Model Complaints Handling Process in April 2017. This is the process in use today across NHS Scotland [NHST-00235].
- 118.7 Healthcare Improvement Scotland (HIS) published a national framework in 2013 to standardise adverse event review and learning across Health Boards, requiring local reporting, investigation and learning (CEL20(2013)) [NHST-04456].
- 118.8 The Responsible Officer role in the NHS is governed by the Medical Profession (Responsible Officers) Regulations 2010, [NHST-04457] later amended in 2013 [NHST-04458] (and updated again in 2025) [NHST-04459]. These regulations require every designated body (such as an NHS Health Board) to appoint a Responsible Officer (RO), usually the Executive Medical Director, who is legally accountable for monitoring doctors’ fitness to practise, overseeing appraisals, and making revalidation recommendations to the (GMC) For trainees, the RO is the Medical Director of NHS Education for Scotland (NES). Prior to 2014 this role did not exist.

119. Please explain the systems which were in place within NHST over the relevant period which governed such investigations, including explaining how and why any such systems evolved and why.

- 119.1 The systems in place for the investigation of professional conduct are laid out in NHS Tayside’s Disciplinary Procedures for Hospital Medical and Dental Staff [NHST-01579]. These procedures are based on a range of Scottish Executive circulars and are described in response to Question 10(f). The following paragraphs broadly outline the mechanisms in place and amendments over the relevant time period. It should be noted that these circulars, and the amendments are still extant.

- 119.2 Circular no. 1990(PCS)8 [NHST-00242] introduced Disciplinary Procedures for Hospital Medical and Dental Staff in Scotland. This circular, dated 19 March 1990, introduced definitions of misconduct to assist Health Boards in defining the nature of the allegations made. These definitions were:

“Personal Conduct: Performance or behaviour of practitioners not associated with the exercise of medical or dental skills”.

“Professional Conduct: Performance or behaviour of practitioners arising from the exercise of medical or dental skills”.

“Professional Competence: Adequacy of performance of practitioners related to the exercise of their medical or dental skills and professional judgement”.

- 119.3 Circular no. 1990(PCS)8 [NHST-00242] states the Chief Administrative Medical Officer (CAMO) (now referred to as the Medical Director) should, on receipt of an allegation, make preliminary enquiries to determine the appropriate disciplinary mechanism to be used. The circular defines seven options that can be taken following a preliminary enquiry.

- “a. There is no substance in the allegations and therefore no further action is necessary*
- b. The case is a minor one which the CAMO considers can be dealt with informally*
- c. The procedures for sick doctors set out in NHS Circular 1982 (PCS) 8 might be appropriate*
- d. The allegation is of personal misconduct in which case the disciplinary provisions set out in section 40 of the General Whitley Council Handbook should be followed.*
- e. The case is appropriate to be dealt with under the Professional Review Machinery (Annex A) [of this circular]*
- f. the case involves less serious allegations about professional conduct or competence and is suitable for the intermediate procedure (Annex B) [of this circular]*
- g. The case involves allegations concerning serious professional conduct or competence and should be dealt with in terms of Annex C [of this circular]”*

Note that options e. and f. above were new procedures introduced under the circular.

- 119.4 Annex A of circular no. 1990(PCS)8 [NHST-00242] introduced Professional Review Machinery, an informal mechanism for reviewing the conduct of hospital consultants who are alleged to have repeatedly failed to honour their contractual commitments. The mechanism requires a professional panel to be set up, chaired by the Chair of the Area Committee for Hospital Medical Services (or its equivalent) and consisting of two other consultants. A fourth member of the panel will be co-opted when allegations are received by the chair and will be a i) consultant in the same specialty as that of consultant against whom the allegations have been made and ii) must be employed by a different Health Board. The panel meets with the consultant against whom the allegations have been made to discuss the matter informally. The panel can conclude that the actions were unfounded, and no further action is required, or if there is substance to the allegations, they can advise the consultant and counsel them regarding their future conduct. A second meeting to review the situation should be held no later than 6 months after the first meeting. If there is no improvement the matter should be referred back to the CAMO.
- 119.5 Annex B of circular no. 1990(PCS)8 [NHST-00242] introduced an Intermediate Procedure for Less Serious Matters involving Professional Conduct or Competence. This procedure involves the use of two independent professional assessors to investigate and advise the CAMO on less serious professional conduct or competence matters. Assessors are nominated by the Scottish Joint Consultants Committee with at least one assessor being from the same specialty as the practitioner concerned. The assessors will investigate and prepare a report with two parts. The first part should present the facts based on the investigation for consideration by the Board and should be provided within thirteen weeks of receiving the statement of case from the CAMO. The second part will be issued four weeks later with a view as to whether the practitioner was at fault and may present recommendations. The CAMO will then decide what further action is required and inform the practitioner accordingly.
- 119.6 Annex C of circular no. 1990(PCS)8 [NHST-00242] outlines a Procedure for Serious Disciplinary Cases to be followed in serious disciplinary cases involving the professional conduct and professional competence of all hospital medical and dental staff, where the outcome of the disciplinary action could be the dismissal of

the practitioner concerned. The procedure allows for the suspension of the practitioner where the interests of the service require that the practitioner should cease their duties whilst the allegations are investigated.

- 119.7 The three definitions of conduct outlined in paragraph 119.2 are handled in different ways. Matters of personal conduct at the time of the publication of the circular in 1990 were subject to the provisions of Section 40 of the General Whitley Council Conditions of Service, [NHST-04676], in line with all other employees. Cases involved professional conduct or competence were dealt with in line with Annex C of the circular.
- 119.8 Preliminary Inquiries should be made by the CAMO when an incident is reported or a complaint made involving professional conduct or competence. A report should then be made to the Chair of the Board to decide whether there is a *prima facie* case which, if well founded, could result in dismissal. Where that is the case, the practitioner should be advised in writing and provided with any correspondence. An investigating panel should be established, consisting of up to five members including a legally qualified chair, and where the case concerns solely professional competence, all other members should be medically qualified. The terms of reference for the panel will include the nature of the incident or complaint. The panel will meet in private to seek to establish the facts of the case, with members able to ask questions of the witnesses presented by both the practitioner and the Health Board. The report of the investigating panel should be presented in two parts. The first part should present the facts based on the investigation. This should be shared with the practitioner and the Health Board with four weeks allowed to consider any correction of facts. The second part will be issued four weeks later with a view as to whether the practitioner was at fault and may present recommendations, at which point the Health Board should decide what action to take, allowing time for the practitioner to submit any mitigations.
- 119.9 Circular No. 1990(PCS)32, 20 August 1990 [NHST-04470] amended Circular 1990(PCS)08 [NHST-00242] by making some minor changes to wording and making alterations to the sections of the circular concerning appeals.
- 119.10 Circular No. 1994 (PCS)11, 16 December 1994 [NHST-00243] provided further guidance to Health Boards on the use of suspensions with the aim of reducing the number of avoidable suspensions and, where suspension was required, ensuring

they were in place for a minimum necessary amount of time. Suspensions are intended to protect the interests of patients, other staff, or the practitioner and/or to assist the investigative process. Given the potential serious consequences, the guidance makes clear that alternatives to suspension - for example, limited or alternative duties should be considered. The circular also outlines the procedure for informing the practitioner of the suspension. It further clarifies that the authority to suspend should be held by the Medical Director, that suspensions should be on full pay, and that suspensions should be reviewed at least every two weeks.

- 119.11 Circular No. PCS(DD)1999/7, 06 April 1999 [NHST-04473] provided the outcome of a short life working group on the Suspension of Medical and Dental Staff and makes some minor updates to the 1990(PCS)08 Circular [NHST-00242]. The report acknowledged that suspension in certain circumstances is mandatory on grounds of patient and public safety. It further acknowledged that employers should always consider suitable alternatives before resorting to suspensions. The report provided principles to help employers investigate allegations against practitioners and included 21 recommendations, some of which were amendments to the previous circulars noted above. Recommendations were made in relation to external advice, honorary contract and locum situations, committees of inquiry, and monitoring of suspensions by the Scottish Executive.
- 119.12 Circular No. PCS(DD)2001/09, 07 August 2001 [NHST-04381] introduced and outlined an appeals procedure developed by a working group in response to recommendation 19 of the report noted in 119.11 above. This procedure enables differences between the employer and the practitioner in relation to the classification of conduct, (i.e., personal or professional) to be resolved.

General

120. **Please explain the process which was followed to generate significant clinical event analysis (“SCEA”) into any cases involving former patients of Mr Eljamel, including the patient(s) to whom they related and the methodology and reasoning why the relevant cases qualified for such an analysis, whereas other cases did not.**

120.1 One case has been identified involving a patient of Mr Eljamel and has been categorised as wrong site surgery. This 'qualified' for SCEA because of the categorisation of 'wrong site surgery', as a 'never event', further explained below:

- SCEA2012-33 AIM 101404 March 2013 [NHST-01506] - surgery on 18 July 2011. This was recorded on the AIM system and was triggered after the patient contacted the Chief Executive on 05 December 2012 [NHST-00441_1-2].

120.2 The SCEA process was managed by staff who are no longer with NHS Tayside, meaning that corporate knowledge of the process followed is limited. However, as the incident progressed through a SCEA process, NHS Tayside can provide details based on policies in place at that time.

120.3 Under NHS Tayside's Significant Event Management (SEM) Policy (2012) [NHST-01552] and AEM Policy (2013) [NHST-01553], a SCEA must be conducted for any incident resulting in permanent psychological or physical harm or death. Additionally, all 'never events' – including wrong site surgery and retained surgical instruments - trigger a SCEA. Other mandatory triggers encompass significant clinical incidents such as the suicide of a patient and medication errors causing death. SEM and AEM policies are summarised below in relation to a SCEA and enclosed at Appendix C where further detail is given.

120.4 The process which was followed for a SCEA at that time commenced when an adverse event was identified and recorded on the AEM system. NHS Tayside's SEM Policy (2012) [NHST-01552] outlines the following:

120.5 *"The purpose of an SCEA is primarily to understand and learn from events and share any learning, changes or improvements to systems and processes with other appropriate stakeholders."*

120.6 *"All incidents requiring SCEA must be recorded in the Electronic Incident Reporting System where possible within 24 hours of the event and have a local review and analysis undertaken within 7 days of the event. This local review must contain a recommendation to proceed to a SCEA. The request for consideration for a SCEA must be submitted by the General Manager/Clinical Service Manager/Head of Service to the SCEA Team via email."*

- 120.7 *“The SCEA team will agree whether a review is required and will contact the Safety, Governance and Risk Team, who will provide administrative support to the process.”*
- 120.8 *“The SCEA Team will consist of:*
- Board Nurse Director (or nominated deputy)*
 - Medical Director (or nominated deputy)*
 - Associate Medical Director for Service*
 - Relevant Head of Service/Service Manager*
 - Head of Safety, Governance and Risk*
 - Patient/Public Representative*
 - Other staff appropriate to the Incident – This can and should include, for example, relevant Mental Health Staff, Primary Care Staff, General Hospital Staff, Police, Local Authority, Voluntary Sector staff, Prison Healthcare Staff and Scottish Prison Service Operational Staff.”*
- 120.9 *“Relatives must be given the opportunity to contribute to and receive feedback following a SCEA. The form of contact may differ due to the circumstances and the Chair of the SCEA should consider meeting with the family themselves supported by the appropriate service manager or known clinician. Where families have indicated they want to be involved in the SCEA review process they must receive a letter, even if a meeting has taken place, from the Chair summarising the learning from the review and advising them of who they can approach if they are dissatisfied, for example, the Mental Welfare Commission, or the NHS Complaints and Advice Team.”*
- 120.10 *“The SCEA should be held within 3 months (90 days) of the event and will be Chaired by either the Board Nurse or the Medical Director as they have the appropriate independence, organisational authority, skills and knowledge to carry out an effective review. If necessary, the Chair will be supported by other relevant experienced personnel independent from the service subject to the SCEA.”*
- 120.11 *“Following a SCEA where there is significant organisational learning or a failure to identify a cause of death, if deemed appropriate by the Board Nurse and/or Medical Director, an Independent Review will be requested and undertaken.”*

120.12 *“The SCEA process will be managed by a member of Safety, Governance and Risk Administration staff. This will include ensuring all necessary information - inclusive of relevant written records, third party information, any relevant policies and procedures, and any relevant good practice guidance - is available to the review team in advance of the meeting.”*

120.13 *“The member of Safety, Governance and Risk Administration staff will also record the SCEA using the template attached in Appendix 7 [of the SEM Policy] with all action points assigned an identified lead and a timeframe for completion. In the first instance, the report will be issued to all attendees confidentially in draft form for amendments or approval. Once agreed by the panel, the confidential final report will be sent to attendees of the review; Health Improvement Scotland (HIS) for suicides; Mental Health Safety, Governance and Risk Committee; and relevant directorate safety, governance and risk committees for ‘never events’. These committees will be responsible for ensuring the follow up and completion of action points. In addition, regular update reports from local safety, governance and risk groups/committees will be provided to the Clinical Quality Forum.”*

121. Please set out the methodology and main findings of any such SCEA and any steps taken by NHST as a result.

121.1 The case relating to Mr Eljamel which proceeded to SCEA is mentioned in paragraph 120.1. The methodology and main findings of SCEA2012-33 AIM 101404 [NHST-01506] is set out below.

121.2 SCEA2012-33 AIM 101404 [NHST-01506]

Methodology

A SCEA meeting was held on 12 March 2013, in the Board Room, Level 10, Ninewells Hospital, Dundee. The final report was prepared based on information from the SCEA review and included evidence from the case notes and the local incident review.

121.3 The methodology also included a review of all communication relating to the patient’s formal complaint letter, the Incident Report, Standard Significant Event Analysis (SSEA) reports, the clinical records and a letter from a Neurosurgeon in Edinburgh which was examined and used to formulate the summary and reports.

As part of the SCEA, a round table meeting was held with panel members and staff members. The review considered a number of points of concern which were identified within the SCEA final report *[NHST-01506]*.

121.4 As part of the review, the Medical Director noted that a local incident review had been carried out, which identified several actions, and an update on the progress of these actions was provided. These included:

- Action to develop a protocol checklist to consider/review the trial of ultrasound techniques to identify/confirm the correct surgical site by 1 May 2013. The update provided was that this was an “ongoing research project between Anaesthetics and Neurosurgery”.
- Action to consider/review use of intra operative imaging to identify/confirm surgical site. The update provided included that this was part of an ongoing research project between Anaesthetics and Neurosurgery. There had only been a small pilot of ultrasound, and this was not currently offered as part of the localisation process. X-ray was the current gold standard.
- Action to review current patient information leaflets for back surgery for an interim period (national information to be available by June 2013). The update provided included that the national information was not going to be available for some time, but work had already begun to develop local patient information leaflets to be used in the interim and this would be completed by the beginning of May 2013. *[NHST-04460; NHST-04461; NHST-04462; NHST-04463; NHST-04464; NHST-04465]*.
- Action to review the procedure for reviewing patients on admission prior to surgery. The update provided included that this had already been implemented, and all patients were now seen by the operating surgeon prior to going to theatre.
- Action to develop and test a communication system to ensure that patients’ telephone enquiries were passed to the relevant consultant and acted upon. The update provided was that this action was complete. The Head of Nursing B confirmed that this action was complete. She and the Administrative Services Manager had reviewed systems to capture telephone calls from patients and

implemented a robust mechanism that would ensure patients' enquiries were actioned in a timely manner.

- Action to review inductions of Junior Doctors' and medical staff inductions to include responsibility to record discussions with patients. The update provided in the SCEA report in 2013 included that such inductions would be implemented in August with the new standard, as part of ensuring that discussions were documented within the case records [NHST-01506].
- Action to review radiologist reporting process to highlight anomalies. The update provided included that within Radiology this was to be taken forward through their quarterly Errors and Complications meeting, with the intention of identifying learning outcomes and implementing improvements.

121.5 The Medical Director confirmed that all the actions identified in the SSEA were either complete or on track to being completed and that progress of actions would be reported through the Clinical Governance Framework including the Clinical Quality Forum.

121.6 *"Actions Identified:*

1. *Arrange to meet with Ms A and share outcome of SCEA and address other issues relating to episode of care.*
 - *Responsible Person: Medical Director/ Quality, Clinical Governance and Risk Team Lead 1 Timeframe: 31 May 2013*
2. *An audit to be carried out from 1 January 2013 to demonstrate reliable data that all surgical pause and safety documentation is completed in each case.*
 - *Responsible Person: Consultant Neurosurgeon A/Head of Nursing B/Neuro Theatre Manager Timeframe: 31 May 2013*
3. *Agree and implement the use of a standard terminology to describe spinal decompression procedures.*
 - *Responsible Person: Consultant Neurosurgeon A/Consultant Neurosurgeon B/ Clinical Lead for Neurosurgery Timeframe: 31 May 2013*
4. *Develop a capital bid for replacement of image intensifier for Neurosurgery.*

- *Responsible Person: Clinical Lead for Neurosurgery/General Manager for Surgery Timeframe: 30 June 2013.*

122. Please explain the process which was followed to generate an adverse event analysis into any cases involving former patients of Mr Eljamel, including the patient(s) to whom they related and the methodology and reasoning why the relevant cases qualified for such an analysis, whereas other cases did not.

122.1 NHS Tayside is reliant on policies and procedures to respond to this question as staff involved at the time are no longer employed in NHS Tayside. For events that did not meet the criteria for SCEA identified in the response to Question 120, NHS Tayside's SEM Policy (2012) [NHST-01552] stated at section 6.2: *"Standard significant event analysis or Local Reviews must be held for all other red incidents and if local teams feel appropriate for amber incidents and clusters of green incidents. They should also be held for all unexpected deaths in hospital."*

122.2 The process for adverse event review is documented in the SEM Policy (2012) [NHST-01552].

122.3 The NHS Tayside AEM Policy (2013) [NHST-01553] states that *Local Incident Reviews 'must be held for all red incidents and if local teams feel appropriate for amber incidents and clusters of green incidents. They should also be held for all unexpected deaths in hospital or complaints.'*

122.4 The process for adverse event review is documented in the NHS Tayside AEM Policy (2013) [NHST-01553].

122.5 Cases involving Mr Eljamel's Patients:

122.6 Four adverse events were identified on the Datix System, where Mr Eljamel's name is recorded as "other people involved in the event". Copies of these Datix have been provided [NHST-01646; NHST-01648; NHST-01649; NHST-01650] and a summary of these is provided below.

- Datix: 11382 (date of event 29/11/2013) [NHST-01649]. This event is classified as a green (minor) incident and categorised as an "equipment incident" [NHST-

01649_2]. The circumstances relate to a consultant requesting a supported (rea) chair for a patient, but due to it being used by another patient, the chair was not able to be provided for two identified patients in the High Dependency Unit. According to the Datix record, there is no evidence of a review being commissioned, or any rationale to support this decision.

- Datix: 1955 (date of event 08/04/2013) [NHST-01648]. This event is classified as a green (minor) incident and categorised as a “delay in admitting to hospital” [NHST-01648_2]. This case related to a 94 year old patient admitted to Perth Royal Infirmary Emergency Department, and the ongoing conversations between Neurosurgical and Orthopaedic specialities to agree where the patient would be admitted in Ninewells. According to the Datix record, there is no evidence of a review being commissioned, or any rationale to support this decision.
- Datix: 8589 (generated 26/09/2013, [NHST-01650] date of event 28/07/2011). This event is classified as an amber (moderate) incident and categorised as “inappropriate surgery performed” (surgery was performed by a doctor under supervision of Mr Eljamel in July 2011). The Datix record states: *“urgent review of patient arranged and seen by Mr Eric Ballantyne on 25 September (2013). Concern raised with the Clinical Director Phil McLoughlin and General Manager Audrey Warden on 24 September (2013).”* [NHST-01650_2]. According to the Datix record, there is no evidence of a review being commissioned, or any rationale to support this decision.

122.7 It is of note that there was an investigation carried out in relation to an associated complaint (Complaint ID: 3035).

- Datix: 6571 (date of event 29/07/2013) [NHST-01646]. This event is classified as a green (minor) incident and categorised as an “intra-operative complication” [NHST-01646_2]. The circumstances of the event are recorded as a *“sharp hook tip broken off in T7/8 disc space”* [NHST-01646_2] during a procedure. The immediate action taken included: *“Surgeon made aware of missing tip and carried out fingertip search, visual search using the microscope and xray carried out – unable to locate tip, ?in suction”* [NHST-01646_2]. According to the Datix record, there is no evidence of a review being commissioned, or any rationale to support this decision.

123. Please set out the methodology and main findings of any such adverse event analysis into and any steps taken by NHST as a result.

123.1 There is no evidence recorded within the adverse events identified in response to Question 122, of a review being commissioned or a rationale being recorded in respect of the decision not to commission a review. At the time, both the NHS Tayside SEM Policy (2012) [NHST-01552] and the NHS Tayside AEM Policy (2013) [NHST-01553] stated:

“Standard significant event analysis or Local Reviews must be held for all other red incidents and if local teams feel appropriate for amber incidents and clusters of green incidents. They should also be held for all unexpected deaths in hospital”.

123.2 It is of note that the AEM Policy was updated in January 2022 [NHST-01554] to state that it was mandatory for all moderate events to have a Local Adverse Event Review (LAER) undertaken and for all extreme and major events to have a SAER undertaken.

Previous investigations into Mr Eljamel

(a) Royal College of Surgeons report relating to Mr Eljamel commissioned by NHS Tayside dated 2013 (reported on 6th December 2013)

124. Why was the 2013 report commissioned by NHST and why was it commissioned when it was?

124.1 The Royal College of Surgeons (RCS) 2013 report [NHST-00072] was commissioned by NHS Tayside due to multiple complaints received over a short period of time with emerging themes relating to personal communications regarding Mr Eljamel. These highlighted instances of poor performance wrong site surgery, lack of interpersonal engagement with patients and relatives and poor junior staff supervision [NHST-01641].

125. By whom was the report commissioned?

- 125.1 The report was commissioned by Dr Andrew Russell, Medical Director of NHS Tayside in 2013.

126. Why was it thought appropriate/ necessary to ask the Royal College of Surgeons to prepare the report?

- 126.1 NHS Tayside has found no evidence regarding the rationale for commissioning the RCS to prepare the report in 2013. The former Medical Director, Dr Andrew Russell, who has since retired from NHS Tayside, would be best placed to provide this information. The Inquiry may wish to direct this question to him.

127. What was the remit of the report which was commissioned and why was the remit set as it was?

- 127.1 The remit of the report was defined within the agreed terms of reference *NHST-01642* set out below.

- 127.2 *“a) To consider concerns about the clinical work of Professor Sam Eljamel, Consultant Neurosurgeon, with specific reference to:*

- *Clinical knowledge, skills, surgical competency and clinical decision making*
- *Interpersonal skills and communication skills with patients, relatives and colleagues*

These concerns were raised following a series of clinical incidents resulting in a high volume of complaints, including from patients who had already sought a second opinion.

b) If applicable: NHS Tayside would be receptive to recommendations in relation to wider aspects of service delivery and team cohesiveness within the Neurosurgery Department that may emerge from the context of the review.

c) If a case note review is required:

To review 7 specific patient case notes and corresponding complaints where concerns have been raised by patients and NHS Tayside, and to extend this review to additional case notes if deemed appropriate during the review process.

The reviewers will then make recommendations for the consideration of the Chief Executive and Medical Director of NHS Tayside as to:

- *whether there is a basis for concern about Professor Sam Eljamel's practice in light of the findings of the review;*
- *possible courses of action which may be taken to address any specific areas of concern which have been identified"*

127.3 The remit was established in direct response to the commissioning request.

128. What materials were made available to the Royal College of Surgeons when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the report to be fulfilled?

128.1 The materials made available to the RCS are detailed in Section 6 of the RCS Final Review report [NHST-00072]. In addition, the RCS Review Team provided a list of documentation [NHST-01643] to NHS Tayside that it requested to view prior to carrying out the planned interviews with key NHS Tayside employees.

128.2 It would be for the RCS Review Team to comment further on why these materials were considered sufficient for the remit to be fulfilled.

129. To what were (sic) extent were materials missing at that time, which would otherwise have been relevant to the remit of the report?

129.1 NHS Tayside found no evidence or documented assessment indicating that any materials were missing at the time of the RCS review. The Inquiry may wish to direct this question to the RCS Review Team, who would be best placed to provide clarification.

130. Further:

- (a) How and why were 14 case note reviews selected for specific review? How representative of the practice of Mr Eljamel were they? To whom did they relate?**

130(a).1 The RCS terms of reference includes at section 2(c) *“to review 7 specific patient cases notes and corresponding complaints where concerns have been raised by patients, and to extend this review to additional cases note if deemed appropriate during the review process” [NHST-00072]*. NHS Tayside holds no evidence or documentation explaining how or why the RCS extended their review to fourteen case notes, other than the terms of reference stating that the original seven cases may be extended if deemed appropriate. They related to 14 former patients of Mr Eljamel. The commissioner of the report and the RCS Review Team would be best placed to provide clarification on this matter.

130(a).2 The fourteen patients involved in the review were [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D], [CAT D] and [CAT D].

- (b) How and why were 7 cases with anonymised patient names allocated to them selected for specific review? How representative of the practice of Mr Eljamel were they? To whom did they relate?**

130(b).1 Please see response to Question 130(a).

- (c) Why was it thought that the RCS was in a position to make recommendations about service delivery within the NHS Tayside neurosurgical service more generally?**

130(c).1 Since 1998 the RCS established the Invited Review Mechanism (IRM) to independently review the practice of Surgeons. The terms of reference for the review [NHST-00072_3] states that, if applicable, NHS Tayside would be receptive to recommendations in relation to wider aspects of service deliver. NHS Tayside holds no evidence or documentation explaining why it was considered that the RCS Review Team was in a position to make recommendations about service delivery

within the Neurosurgical service. The commissioner of the report and the RCS review team would be best placed to provide clarification on this matter.

131. What role were patients or their representatives permitted to play in the compilation of the report and why?

- 131.1 No patients or their representatives were interviewed or examined during the course of the Invited Review visit as stated in the report [NHST-00072_6]. NHS Tayside holds no documentation or evidence why patients or their representatives were not included in the terms of reference [NHST-00072_2]. The commissioner and RCS would be best placed to answer this question.

132. What were the main conclusions/ recommendations of the report and what was the reasoning behind these conclusions/ recommendations?

- 132.1 The main conclusions and recommendations of the RCS review report are set out in Sections 8 and 9 of the RCS final report specifically on pages 21 and 27 [NHST-00072_21-27]. The reasoning behind these conclusions and recommendations would be a matter for the RCS Review Team to address.

133. What action was taken by NHST as a result of the report being received and why?

- 133.1 The actions taken by NHS Tayside following receipt of the RCS report are described in the NHS Tayside Due Diligence Review [NHST-00075_29] and comprise:

“Following receipt and review of the RCS final report, a meeting was scheduled for 11:30am on Tuesday, 10 December with the Medical Director, Operational Director, Associate Medical Director of Surgery and the General Manager of Specialist Services. At this meeting the decision was made to suspend Professor Eljamel. At 2.30pm on the 10 December 2013, Professor Eljamel was suspended with full pay in person and by formal letter by the Associate Medical Director for Surgery.

On the 27 January 2014, NHS Tayside provided an update to the RCS regarding the recommendations set out in the report. It detailed that Professor Eljamel had been suspended from duties, and a referral had been made to the GMC. The update also detailed that there had been 150 high risk spinal patients identified who required a review in line with their recommendation to look back at spinal patients over a period of the preceding three years. The update added that approximately 90 had already been reviewed prior to this date.

A further update was provided to the RCS on 15 August 2014. A letter on 15 August 2014 from the AMD for the Surgical Division to the RCS states that all 18 recommendations have been addressed. It stated that all identified patients had now been met with and clinically reviewed, the GMC investigation was ongoing, and that Professor Eljamel had retired from NHS Tayside on the 31 May 2014.

There is no documentation to provide clarity or further information as to how the 18 recommendations from the RCS were addressed and met. The due diligence review did not identify a formal governance route for the reporting of the recommendations for the Board to be assured that they were appropriately implemented.”

133.2 NHS Tayside holds no further evidence regarding the rationale for these actions but considers it likely that there were verbal discussions leading to the decided actions. The Medical Director in post at the time, along with the others noted as being involved in the decisions, would be best placed to explain the reasoning behind these decisions, and the Inquiry may wish to direct this question to them.

134. Why did NHST not progress the internal investigation into Mr Eljamel which it had commenced at the time of Mr Eljamel's suspension in December 2013 when he his (sic) resigned from his post in May 2014 (see NHST-00076, page 12)?

134.1 It is recorded in a letter dated 13 February 2014 that it was agreed by the Medical Director Dr Andrew Russell not to proceed with the internal investigation [NHST-01561]. NHS Tayside holds no evidence regarding why the internal investigation into Mr Eljamel did not progress following his resignation in May 2014. It is likely that this decision would have been the result of a verbal discussion between the

Medical Director and others. This is a matter for the Medical Director and others in post at that time, who would be best placed to provide clarification.

(b) Interim report of NHS Tayside relating to Mr Eljamel dated October 2013

135. Why was it thought appropriate for an interim report to be prepared in October 2013? Is this, in fact, the same as the interim report by the Royal College of Surgeons of October 2013, NHST-00073 sent to the NHST Medical Director on 4 October 2013 [NHST-00071]?

135.1 NHS Tayside holds no evidence explaining why it was considered appropriate for an interim report to be prepared by the RCS in October 2013. This is a matter for the RCS Review Team, who would be best placed to provide clarification. The above statement made by the Inquiry is correct, the interim report referred to is *NHST-00073*.

136. By whom was the report prepared?

136.1 The letter from the RCS sent to the Medical Director of NHS Tayside on 4 October 2013 [*NHST-00071*] was prepared by Steven Wakelin, IRM Manager, on behalf of the RCS.

136.2 The document referenced is a draft report sent by the RCS to NHS Tayside [*NHST-00073*] was prepared by the reviewers for the RCS, as indicated on that document [*NHST-00073_1*].

137. What was the remit of the report which was commissioned and why was the remit set as it was?

137.1 The remit of the report is set out in Section 2, of the document referenced as a draft report sent by the RCS to NHS Tayside [*NHST-00073_3*] which states;

137.2 *“To consider concerns about the clinical work of Professor Sam Eljamel, Consultant Neurosurgeon, with specific reference to:*

- *Clinical knowledge, skills, surgical competency and clinical decision making*
- *Interpersonal skills and communication skills with patients, relatives and colleagues*

137.3 *These concerns were raised following a series of clinical incidents resulting in a high volume of complaints, including some from patients who had already sought a second opinion.”*

138. What materials were made available to those involved in preparing the report when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the report to be fulfilled?

138.1 The materials made available to the RCS are detailed in Section 6 of the document referenced as a draft report sent by the RCS to NHS Tayside [NHST-00073_6]. It would be for the RCS Review Team to comment further on why these materials were considered sufficient for the remit to be fulfilled.

139. To what extent were materials missing at that time, which would otherwise have been relevant to the remit of the report?

139.1 NHS Tayside have found no evidence that any materials were missing at the time of the review. The Inquiry may wish to direct this question to the RCS Review Team, who would be best placed to provide clarification.

140. What role were patients or their representatives permitted to play in the compilation of the report and why?

140.1 No patients or their representatives were interviewed or examined during the course of the Invited Review visit as stated [NHST-00072_6]. NHS Tayside would direct the Inquiry to the RCS Review Team to consider this question.

141. What were the main conclusions/ recommendations of the report and what was the reasoning behind these conclusions/ recommendations?

141.1 As *NHST-00073* is a draft report prepared for factual accuracy checking, it does not contain any conclusions or recommendations. The Inquiry may wish to direct this question to the RCS Review Team, who would be best placed to provide clarification.

142. What action was taken by NHST as a result of the interim report being completed and why?

142.1 As indicated in the response to Question 141, the draft report was prepared for factual accuracy checking and therefore did not contain any recommendations to act upon. NHS Tayside therefore holds no evidence of actions taken as a result of this draft report.

(c) Final report of NHS Tayside relating to Mr Eljamel from December 2013

143. What further report was compiled within NHST in December 2013, in light of the Royal College's findings and conclusions? By whom was any such report prepared?

143.1 NHS Tayside refers the Inquiry to the response provided to Question 133.

144. How were the findings of the RCS and/ or any report compiled by NHST disseminated (a) internally within NHST and/ or (c) to patients or their representatives?

144(a).1 The Medical Director received the RCS report [*NHST-00072*] on 9 December 2013 via Royal Mail First Class mail [*NHST-04469*]. The report was shared the same day with the Associate Medical Director, Surgery and the General Manager, Specialist Services [*NHST-04468*]. The report has been shared many times internally since then for various reasons.

144(b).1 NHS Tayside has no record of the RCS report [NHST-00072] being disseminated to patients or their representatives in light of the RCS findings.

145. What was the remit of any further report which was commissioned and why was the remit set as it was?

146. What materials were made available to those involved in preparing any further NHST report when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the report to be fulfilled?

147. To what extent were materials missing at that time, which would otherwise have been relevant to the remit of the report?

148. What role were patients or their representatives permitted to play in the compilation of any further report and why?

149. What were the main conclusions/ recommendations of any further report and what was the reasoning behind these conclusions/ recommendations?

150. What action was taken by NHST as a result of any further report being completed and why?

145.1 In relation to Questions 145, 146, 147, 148, 149 and 150, NHS Tayside has no record of any further report commissioned in light of the RCS report. The Medical Director in post at the time would be best placed to provide clarification on this matter.

(d) The NHS Tayside review of spinal cases from 2010 to 2013, a direct recommendation from the RCS review (NHST-00076, page 14)

151. Why was it thought appropriate for a further review to be undertaken at that time?

151.1 The RCS report recommended that a review of Mr Eljamel's spinal surgery cases be undertaken to ensure there were no wrong-site surgeries that had gone unaddressed. The recommendation was to review such cases from the past three years, with scope to extend if further issues were identified and ensuring that any affected patients were informed and considered for further treatment [NHST-00072].

- 151.2 The authors of the RCS report would be best placed to provide further commentary on why it was considered appropriate for this review to be undertaken at that time. Given the recommendation by the RCS report [NHST-00072], NHS Tayside undertook the review.

152. How and why were the case selected? What proportion of the total number of spinal cases undertaken by Mr Eljamel did these 150 cases represent?

- 152.1 Information as to the cases selected for review is set out in NHS Tayside's Due Diligence Review [NHST-00075]. It is stated that the Clinical Management Team assessed the cohort of patients and agreed to review high-risk patients who had undergone spinal surgery by Mr Eljamel in the three-year period 2010 to 2013, and who had been referred to the Chronic Pain clinic in NHS Tayside for ongoing care at some point post-surgery. 150 patients were identified. Of these, 131 patients agreed to be reviewed [NHST-00075_29].
- 152.2 NHS Tayside does not hold the exact number of spinal cases undertaken by Mr Eljamel during his employment in NHS Tayside from 1995 to 2014. Therefore, it is not possible to confirm what proportion the selected 150 cases represent without reviewing all available medical records of former patients treated by Mr Eljamel.

153. By whom was the review undertaken?

- 153.1 The review was undertaken by Mr David Mowle, Consultant Neurosurgeon, NHS Tayside.

154. Why was an independent review not considered appropriate?

- 154.1 NHS Tayside has no evidence or documentation to explain why an independent review was not considered at the time. The Medical Director in post at the time would be best placed to provide clarification on this matter.

155. What was the remit of the review which was commissioned and why was the remit set as it was?

155.1 The remit of the review [NHST-01666] commissioned was to undertake a case note and clinical review for the spinal surgery patients identified who agreed to individual review by a neurosurgeon at a clinical consultation. The Medical Director in post at the time would be best placed to explain why this remit was set.

156. What materials were made available to those involved in preparing the report when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the report to be fulfilled?

157. To what extent were materials missing at that time, which would otherwise have been relevant to the remit of the report?

158. What role were patients or their representatives permitted to play in the compilation of the report and why?

159. What were the main conclusions/ recommendations of the report and what was the reasoning behind these conclusions/ recommendations?

156.1 In relation to Questions 156-159, NHS Tayside does not hold a formal report in relation to this review. This is because the review undertaken was a case note and clinical review for patients who wished to see a Neurosurgeon and have a clinical consultation. The outcomes of such a review would be in the individual patient's record. The Consultant Neurosurgeon who undertook this review, Mr David Mowle, would be best placed to provide clarification on this matter.

160. What action was taken by NHST as a result of the spinal cases review report being completed and why?

161. How was the report of this review (a) disseminated within NHST (b) disseminated to patients/ their representatives?

160.1 In relation to Questions 160 and 161, NHS Tayside does not hold a formal report in relation to this commission. This is because the review undertaken was a case note and clinical review for patients who wished to see a Neurosurgeon and have a clinical consultation. The Medical Director in post at the time would be best placed to provide clarification on this matter.

(e) The NHS Tayside review of complainant cases relating to Mr Eljamel 2014/15

162. Why was it thought appropriate for a further report to be prepared at that time?

162.1 As stated within NHS Tayside's Due Diligence Review [NHST-00075_30] the General Manager for Specialist Services and the Neurosurgical Clinical Lead carried out reviews of the care and treatment of patients who came forward to NHS Tayside to complain or request a review during 2014/2015. They also completed reviews of historic complaints, and of any other patients identified as possible wrong-site lumbar surgery cases.

162.2 This was not a single review, but a series of case-by-case reviews undertaken as and when patients came forward to request a review or complain during 2014/2015. Therefore, there was no single commissioned report.

163. By whom was the report commissioned and prepared?

163.1 Please see response to Question 162.

164. Why was an independent review not thought appropriate?

164.1 The General Manager and Neurosurgical Clinical Lead in post at the time would be best placed to respond to why an independent review was not thought to be appropriate.

165. What was the remit of the report which was commissioned and why was the remit set as it was? On what basis were the cases which were looked at selected?

166. What materials were made available to those involved in preparing the report when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the report to be fulfilled?

- 167. To what extent were materials missing at that time, which would otherwise have been relevant to the remit of the report?
- 168. What role were patients or their representatives permitted to play in the compilation of the report and why?
- 169. What were the main conclusions/ recommendations of the report and what was the reasoning behind these conclusions/ recommendations?
- 170. What action was taken by NHST as a result of the further report being completed and why?

165.1 In response to Questions 165-170, please refer to the answers provided to Questions 162 and 163 for further detail. This was not a single report, but a series of case-by-case reviews undertaken as and when patients came forward to request a review or complain during 2014/2015.

165.2 The General Manager and Neurosurgical Clinical Lead in post at the time would be best placed to provide clarification on this matter. Given this was not a report, instead a series of reviews, patients or their representatives were not involved in the compilation of a report.

(f) The External Review by the Executive Medical Director of NHS Lothian to review the process and decision-making regarding the management of Mr Eljamel 2018/2019

171. Why was the NHS Lothian report commissioned by NHST why was it commissioned when it was?

171.1 The report was commissioned following enquiries regarding Neurosurgery and Mr Eljamel [NHST-01468]. NHS Tayside does not know what specific enquiries the commissioning email refers to.

171.2 The above report was commissioned to undertake a desktop review of NHS Tayside's handling of the case involving Mr Eljamel. The purpose was to determine whether the actions taken by NHS Tayside were reasonable, timely and appropriate [NHST-01578]. Furthermore, the report was to examine the process and decision making in relation to the handling of complaints about Mr Eljamel, and to determine if further data should be sought and if there were any future improvements that NHS

Tayside could make to improve learning for the Board [NHST-01468]. The report was commissioned in response to correspondence from the Health Secretary [NHST-04712] seeking assurance on the mechanism in place for reviewing complaints of professional practice and how Boards were assured of the safety and quality of surgical practices of its employees, and the airing of the BBC Documentary “Harmed by my Surgeon” in September 2018.

172. By whom was the report commissioned?

172.1 The report was commissioned by Annie Ingram, Deputy Chief Executive, NHS Tayside, on behalf of Malcolm Wright, Chief Executive, NHS Tayside [NHST-01468].

173. Why was it thought appropriate/ necessary to ask NHS Lothian to prepare the report at that time?

173.1 NHS Tayside has no evidence or documentation to explain why it was thought appropriate/necessary to ask NHS Lothian to prepare a report at that time in addition to the information already provided in the response to Question 171. It is likely that it was considered that an external assessment from out with NHS Tayside would strengthen the report. NHS Tayside would direct the Inquiry to Malcolm Wright, Chief Executive and/or Annie Ingram, Deputy Chief Executive who would be best placed to provide further clarification on this matter.

174. What was the remit of the report which was commissioned and why was the remit set as it was?

174.1 The remit of the commissioned report was to undertake a desktop review of NHS Tayside’s handling of the case involving Mr Eljamel to determine whether the action taken by the Board was reasonable, timely and appropriate, and that this should include a review of the timeline of events, a review of the Board’s handling of complaints and the action taken. The review was to establish if any further data should be sought and identify areas for improvement. [NHST-01578].

174.2 NHS Tayside would direct the Inquiry to Malcolm Wright, Chief Executive and/or Annie Ingram, Deputy Chief Executive who would be best placed to provide clarification on why the remit was set as it was.

175. What materials were made available to NHS Lothian when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the report to be fulfilled?

175.1 The materials made available to NHS Lothian are listed in the report [NHST-01578_1-2]. The report consisted of a desktop review of documents held and interviews with four members of staff on 23 November 2018. The documents provided addressed three topics:

175.2 *“1. Concerning investigations of the incidents and complaints:*

- *A spreadsheet of patients involved in the recall exercise.*
- *A significant clinical event analysis (2012, case 33) and the tabular timetable used as part of the root cause analysis.*
- *Details of the adverse events contained within the Datix System printed in October 2018.*

2. Concerning the investigation of the individual:

- *A letter from Mr Philip McLaughlin to Mr Eljamel dated 21 June 2013.*
- *The interim letter from the RCS dated 4 October 2013.*
- *The final report from the RCS dated 6 December 2013.*
- *A letter from Dr Andrew Russell to the GMC (Mr Willie Paxton) dated 20 December 2013.*
- *A letter from Dr Andrew Russell to Professor John Connelly in his university role dated 17 February 2014.*
- *A letter from Dr Russell dated 17 February 2014 to the GMC explaining that in view of Mr Eljamel's notification of intention to retire, NHS Tayside was not pursuing a formal investigation.*
- *Details of the GMC entry and conditions placed on the registration of Mr Eljamel from 26 February 2014.*

3. NHS Tayside's reflections and learning:

- *A letter from Dr Lee Jordan concerning his initial and final observations.*
- *An SBAR (Situation, Background, Assessment, Recommendations) Briefing report provided to the Chief Executive and Chairman dated 1 August 2018.”*

175.3 NHS Tayside would direct the Inquiry to Malcolm Wright, Chief Executive and / or Annie Ingram, Deputy Chief Executive who would be best placed to provide clarification about why these materials were considered to be what was needed for the remit of the report to be fulfilled.

176. To what were (sic) extent were materials missing at that time, which would otherwise have been relevant to the remit of the report?

176.1 NHS Tayside is unaware of any evidence or documented assessment indicating that any materials were missing at the time of the review. The Inquiry may wish to direct this question to Malcolm Wright, Chief Executive and / or Annie Ingram, Deputy Chief Executive, who were involved in the commissioning of the report.

177. What role were patients or their representatives permitted to play in the compilation of the report and why?

177.1 The report was a desktop review of NHS Tayside's handling of the case involving Mr Eljamel. Involvement of patients or their representatives was not within the scope of the review. NHS Tayside would direct the Inquiry to Malcolm Wright, Chief Executive and / or Annie Ingram, Deputy Chief Executive who would be best placed to provide clarification about why patients or their representatives were not involved.

178. What were the main conclusions/ recommendations of the report and what was the reasoning behind these conclusions/ recommendations?

178.1 Observations along with seven recommendations (set out below) were stated in the report which is referred to for its terms [NHST-01578].

178.2 “Recommendations:

- *NHS Tayside might consider their current processes and test out whether they believe and can evidence that these events would be identified earlier or handled differently.*
- *NHS Tayside should consider its SAE policy and whether there are opportunities to strengthen this, and to consider the effect on the investigation of participation of individuals responsible for the care of the patient in a roundtable type approach.*
- *I have not undertaken detailed examination of any focus groups held with trainees, or individual pieces of feedback, but would recommend that NHS Tayside has a clear system in place to ensure that any adverse or concerning comments identified by trainees regarding individual consultant behaviour in any specialty have a level of visibility within the organisation rather than solely within an educational line.*
- *Should a patient recall need to be undertaken of any significant volume then a formalised structure (such as an incident management team approach) should be used for this to provide structure, additional resource, and oversight, through a formal reporting mechanism.*
- *In the future should NHS Tayside have cause to restrict or place a consultant under similar conditions, I recommend there is greater clarity about what is meant by restricted practice. There is clearly a balance to be struck between confidentiality and acknowledgement that during a process of investigation concerns are being explored and may not be substantiated, and the need to ensure that the safest possible patient care is undertaken.*
- *With appropriate regard to the duty of care owed to individuals, NHS Tayside should consider how to ensure that appropriate dissemination of such reports is undertaken, with discussion of necessary actions with clinical teams, for subsequent reporting for oversight and assurance at the relevant governance committee.*

- *The Responsible Officer in NHS Tayside is notified when any doctor connected to them applies for voluntary erasure through current processes and there is a short period (ten days) to indicate to the GMC that there are concerns under investigation to ensure that voluntary erasure does not proceed. I recommend that the RO reviews internal processes to ensure that any necessary action to communicate with the GMC can be taken within the short timeline.”*

178.3 NHS Tayside would direct the Inquiry to the author of the report, Tracey Gillies, who would be best placed to explain the reasoning behind these observations and recommendations.

179. What action was taken by NHST as a result of the report being received and why?

179.1 The then Medical Director, Professor Peter Stonebridge, asked the Associate Medical Director for Medical Workforce, Dr Elaine Henry, to map out an action plan following receipt of the report, in response to its recommendations [NHST-01631].

179.2 The action plan [NHST-01631] which was developed contained actions in eight areas in response to the report's recommendations:

1. Culture of Neurosurgical Unit
2. Appraisal and revalidation
3. Significant Adverse Event Policy
4. Interactions with trainees
5. Patient recall exercise
6. Restriction and supervision of practice
7. RCS Report regarding the practice of Mr Eljamel
8. Communications timelines with regulatory bodies

179.3 NHS Tayside holds no record of monitoring of the actions relating to the action plan. This was previously noted in the NHS Tayside Due Diligence review [NHST-00075]. NHS Tayside has been unable to identify any documentation that evidences formal monitoring of the action plan and are therefore unable to confirm where or through which governance route the actions were monitored.

(g) The Scottish Government Review of Unresolved and Outstanding Concerns regarding Mr Eljamel, Former Consultant Neurosurgeon at NHS Tayside 2022

180. Why was the Scottish Government review commissioned when it was?

180.1 The Scottish Government Review of Unresolved and Outstanding Concerns [NHST-04351] regarding Mr Eljamel was commissioned by the Scottish Government in 2022. NHS Tayside would direct the Inquiry to the Scottish Government, who would be best placed to answer this question.

181. By whom was the review commissioned?

181.1 The Scottish Government Review of Unresolved and Outstanding Concerns [NHST-04351_2] states that Jeane Freeman, former Cabinet Secretary for Health and Sport, commissioned this review.

182. What were the “*outstanding questions and unresolved concerns of two patients which was shared with NHS Tayside in August 2022*” (NHST-00076, page 2)?

182.1 NHS Tayside would direct the Inquiry to the Scottish Government, who would be best placed to answer this question.

183. Who were the two patients?

183.1 The review concerned two former patients of Mr Eljamel who had been in communication with the Scottish Government regarding the care and treatment they received from him. The two patients were Jules Rose and Patrick Kelly.

184. Why was it thought appropriate/ necessary for the Scottish Government to undertake such a review?

184.1 NHS Tayside would direct the Inquiry to the Scottish Government who would be best placed to answer this question.

185. What was the remit of the review which was commissioned and why was the remit set as it was?

185.1 NHS Tayside would direct the Inquiry to the Scottish Government who would be best placed to answer this question.

186. What materials were made available to the Scottish Government when the review was commissioned? Why were those materials considered to be what would be needed for the remit of the review to be fulfilled?

186.1 NHS Tayside includes with this submission an email trail [NHST-01677] between NHS Tayside and Professor Craig White of the Scottish Government, which includes the list of documents that NHS Tayside provided for the review.

186.2 The documents shared with the Scottish Government are: *NHST-01630; NHST-01549; NHST-01657; NHST-01687; NHST-01686; NHST-01658; NHST-01685; NHST-01506; NHST-01566; NHST-01564; NHST-01659; NHST-01660; NHST-01656; NHST-01688; NHST-01689 and NHST-01658*. Within *NHST-01677* there is reference made to emails that were shared with the Scottish Government, (number fourteen in the list of documents). NHS Tayside has undertaken searches to track down those emails but has been unable to identify which emails were shared.

186.3 Health records for Patients A and B (Jules Rose and Patrick Kelly) were also shared with the Scottish Government via Objective Connect.

186.4 The remit of the review was set by Scottish Government, and the materials provided were requested by Scottish Government as set out in the terms of reference.

187. To what were (sic) extent were materials missing at that time, which would otherwise have been relevant to the remit of the review?

187.1 NHS Tayside does not hold any evidence or documented assessment of whether or not materials were missing at the time of the Scottish Government's review. NHS Tayside would direct the Inquiry to the Scottish Government who would be best placed to answer this question, if it considered that materials which would have been relevant were missing.

188. What role were patients or their representatives permitted to play in the review and why?

188.1 NHS Tayside would direct the Inquiry to the Scottish Government who would be best placed to answer this question.

189. What were the main conclusions/ recommendations of the review and what was the reasoning behind these conclusions/ recommendations, for NHST, the Board of NHST the Scottish Government (see NHST-00076, page 2)?

189.1 The main conclusions and recommendations are stated within the Scottish Government Review of Unresolved and Outstanding Concerns [NHST-04351]. To understand the reasoning behind those conclusions and recommendations, NHS Tayside would direct the Inquiry to the Scottish Government and to the two independent Neurosurgeons who undertook the review. The recommended actions for NHS Tayside, Scottish Government and NHS Scotland are detailed below.

“Recommended Actions

Recommended Actions for NHS Tayside

62. There should be mechanisms in place to ensure that anyone with an ongoing concern, interest or need for updates on the way in which learning, change and improvement actions are being implemented can access this information and any support required.

63. *NHS Tayside should review the way in which it identifies and measures the implementation and effectiveness of actions arising from internal and external review processes such as those commissioned in respect of Professor Eljamel's practice. This should include action plan content and subsequent relevant assurance through clinical governance processes to the Board's delegated committee with responsibility for clinical governance. This should be overseen by clinicians with lead responsibility for clinical governance in services.*

64. *NHS Tayside should outline what arrangements they have in place to ensure that all patients returning to theatre within 30 days are identified and discussed through relevant governance and improvement support processes.*

65. *A session should be offered by the Chair and Chief Executive of NHS Tayside to Mr. Kelly and Ms. Rose to discuss their experiences and consider ways in which the learning from all of the various reviews (and this report) can be implemented and provide robust assurance that changes made are resulting in reliable delivery of these processes. This should also consider any further action that can be taken to investigate areas of ongoing concern such as the involvement of a Consultant Urologist in Mr. Kelly's surgery and the unanswered questions in respect of any staff recollections recorded at the time in respect of Mr. Kelly's surgery.*

66. *Ms. Rose should receive an apology for the risks to patient safety that resulted from the decision-making about the scope and practical arrangements for the supervision of Professor Eljamel.*

67. *NHS Tayside should consider whether the current implementation of medical appraisal processes are sufficiently robust to ensure that the issues identified through the reviews relating to Professor Eljamel's practice are considered and captured in appraisal discussions and documentation, including the improved clinical governance processes that were reported to the Scottish Government in 2018.*

68. *NHS Tayside should ensure that Mr. Kelly and Ms. Rose are receiving the appropriate professional care and support to consider ways in which the significant distress associated with their experiences of being treated by Professor Eljamel can be addressed. It should be recognised that this may need to be supported by an appropriately skilled clinician who understands and is able to assist them in making*

sense of the links between their physical health, experiences of prior aspects of their care by Professor Eljamel and their beliefs about the causal and contributory factors to their experiences. This should include consideration of any interventions with the potential to consider workable and effective ways of minimising the ongoing negative and distressing impact of their experiences.

69. NHS Tayside should recognise that it is only through respectful, personalised and ongoing dialogue with Mr. Kelly and Ms. Rose that some of the unresolved and significant questions can be addressed in ways that help with the process of making sense of personally traumatic experiences.

Recommended Actions for Scottish Government

70. Develop a process for the commissioning independent clinical reviews that is standardised across the DG Health and Social Care and available for officials to implement against agreed timescales and to take account of specific issues arising in procuring independent clinical advice.

71. Ensure that officials working across a range of policy areas implicated by this review are aware of the recommended actions and that responses inform further actions that form part of the cycle of review and assurance provided to Ministers in respect of quality and performance of the Board's services.

72. Require that NHS Tayside submit an action plan with appropriate measures of implementation and effectiveness in relation to the actions that will be taken in response to this review process.

Recommended Action for NHS Scotland (from consultant neurosurgeons)

73. Establish a regional or national pathway for orbital tumours that identifies those with experience, clinical, surgical and radiological, in this area and encourages shared experience with opportunity for discussion and joint operating.

74. Guidelines for Consultant Supervision should be developed for NHS Boards where there is a need to implement supervision of a clinician following concerns in respect to the aspects of practice of Professor Eljamel that were inadequate.

75. Consider joining the National Neurosurgical Audit Programme.

Conclusion

76. NHS Tayside and Scottish Government should consider these recommended actions and provide Mr. Kelly and Ms. Rose with copies of actions plans that include measures of implementation and effectiveness for all actions identified and a clear description on how assurance of effective implementation will be measured and reported on.

77. We would like to thank Mr. Kelly and Ms. Rose for their contributions to this review. Contributions that were often and understandably very upsetting – and that both continue to experience significant levels of trauma, distress and impairment in their quality of life; highlighting the impact of the unresolved questions raised by their experiences and need for supportive dialogue and assurances of learning, change and improvement. We are also grateful to NHS Tayside for providing information requested during this review process and to the two independent Consultant Neurosurgeons for their work on the casenote review.”

190. What action was taken by NHST as a result of the review being received and why?

190.1 NHS Tayside accepted the eight recommendations of the Scottish Government review.

190.2 The proposed actions in relation to the recommendations were presented to the Care Governance Committee on the 1 December 2022 [NHST-04689]. All actions were in direct response to the recommendations.

190.3 Four of the actions were related to the two patients who were the subject of the review. A meeting with the two patients took place in October 2022 [NHST-01692] and the actions have been completed. They are as follows:

1. Mechanisms in place for anyone with an ongoing concern, interest or need for updates on the way in which learning, change and improvement actions are being implemented, can access this information and any support needed.

The Medical Director commissioned a review of the Complaints and Feedback process.

2. Review the way in which NHS Tayside supply action plans and subsequent relevant assurance from reviews through clinical governance processes to the Board's delegated committee.

The Care Governance Committee will receive progress reports, updates and action plans by request and completed action plans for assurance on effectiveness of implementation.

3. Ensure all patients returning to theatre within thirty days of original operation are identified and discussed through relevant governance and improvement processes.

A Standard Operating Procedure [NHST-04690] was established and implemented to highlight patients unexpectedly returning to theatre, with relevant clinical governance groups scrutiny and any learning gleaned from these cases.

4. Consider if medical appraisal is robust to ensure issues found by reviews about individuals' practice is considered and captured in appraisal discussions and documentation with improved clinical governance processes.

- 190.4 There are now strengthened governance structures in place including an alert system which triangulates issues of complaint and concerns about a clinician's performance from several systems including safety incidents, university concerns, peer concerns, legal issues, HR (Human Resource) concerns and other routes such as whistleblowing. This has been strengthened further by establishment of a Responsible Officer Advisory Group (ROAG), which had its first meeting on 11 August 2022 [NHST-04787].

191. In particular, at NHST-00075, page 31/32, it is stated that:

“The due diligence review has identified that the Board Medical Director commissioned an Action Plan in June 2019 in response to the recommendations made in Ms Gillies’ review. The action plan was developed

and it was stated that there would be a report completed within 6 months detailing what actions had subsequently been taken. The review has identified no follow-up to the action plan through formal Tayside NHS Board or service level governance processes and therefore no confirmation that the recommendations were addressed and implemented adequately.”

(a) What steps were included in the action plan?

191(a).1 On review of the action plan developed in response to the NHS Lothian report by Tracey Gillies [NHST-01578], eight observations and recommendations were identified. This action plan [NHST-01631] was developed by Dr Elaine Henry Associate Medical Director for Medical Workforce and presented to the Medical Director Professor Peter Stonebridge.

(b) Why were they so included?

191(b).1 The eight observations and recommendations relate directly to the recommendations contained within the NHS Lothian report by Tracey Gillies [NHST-01578].

(c) What action was taken to implement the action plan and why?

191(c).1 NHS Tayside does not hold any documentation or evidence that describes the action taken to implement the action plan and why. NHS Tayside would direct the Inquiry to the Medical Director in post at the time, who would be best placed to answer this question.

192. Further, at NHST-00076, page 3, it is stated that:

“Since the publication of the Scottish Government review in 2022 and the subsequent meeting and ongoing engagement with the two patients involved, the Chief Executive and Board Executive Medical Director commissioned a programme of work to gain a better organisational understanding of NHS Tayside’s decision-making relating to Professor Eljamel and the subsequent

actions taken to respond to previous external reviews and actions to address unresolved ongoing concerns by former patients.

The Chief Executive and Executive Medical Director identified that there was no single, comprehensive archive or document store recording events and decisions relating to Professor Eljamel and therefore an information store was established for all documentation held by NHS Tayside.”

(a) Why was the programme of work commissioned at that time?

192(a).1 As stated within *NHST-00076_3*, the Chief Executive and Executive Medical Director identified that there was no single, archive or document store recording events and decisions relating to Mr Eljamel and therefore an information store was established for all known documentation held by NHS Tayside at the time. This store of information is held by the Patient Liaison Response Team (PLRT) and has been since the creation of PLRT in March 2023.

(b) What did the programme of work comprise?

192(b).1 The programme of work undertaken was to identify and catalogue all documents relating to Mr Eljamel that were known at the time to the organisation.

(c) Please provide an inventory of the documents in the information store and an explanation of the efforts undertaken to compile it.

192(c).1 NHS Tayside has provided the Inquiry with an overview of the evidence inventory [*NHST-01682*] compiled regarding the known corporate documents relating to Mr Eljamel that are held. The inventory was compiled based on the documents that were provided to the Patient Liaison Response Team by the corporate team, namely members of the Executive Team of NHS Tayside. It also contains information that was collated for the purposes of the 2023 Due Diligence Review [*NHST-00075*].

192(c).2 NHS Tayside continues to add to this inventory as more documents of relevance are located in the course of its work for this Inquiry.

(d) Why was there no comprehensive archive of documents relating to Mr Eljamel, given the number of investigations and reviews which had been

undertaken concerning him and the systems surrounding him since his resignation in May 2014?

192(d).1 NHS Tayside does not hold any documentation or evidence that explains why there was no comprehensive archive of documents relating to Mr Eljamel prior to 2022. Whilst there was no comprehensive archive of documents, NHS Tayside did retain documents that were related to Mr Eljamel. These documents, whilst not held centrally, were retained in the relevant departments and/or offices that they were created in or related to.

193. By whom was mediation carried out relating to the outstanding concerns of the two patients (see NHST-00076, pages 2-3)?

193.1 The mediation was carried out by Mr Murray Anderson-Wallace.

(h) The NHS Tayside Executive Medical Director Response to Patient A on undertaking a detailed review of surgery carried out and matters arising in theatre 2023

194. Who was patient A? Why was the review of the case of patient A and why was it commissioned when it was?

194.1 Patient A was Patrick Kelly.

194.2 A recommendation from the Scottish Government Review of Unresolved and Outstanding Concerns regarding Mr Eljamel, dated May 2022 [NHST-04351] was that both patients “should be offered a session with the Chair and Chief Executive of NHS Tayside to discuss their experiences, this report and how further change, learning and improvement can be put in place.”

194.3 A meeting took place on 4 October 2022 [NHST-01692]. An output of this meeting was that the then Medical Director would look into the circumstances around Patient A’s surgery – Patient A being a former patient of Mr Eljamel - and try to ascertain what happened on the day of his surgery, and to contact any staff who may have

been in theatre that day. The Medical Director agreed to get back to Patient A regarding this in due course.

195. By whom was the review commissioned and carried out? Why was an independent review not thought appropriate?

195.1 The review was commissioned by the Medical Director in post at that time, Dr Pamela Johnston [NHST-01672].

195.2 The review was carried out by Mr David Bennett, Consultant Neurosurgeon & Clinical Lead; Ms Heinke Pulhorn, Consultant Neurosurgeon; Dr Sanjay Pillai, Consultant Interventional Radiologist, and Dr Avinash Kanodia, Consultant Neuroradiologist. Mr Sean McArtney, Acute Operational Nurse Director, was also involved and met with some of the staff who were present in theatre on the day of the patient's procedure in relation to any recollection they may have regarding the patient's surgery [NHST-01672].

195.3 NHS Tayside does not hold any documentation or evidence that describes why an independent review was not commissioned. It is likely that those undertaking the review would be deemed to have sufficient skills to be able to provide an assessment. NHS Tayside would direct the Inquiry to the Medical Director in post at the time as the person best placed to answer this question.

196. Why was it thought appropriate/ necessary for such a review to be undertaken at that time?

196.1 On review of the draft file note from the meeting on 4 October 2022 [NHST-01692], such a review is recorded as an agreed outcome of the meeting. It also states in the draft file note from the meeting on 4 October 2022 [NHST-01692] that it was acknowledged that this meeting had been at the request of the Cabinet Secretary following the Scottish Government Review of Outstanding and Unresolved Concerns, 2022 [NHST-04351].

197. What was the remit of the review which was commissioned and why was the remit set as it was? In particular, why was a more wide reaching review of cases of former patients of Mr Eljamel not commissioned at that time?

197.1 On review of the draft note file for the meeting held on 4 October 2022 [NHST-01692], it was agreed that the then Medical Director would look into the circumstances around Patient A's surgery to try and ascertain what happened on the day of their surgery and would also try where possible to contact any staff who may have been in theatre that day. On this basis, the remit of the review commissioned was formed.

197.2 NHS Tayside does not hold any documentation or evidence that describes why a more wide-reaching review of cases of former patients was not commissioned. NHS Tayside directs the Inquiry to the Medical Director in post at the time who would be best placed to answer this question. The review was as a direct result of a recommendation in the Scottish Government report [NHST-04351] relating to a single patient. There was not recommendation to undertake a wider review beyond those already undertaken.

198. What materials were made available when the review was commissioned? Why were those materials considered to be what would be needed for the remit of the review to be fulfilled?

198.1 The materials that were made available when the review was commissioned are documented in a letter sent from the then Medical Director to Patient A dated 23 February 2023 [NHST-01672]. It is recorded there that the medical records, operation note and imaging relating to Patient A's surgery were reviewed.

198.2 NHS Tayside does not hold any documentation or evidence for the reason why those materials were considered to be what was needed for the remit of the review to be fulfilled. NHS Tayside directs the Inquiry to the Medical Director in post at the time who would be best placed to answer this question.

199. To what were (sic) extent were materials missing at that time, which would otherwise have been relevant to the remit of the review?

199.1 NHS Tayside does not hold any evidence or documented assessment of whether or not materials were missing at that time of the review relating to Patient A. NHS Tayside directs the Inquiry to the Medical Director in post at the time who would be best placed to answer this question.

200. What role were patient A or their representatives permitted to play in the review and why?

200.1 The role Patient A or their representatives were permitted to play in the review is described in the letter [NHST-01672] sent to the patient on 23 February 2023. It stated that Patient A submitted questions via email dated 11 January 2023 [NHST-01695]. These questions were responded to in the letter [NHST-01672_3-4]. NHS Tayside directs the Inquiry to the Medical Director in post at the time who would be best placed to answer why Patient A or their representative were permitted to participate in the review to this extent.

201. What were the main conclusions/ recommendations of the review and what was the reasoning behind these conclusions/ recommendations?

201.1 The review was commissioned to address specific questions raised by Patient A and did not include any conclusions/recommendations or actions for NHS Tayside. However, the letter to Patient A dated 23 February 2023 [NHST-01672_3-4] sets out the questions asked by Patient A and NHS Tayside's response to those questions and the reasoning behind the response.

202. What action was taken by NHST as a result of the review being received and why?

202.1 The review was commissioned to address specific questions raised by Patient A and did not include any recommendations or actions for NHS Tayside.

(i) The NHS Tayside look back at operative cases during the period of Mr Eljamel's supervision (21 June 2013 to 10 December 2013) June 2023

203. To which patients did this review relate? Why was the review of the case of patient A and why was it commissioned when it was?

203.1 This review, dated June 2023, related to 104 patients involved in operations undertaken during Mr Eljamel's period of supervised practice, 21 June 2013 to 10 December 2013, prior to his formal suspension [NHST-01667; NHST-01668].

203.2 NHS Tayside understands that the second part of this question refers to "The NHS Tayside Executive Medical Director Response to Patient A on undertaking a detailed review of surgery carried out and matters arising in theatre 2023". NHS Tayside would direct the Inquiry to the response to Questions 194-202 for further detail.

204. By whom was the review commissioned and carried out? Why was an independent review not thought appropriate?

204.1 The review was commissioned by the Medical Director in post at the time, Dr Pamela Johnston. NHS Tayside understands that it was commissioned as a subset of NHS Tayside's Due Diligence review. The review was undertaken by a Senior Orthopaedic Surgeon in a senior medical leadership position, who was independent from the Neurosurgical department. NHS Tayside does not hold any documentation or evidence to understand why an independent review separate from NHS Tayside was not thought appropriate. It is likely that the person identified to undertake the assessment was felt to be sufficiently removed to provide an objective assessment. NHS Tayside would direct the Inquiry to the Medical Director in post at the time, who would be best placed to provide further information to answer this question.

204.2 The review was carried out by Mr Ben Clift, Associate Medical Director for Medical Workforce and Consultant Orthopaedic Surgeon.

205. Why was it thought appropriate/ necessary for such a review to be undertaken at that time?

205.1 NHS Tayside does not hold any documentation or evidence to understand why it was thought to be appropriate/necessary for the review to be undertaken. NHS Tayside would direct the Inquiry to the Medical Director in post at the time, who would be better placed to answer this question.

206. What was the remit of the review which was commissioned and why was the remit set as it was? In particular, why was a more wide reaching review of cases of former patients of Mr Eljamel not commissioned at that time?

206.1 NHS Tayside would direct the Inquiry to the response provided to Question 203 which describes the remit of the review.

206.2 NHS Tayside would direct the Inquiry to the Medical Director in post at the time, who would be better placed to answer why the remit was set as it was and why a more wide-reaching review of cases was not commissioned at the time.

207. What materials were made available when the review was commissioned? Why were those materials considered to be what would be needed for the remit of the review to be fulfilled?

207.1 This review was a retrospective review of operative cases. To complete the review, the relevant materials made available were patients' medical records, including operation notes, as these were deemed relevant to fulfil the remit of the review.

208. To what extent were materials missing at that time, which would otherwise have been relevant to the remit of the review?

208.1 In reviewing the evidence referenced in response to Question 203, NHS Tayside notes that at the time of the review, 26 of the 111 patient records had been destroyed in accordance with NHS Tayside's records retention policy.

209. What role were interested patients or their representatives permitted to play in the review and why?

209.1 The review was a retrospective review of operative cases. There is no record of the involvement of patients or their representatives in the process. NHS Tayside would direct the Inquiry to the author and commissioner of the report who would be better placed to answer this question.

210. What were the main conclusions/ recommendations of the review and what was the reasoning behind these conclusions/ recommendations?

210.1 The following main conclusions and findings are detailed within the report *NHST-01668_1*.

- *“The note keeping and physical state of the paper records is generally of a high standard. There were very few sets of notes that were presented in a disorganised way.*
- *Mr Eljamel was clearly involved consistently in the preoperative decision making, most of the consenting, the actual surgery, and the postoperative review. This is in both dictated and handwritten entries.*
- *The consenting generally describes the risk and nature of ‘standard’ complications, as is appropriate.*
- *There is no physical record of consistent formal supervision in these notes, which is not to say that some sort of oversight was not taking place.*
- *Some of the issues related to outcome are difficult to phrase simply, as a number of these cases relate to chronic incurable conditions, with no hard ‘good/bad’ clinical endpoint.*
- *The clinical case mix as far as I can see, was a range of general neurosurgical problems, including some relatively complex cases*
- *There is evidence of appropriate collaboration with other specialties, such as endocrinology, psychiatry, Ear Nose Throat (ENT) and similar”*

211. What action was taken by NHST as a result of the review being received and why?

211.1 The findings from this review were incorporated into the Due Diligence review report of 25 August 2023 [NHST-00075] and subsequently presented to the NHS Tayside Board.

(j) The NHS Tayside due diligence review of documentation held relating to Mr Eljamel dated 25 August 2023 and the NHS Tayside Executive medical director report relating to Mr Eljamel dated 25 August 2023

212. Why was it thought appropriate for a further review to be prepared?

212.1 In the Due Diligence Review report dated 23 August 2023 [NHST-00075_4], it is noted that the review was commissioned by the Executive Medical Director in response to an increasing number of ongoing and unresolved queries and concerns raised by former patients of Mr Eljamel. It is also noted that the aim of the review was to enable the Medical Director to provide a fresh assessment to the board of the professional, clinical and corporate governance position relating to Mr Eljamel's tenure, with associated recommendations and actions for the Board for assurance and ongoing monitoring. For further response to this question, NHS Tayside would direct the Inquiry to the Executive Medical Director in post at the time.

213. By whom were the reports commissioned and prepared?

213.1 The review was commissioned by the Executive Medical Director in post at the time, Dr Pamela Johnston.

213.2 The Due Diligence Review report dated 23 August 2023 [NHST-00075] was prepared by the Associate Medical Director for Clinical Governance in post at the time, Dr Sharon Hilton-Christie, and the Associate Medical Director for Quality Management in post at the time, Mr Shobhan Thakore. The Executive Medical Director prepared a report of Findings and Recommendations dated 25 August 2023 [NHST-00076] which she presented to the Board on 31 August 2023.

214. Why was an independent review not thought appropriate?

- 214.1 NHS Tayside does not hold any documentation or evidence that describes why an independent review was not thought appropriate. NHS Tayside directs the Inquiry to the commissioner of the review, the Medical Director in post at the time, who would be better placed to answer this question.

215. What was the remit of the review which was commissioned and why was the remit set as it was?

- 215.1 A stated aim of the Due Diligence Review report dated 23 August 2023 [NHST-00075] was to present facts to assist the Medical Director in their assessment of the adequacy of procedures to detect signals of concerning practice relating to Mr Eljamel. In particular, the report focused on the period leading up to the point where Mr Eljamel was placed under supervision on 21 June 2013 to his suspension on 10 December 2013. The review focused on this period as a key remit of the review was to assess the adequacy of procedures to detect signals of concerning practice relating to Mr Eljamel, and this was the time period in which those signals occurred.
- 215.2 As noted above at paragraph 212.1, a stated aim of the review was also to enable the Medical Director to provide a fresh assessment to NHS Tayside of the professional, clinical and corporate governance position relating to Mr Eljamel's tenure with associated recommendations and actions for the Board for assurance and ongoing monitoring.
- 215.3 For further response to this question, as to why the remit was set as it was, NHS Tayside would direct the Inquiry to the Executive Medical Director in post at the time.

216. Given its remit, why did the due diligence review “*focus[es] on the period leading up to the point where Professor Eljamel was placed under supervision on 21 June 2013 to his suspension on 10 December 2013*” (NHST-00075, page 4)?

216.1 Please see response provided in paragraph 215.1 above.

217. What materials were made available to those involved in preparing the review when the report was commissioned? Why were those materials considered to be what would be needed for the remit of the review to be fulfilled?

217.1 The materials that were made available to those involved in preparing the Due Diligence Review report dated 23 August 2023 [NHST-00075] included information regarding Mr Eljamel that was held at the time. This is provided on the Information Catalogue held by the PLRT [NHST-01682]. Key information included documents related to the supervision and suspension of Mr Eljamel, complaint files, correspondence between senior leaders regarding Mr Eljamel and information from Mr Eljamel's personal file. Data relating to Mr Eljamel's surgeries performed was also collated and analysed as part of the review.

217.2 The Due Diligence Review report dated 23 August 2023 [NHST-00075] was prepared to be a review of all known information and documentation relating to Mr Eljamel at the time of the review, therefore this is the information that was reviewed.

218. At NHST-00075, page 4, it states that:

“It must be stated at the outset that this has involved all of the information which NHS Tayside has identified and which can be found as at 2023 at the time of this review. Due to the time which has elapsed since Professor Eljamel last worked for NHS Tayside (nearly 10 years) and the preceding 18-year period in which he was employed as a surgeon in NHS Tayside, some records no longer exist as they have been disposed of in line with the records and retention policies which must be followed for data protection purposes, some information is no longer available due to the decommissioning of old data management systems and technologies, and there is limited organisational and professional knowledge from the current operational, medical and corporate leadership lines who were not in post in NHS Tayside at the time”

In this regard:

(a) What was the basis for the assessment that some records were not available due to compliance with records retention policies?

218(a).1 NHS Tayside has a records retention policy [NHST-00050-00063] which should be followed by all employees, for all records created. It is believed that basis for the above statement is that due to the passing of time from Mr Eljamel's departure from NHS Tayside, some records had been destroyed in line with this policy.

(b) What data management systems and technologies had been decommissioned, which would have allowed access to a greater volume of relevant materials

218(b).1 NHS Tayside has provided information regarding the data management systems which have since been decommissioned in response to the Questions in Part E.

(c) What efforts were made at that time to access such materials despite technological difficulties which may have been encountered, in particular relating to the pre-2012 system for recording adverse incidents?

218(c).1 Further information relating to the systems used pre-2012 to record adverse incidents is included in response to Question 114.

(d) Why was it the case in 2023 that "*Prior to this there was no electronic system and it has therefore not been possible for the review team to gather examples of incidents reported prior to 2012*" (NHST-00075, page 9)?

218(d).1 NHS Tayside has provided information relating to the systems used pre-2012 to record adverse incidents in response to Question 114.

(e) What organisational and professional knowledge from the then current organisational, medical and corporate leadership lines was available which was relevant to the matters being examined in the review at that time? What knowledge of this nature was relied upon in the review?

218(e).1 NHS Tayside would direct the Inquiry to the commissioner and authors of the review report who would be best placed to answer this question.

219. To what extent were materials missing at that time, which would otherwise have been relevant to the remit of the review?

219.1 NHS Tayside has provided information relating to potentially missing information in response to Question 114.

220. Please identify patients A to F (NHST-00075, page 18). Why were their cases selected for case story in the due diligence review?

220.1 Patients A-F are listed below:

Patient A	Patrick Kelly
Patient B	Jules Rose
Patient C	CAT D
Patient D	CAT D
Patient E	CAT D
Patient F	CAT D

220.2 On the Due Diligence Review report dated 23 August 2023 [NHST-00075_17], it is recorded that *“Patients A and B were subjects within the Scottish Government report on unresolved concerns. Patients C to F were lodged as incidents in line with the Adverse Events Policy and had varying levels of investigations. As such these are felt to be a sample that represents the wider experience of patients affected by Professor Eljamel.”* It should be noted that NHS Tayside is uncertain why Patient E was included within the Due Diligence Review. From the documents and evidence that are currently available to NHS Tayside, there is no indication that Mr Eljamel was involved in the adverse event. NHS Tayside would direct the Inquiry to the commissioner and authors of the review report.

221. What role were patients or their representatives permitted to play in the compilation of the review and why?

221.1 Patients or their representatives did not play a part in the compilation of the review, however previous concerns raised by patients or their representatives were included in the review. They did not play a part in the review as the 2023 Due Diligence Review was a review of all known documentation and previous reviews in relation to Mr Eljamel.

222. What were the main conclusions/ recommendations of the review and what was the reasoning behind these conclusions/ recommendations?

222.1 The conclusions and recommendations from the Due Diligence Review report dated 23 August 2023 [NHST-00075] were presented to the NHS Tayside Board by the then Executive Medical Director on 31 August 2023 [NHST-01610_401]. A non-exhaustive summary of the conclusions includes:

- The behaviour of individual doctors

Mr Eljamel was not open and honest with patients and colleagues. Whilst such behaviours are rare within the medical profession, there is a need to have systems in place to detect and act on these if they occur.

Since Mr Eljamel practised in Tayside, NHS Tayside had overhauled the governance and alert systems in place for professional governance.

- Monitoring signals of poor practice or harm

Whilst there were multiple ways in which signs of poor practice could appear, the way in which some of those signs were joined up was lacking, and feedback from trainees was not always seen by line managers.

Since Mr Eljamel practised in NHS Tayside, joining up of potential alerts is achieved through an Executive Director-led Safety Oversight Group which responds to emerging potential issues.

- Guidance to ensure consistency in governance processes

There was variability in the organisational response to signs of poor practice within the system. Some complaints did not lead to formal investigation using governance processes, and there was a variation in response times. Once multiple signs of poor practice were considered together in 2013, decision-making related to Mr Eljamel's practice was delegated too far down the organisation. Restrictions placed on Mr Eljamel's practice in 2013 were not adequate and decision-making was not sufficiently well documented. The level of supervision decided upon was not proportionate to the concerns being raised at the time and once implemented was not monitored effectively. During the period of Mr Eljamel's employment, there was an absence of an advanced process of professional governance from concerns being raised to their being acted upon, and in ensuring clear documentation of decisions made. However, this had been addressed with a process in place through the establishment of the Responsible Officer Advisory Group (ROAG).

- Assurance that learning occurred and would be spread

Reliable documentation of actions arising from recommendations from previous reviews from 2013 to 2022 was not consistently present, and monitoring and assurance routes for those actions were variable.

However, revised systems have greatly improved the opportunities to connect signs of poor practice and adopt whole system learning from events.

- Communication with patients affected by Mr Eljamel's practice

The communication with patients throughout the process was of variable quality, fragmented, and generally poor. There had been no central coordination to ensure a truly person-centred approach. Where concerns were raised by patients, the issue was managed through a small subset of the Acute Management Team. There was a lack of visibility within NHS Tayside, no governance routes to assure and scrutinise, and no indications or reporting of improvement through action plans.

Since the establishment of the Patient Liaison Response Team (PLRT) in early 2023, patients with long-running concerns have a single point of contact to build

improved relationships and understanding of concerns, to achieve a more consistent and person-centred approach.

222.2 The recommendations made were themed under three key areas of governance: Professional Governance, Clinical Governance, and Corporate Governance. The detail of these is set out in the then Executive Medical Director's report presented to the Board on 31 August 2023 *[NHST-01610]*.

222.3 In the event that the Inquiry wishes further information as to the reasoning for the conclusions and recommendations, additional to what is set out in the Due Diligence Review and in the then-Executive Medical Director's report to the Board, it is suggested that it should address its question to the said Executive Medical Director who will be best placed to respond.

223. What action was taken by NHST as a result of the further review/ reports being completed and why?

223.1 An action plan was developed against the recommendations and reported through the Care Governance Committee, re-named the Clinical Governance Committee in 2024 *[NHST-04666; NHST-04667; NHST-04668]*.

Appendix B - Part G – Complaints and legal claims

224. Please provide details of formal complaints and legal claims made to NHST against Mr Eljamel by (i) former patients (ii) any other party, including:

- a) The identity of the complaining/claiming party;**
- b) The nature of the complaint/claim, including the date and nature of the surgery/ treatment to which the complaint/claim related;**
- c) The date of the complaint/claim;**
- d) The outcome of the complaint/claim (including an explanation of what the outcomes meant in practice);**
- e) Any steps taken by NHST as a result of the outcome of the complaint/claim and**
- f) The time taken to resolve the complaint/claim.**

224.1 NHS Tayside has provided two separate spreadsheets as evidence which shows the requested information for Question 224 (a)-(f) in relation to complaints *[NHST-01551]* and legal claims *[NHST-01584]*.

224.2 The following is a summary of the information contained within the spreadsheet as it relates to complaints received about care delivered by Mr Eljamel.

224.3 The term 'complaints' has been used to encompass all communications, relating in some way to Mr Eljamel sent to the Complaints and Feedback Team. Three of these complaints cross over between private and NHS care provision.

224.4 There have been 111 complaints from 107 patients or their representatives (such as family members). Within this number there are two complaints that although the patient or their representative complained about Mr Eljamel, following the complaints review process it was found that Mr Eljamel did not treat these patients. The patient or their representative was informed of this in the complaint response.

224.5 Each complaint is allocated a theme. This takes into account concerns about clinical treatment, communication, disagreements with treatment/care, errors, negligence, poor medical treatment, pain, and dissatisfaction with outcome. It also includes those who were using the complaints process to ask about access to medical records, a review of care received and those asking about the care they had and/or who delivered it.

224.6 Any further information NHS Tayside has to share about the Questions 224 (a)-(f) in addition to the spreadsheets mentioned above is included below.

224.7 There have been 22 legal claims from 22 patients or their representatives.

a) The identity of the complaining/claiming party;

224(a).1 The identity of the complaining/claiming party is contained within the spreadsheets previously shared with the Inquiry; complaints [NHST-01551] and legal claims [NHST-01584].

224(a).2 On around 18 July 2025, NHS Tayside provided to the Inquiry via email an updated list of names via email of those who had complained. It should be noted that on that list there were two similar names, which was believed to be the same person who had complained twice. However, upon review, it has been identified that although this was the same person, there had only been one complaint submitted. The person referred to is listed as complaint numbers 2 and 26 on the provided list.

224(a).3 On around 21 April 2026, NHS Tayside provided the Inquiry with an updated list of names of those who had complained [NHST-04786]. This was provided to the Inquiry following NHS Tayside discovering a further six complaints relating to Mr Eljamel. The circumstances of how these were identified are detailed in the below paragraphs.

224(a).4 The first was discovered on around 15 December 2025, as part of the work undertaken in preparation of this statement.

224(a).5 The second, third and fourth complaint files were discovered on around 05 January 2026, following a review of complaints files held by NHS Tayside that may be of relevance to the Infected Blood Public Inquiry. NHS Tayside has a Do Not Destroy notice from the Infected Blood Inquiry, and as such complaint files that fell under that Notice were retained.

224(a).6 The fifth was discovered on around 22 January 2026. NHS Tayside was undertaking work relating to documents management to ensure that the files provided to the Inquiry were all scanned in and saved appropriately. During this process it was

discovered that there was a complaint letter included in printed copies of emails. This was investigated and it was found that this was a complaint that related to Mr Eljamel.

224(a).7 The sixth was discovered on around 16 April 2026 while NHS Tayside was undertaking work and searches in response to a request for evidence by the Inquiry.

b) The nature of the complaint/claim, including the date and nature of the surgery/ treatment to which the complaint/claim related;

224(b).1 The specific details of each complaint or claim are provided in the spreadsheets previously shared with the Inquiry as outlined above [NHST-01551; NHST-01584]. For context, the table below summarises the broad complaint themes and the types of surgery/treatment involved:

Complaint Theme	Type of Surgery/Treatment
Poor medical treatment	Microdiscectomy
Communication	Decompression
Disagreement with treatment	Tumour/Meningioma Excision

The surgeries and treatments associated with these complaints took place between October 1995 and December 2013.

224(b).2 The following section provides an overview of the related claims, summarising their broad themes and types of surgery or treatment involved:

Claim Theme	Type of Surgery/Treatment
Wrong site surgery	Microdiscectomy
Suboptimal surgery	Lumbar decompression
Informed consent	Transsphenoidal excision of pituitary adenoma

The claims were received between August 2013 and September 2025.

c) The date of the complaint/claim;

224(c).1 Complaints - The date range of the complaints received is from October 1996 to August 2023.

224(c).2 Claims - The date range of the claims received is from August 2013 to September 2025.

d) The outcome of the complaint/claim (including an explanation of what the outcomes meant in practice);

224(d).1 The outcome codes for complaints listed on the spreadsheet for complaints [NHST-01551] and an explanation of the outcome codes is provided below:

- Upheld – every issue raised in the complaint NHS Tayside has apologised for as care/experience has fallen below the aimed for standards within the service area that the complaint is regarding.
- Partially upheld – some issues NHS Tayside has apologised for, but some of the feedback was within the aimed for standards.
- Not upheld – every issue raised within the complaint has been within the aimed for standards.
- Transferred to another unit – the complaint has come into NHS Tayside, but it is not for NHS Tayside, so it is passed to another organisation – e.g. Council (Social Work), Scottish Ambulance Service, or NHS Fife - to respond to the patient directly.
- Consent not received – a representative/family member/carers or indeed the patient themselves has raised a complaint on behalf of a patient. They do not provide relevant consent and/or documentation that they can act on the patient's behalf, therefore NHS Tayside does not provide the complainant with a response.
- Complaint not on Datix – the complaint is not logged on the Datix system, which is the system used to record complaints. For six of the complaints, this is because they were received prior to the introduction of Datix in 2013. For the remaining one, we do not know why it is not on Datix as it was received in 2015.
- Enquiry – logged onto Datix as an enquiry not a complaint which means there is no outcome code assigned. These are investigated in the same way as a complaint ensuring a response. Often this is due to the amount of time lapsed.

224(d).2 Further to the above information regarding the “enquiry” coding, NHS Tayside received complaints relating to Mr Eljamel following his departure. These were logged as “enquiries” and coded as such. This was because the normal complaints procedure would class these as “out of time” and NHS Tayside wanted to ensure they would be investigated appropriately.

224(d).3 These were fully investigated where possible to ensure that a response could be provided to the complainant. In many cases meetings with the complainant/family/representative was offered and carried out by the clinical teams supported by a consultant. This was followed up with a letter and an apology, if relevant depending on the circumstances of the complaint. The cases where complaints were not fully investigated was due to clinical records not being available as they had been destroyed in accordance with NHS Tayside Health Records Strategy and Policy. It should be noted that these cases were prior to NHS Tayside receiving the Do Not Destroy Notice from the Inquiry.

224(d).4 The table below provides an overview of the numbers regarding the outcome coding.

Outcome code for Mr Eljamel Complaints		
No.	Outcome Code	Number
1	Complaint not on Datix	7
2	Consent not received	1
3	Enquiry	66
4	Fully Upheld	12
5	Not upheld	6
6	Partially Upheld	12
7	Transferred to another unit	7
8	Total	111

e) Any steps taken by NHST as a result of the outcome of the complaint/claim and

224(e).1 NHS Tayside is unable to provide specific outcomes, action plans, or documentation, in relation to complaints, beyond what is listed in the spreadsheet for complaints identified above *[NHST-01551]*.

224(e).2 It has always been, and continues to be, the responsibility of the clinical team involved in the complaint to ensure that any learning arising from complaints is shared with the relevant areas and that all necessary actions are implemented.

224(e).3 The current practice in NHS Tayside is that learning is the responsibility of each local governance group. An example from practice is included in each quarterly paper we provide to the Clinical Governance Committee, as part of the regular reporting of complaints data which includes updates on all Key Performance Indicators (KPIs) for Complaints Handling, a quarterly report from Care Opinion, and a patient story or narrative from a clinical service to illustrate how feedback is being used to drive and sustain improvements. In quarter two of this year (July 2025 to September 2025), NHS Tayside started to include feedback from patients about their experience accessing the feedback team, which is a KPI. This has been mostly positive with minor areas for development around communication. The Patient Experience Team is currently working to improve the sharing of information around closing the loop on learning using the Datix system, and a test is currently being carried out in two areas within NHS Tayside.

224(e).4 NHS Tayside has no evidence regarding any steps that were taken following the outcome of the legal claims shown in the spreadsheet for legal claims *[NHST-01584]*.

f) The time taken to resolve the complaint/claim. With NHS T

224(f).1 The time taken to resolve complaints and claims is contained within the spreadsheet *NHST-01551 and NHST-01584*.

- The average duration to close a complaint was 76 days.
- The average duration of a claim was approximately 3 years and 1 month

225. Please explain what systems existed over the relevant period to make patients and others aware of the existence of the NHST complaints system and the means by which a complaint could be intimated and would be handled.

- 225.1 Individuals would have been made aware of the existence of the complaints system through several methods which are demonstrated in the evidence provided to the Inquiry along with this submission. The “Dundee Teaching Hospitals, a Complaints Management Review” dated April 1998 [NHST-01526] details processes and recommendations. This refers to information from The NHS Complaints Procedure (1996) [NHST-01684]. This is supported by the Scottish Government Document “Can I help you? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services” [NHST-01645] which NHS Tayside was using from 2005, and which was updated in 2012. This is Scottish Government guidance. NHS Tayside does not hold the 2005 version of this guidance. NHS Tayside has no evidence regarding the systems that existed prior to April 1998 to make patients and other aware of the existence of its complaints system and the means by which a complaint could be intimated and would be handled.
- 225.2 Individuals would also be made aware of the complaints process through face-to-face contact between patients, families, and staff when it was identified that an individual was considering making a complaint. Early resolution would be attempted locally, however if unsuccessful then staff provided individuals with the key information and methods of making a complaint to NHS Tayside. This involved providing contact details, information leaflets [NHST-01527], or a complaint form to initiate the complaints process. NHS Tayside is unaware of any policies which direct staff to support complainants with engagement with the Patient Experience Team (or CAFT previously). The Complaints Management Procedure [NHST-01529] demonstrates the good principles of complaint handling, apologies, and dealing with complaints using local resolution.
- 225.3 Alternatively, individuals would be made aware of the complaints process through published materials that were available throughout NHS Tayside, including on our public website, main reception desks and from patient facing teams/departments [NHST-01527; NHST-01528]. In 2013, NHS Tayside developed a Complaints Management Procedure [NHST-01529]. This internal guidance document details

the procedure for making a complaint and contains an example of a feedback form that was available to the public. The document “Can I help you?” supported complainants to make complaints to NHS Tayside prior to 2013 [NHST-01645]. These materials outline the nature of the complaint and feedback process, who can complain, what can and cannot be complained about, how to complain, the expected response times to different complaints, who can offer support with complaints, and the contact details of the Scottish Public Services Ombudsman (SPSO) if someone is unhappy with their complaint response or the nature in which their complaint has been handled.

- 225.4 NHS Tayside Complaints Team has followed the guidance from the SPSO Model Complaints Handling Procedure [NHST-01530; NHST-01531] from 1 April 2017. Although the expected timelines for handling complaints were unchanged from previous guidance, this new procedure formalised a two-stage process with oversight from the SPSO. Information is now hosted on the NHS Tayside public facing webpages regarding this process and includes information about the relevance of the SPSO in the complaints process.
- 225.5 Following the new national guidance, NHS Tayside prepared an updated local Complaints Procedure in April 2017 [NHST-01700] and updated this regularly. The most recent of these was in October 2020 [NHST-01532], which details the updated process aligned to complaints stages and the SPSO Model Complaints Handling Procedure, as detailed in this response [NHST-01530; NHST-01531].
- 225.6 NHS Tayside continues to follow the SPSO Complaints Handling Procedure, [NHST-00235] referred to above, to present day.

Appendix B - Part H - Documents

226. Please set out the broad locations of where documents thought to be relevant to the requests made in this rule 8 request were stored, including hard copy or electronic systems, and the identity of the party who or which controls or administers such systems.

226.1 The broad locations that NHS Tayside has searched, in relation to this witness statement request, include key departments across NHS Tayside that have been involved in providing responses to this witness statement request. These are set out in the following paragraphs.

226.2 The offices of the Chief Executive and their team. This includes the Executive Board Members / Executive Directors who are the Executive Medical Director and the Executive Nurse Director. The other members of the Chief Executive Team who have been responsible for providing this response to the witness statement request include the Interim Deputy Chief Executive, the Director of People and Culture, the Chief Officer Acute Services, the Board Secretary and the Director of Communications and Engagement.

226.3 The corporate document repository relating to Mr Eljamel which was established in 2023 is managed by the PLRT. The two person PLRT report to the Board Secretary. An overview of the Information Catalogue [NHST-01682] is included in the response to this witness statement request, which shows the information that is held within this repository. The Head of PLRT, currently Donna McEwan, is responsible for the management of the repository.

226.4 The Health Records Department, encompassing all electronic storage systems that they manage and physical files that they hold. The search in relation to this witness statement request has not included a full search of patients' medical records. NHS Tayside will only access patient medical records when specifically asked to do so, or for a specific reason. The Head of Health Records, currently Heather Anderson, has overall responsibility for the management and storage of a patient's medical record when it is returned to the Health Records libraries following use by a clinician or for other purposes. It is the responsibility of Clinical Service Managers/Heads of Department/Service to ensure that records controlled within their unit are managed

in a way that meets the aims of the NHS Tayside Health Records Management Policy.

- 226.5 The Information Governance and Cyber Assurance Team, encompassing all electronic storage systems that they manage, and physical files that they hold. The Head of Information Governance and Cyber Assurance, Alison Dailly, was responsible for this information and these systems. Alison Dailly retired from NHS Tayside on 31 March 2026. The Information Governance and Cyber Assurance Team report to the Board Secretary and from 1 April 2026 the Team will report to the Director of Corporate Affairs.

- 226.6 The Patient Experience Team which include NHS Tayside's Complaints Team, encompassing all electronic storage systems that they manage, and physical files that they hold. The Head of Patient Experience, currently Honor MacGregor, is responsible for this information and these systems.

- 226.7 Patient Safety, Clinical Governance and Risk Management, encompassing all electronic storage systems that they manage, and physical files that they hold. The Head of Patient Safety, Clinical Governance and Risk Management, was Tracey Passway, and was responsible for this information and the systems. Tracey Passway retired from NHS Tayside on 31 March 2026.

- 226.8 The Neurosurgery department and the wider Specialist Services Care Group, encompassing all electronic storage systems that they manage, and physical files that they hold. The Associate Director of Access and Assurance, currently Jessica Henderson, has overall responsibility for these systems.

- 226.9 The People & Culture Directorate, encompassing all electronic storage systems that they manage, and physical files that they hold relating to the workforce of NHS Tayside. Similar to Health Records, HR files have not been accessed where it is not specifically required to do so. NHS Tayside has, however, accessed Mr Eljamel's HR file [NHST-04741] to respond to this witness statement request. The Deputy Director of People and Culture, currently Kevin Colclough, has overall responsibility for these systems.

- 226.10 The Business Unit Department which includes NHS Tayside's Legal Team are responsible for the electronic storage systems that they manage, and physical files

that they hold. Although the Business Unit manage systems that holds information/data, personnel from the Business Unit department may not have input this information/data into these systems. The Assistant Director for Performance and Activity, currently Brian Reynolds, has responsibility for the systems that manage the information/data however, the owner of the information/data has responsibility for the information/data itself.

- 226.11 The office of the Director of Research and Development and Tayside Medical Science Centre (TASC), currently Professor Russell Petty, encompassing all electronic storage systems that they manage, and physical files that they hold.
- 226.12 Corporate information is held within NHS Tayside's electronic document management system known as the NHS Tayside Docstore. The Corporate Records Manager, currently Lynda Petrie, is responsible for the overall management of the Docstore, however each individual area within NHS Tayside is responsible for the documents that they upload onto the system, and this is detailed in individual Record Management Plans.
- 226.13 Corporate records from Dundee Teaching Hospital NHS Trust, Tayside University Hospitals NHS Trust, Tayside Health Board and Tayside NHS Board held physically and electronically and archival records held on behalf of Tayside by the University of Dundee have been accessed and searched for information relating to this witness statement request. The Board Secretary, currently Margaret Dunning, is responsible for the management of these corporate records.
- 226.14 Relevant emails and records of the individuals listed in response to Question 228, and those teams listed above.

227. As far as the searches for documents undertaken by NHST as per the request made in Appendix C below are concerned, as regards of the categories of documents which has been requested:

- (a) Please indicate what searches for documents have been undertaken for each category, including where such searches were undertaken and why these searches were thought to be comprehensive as regards the documents**

sought in each category, including details of search terms used on electronic systems of document storage);

- 227(a).1 The locations set out in response to Question 226 above were also searched for information in relation to Appendix C. Set out below are the categories of documents that the Inquiry has asked for, and information relating to the search terms used. If there are any areas searched in addition to those listed in Question 226 above, this is indicated below. In addition to the below keywords for each part, the follow keywords were searched for in all areas: Eljamel, Neurosurgeon. The searches undertaken were considered comprehensive as they encompassed all identified locations, included additional relevant areas where appropriate, and applied both specific and overarching keywords across all categories of interest. The date ranges searched for varied depending on the question being asked. Where the question referred to the relevant period, the date range was 1995 – 2015. If there was information of relevance outside of this range, it was also provided. Where no date was specified in the question, the search period was 1995 to 2025.
- 227(a).2 Part B – Structures and Systems (Request 2 to 8)
- 227(a).3 This section of Appendix C covers a wide variety of topics. All areas listed in response to Question 226 above were therefore searched. Keywords from the documents requested were used to search for relevant information.
- 227(a).4 The keywords include, but are not limited to: policies, practice, guidelines, framework, handbook, best practice, research, spinal surgery, neurosurgery, neuroscience, neurology, specialist services, corporate governance, clinical governance, information governance, professional governance, training, supervision, suspension, referrals, private practice, risk management, whistleblowing, complaints, feedback, investigation, reviews, adverse event, serious clinical adverse event (SCEA), mortality and morbidity, multidisciplinary team meetings (MDT), Healthcare Improvement Scotland (HIS), Scottish Executive, Scottish Government, resignation, General Medical Council (GMC), information sharing, regulatory bodies, NHS Scotland circular entitled Clinical Governance NHS MEL(1998)75 (as updated in the year 2000), oversight, provision of healthcare, all names of bodies listed in Request 6, appraisal, reporting, validation, revalidation, appointment process, workload.

227(a).5 Part C - The NHS Tayside neurological service and the work of Mr Eljamel (Request 9 to 18)

227(a).6 This section of Appendix C is in relation to the neurological service. The majority of searches were therefore undertaken within the Specialist Services Clinical Care Group, within which Neurosurgery and Neurology sit. Keywords from the documents requested were used to search for relevant information.

227(a).7 The keywords include, but are not limited to: professional work, theatre lists, theatre logs, patient lists, surgery lists, neurosurgery lists, on-call lists, waiting lists, structure, allocation of work, outcomes, National Health Service in Scotland Circular Clinical Governance NHS MEL(1998)75 and subsequent updates, staff rotas, facilities, standard practice and procedures to the items listed in Request 16, action plan, Scottish Government Review, Tracey Gillies Review.

227(a).8 Part C - Involvement in and impact of commitments to private practice (Request 19 to 20)

227(a).9 This section of Appendix C is in relation to the private practice Mr Eljamel was involved in. The majority of searches were therefore undertaken within the Specialist Services Clinical Care Group (which Neurosurgery and Neurology sits within), the PLRT Repository, and Human Resources. Keywords from the documents requested were used to search for relevant information.

227(a).10 The keywords include, but are not limited to: private practice, private work.

227(a).11 Part D - Mr Eljamel's appointments (Request 21 to 26)

227(a).12 This section of Appendix C is in relation to Mr Eljamel's appointments. The majority of searches were therefore undertaken within the Specialist Services Clinical Care Group, within which Neurosurgery and Neurology sit, the PLRT Repository and Human Resources. Keywords from the documents requested were used to search for relevant information.

227(a).13 The majority of documents that this section requests have been taken from Mr Eljamel's HR file [NHST-04741], which is held in paper form (although this has now been scanned in electronically). A review of this file was undertaken by the Director

of People and Culture, and others working on their behalf. During this review, relevant documents from the HR file were set aside for inclusion as part of this response and have been provided with this response. Key information that was searched for includes information about Mr Eljamel's appointment to all roles listed in this witness statement request, including interviews, appointment paperwork and references.

227(a).14 This information was then cross-referenced with information held in the PLRT Repository to ensure it was accurate and complete.

227(a).15 Part E - Document management withing NHS Tayside (Request 27)

227(a).16 This section of Appendix C covers document management within NHS Tayside. All areas listed in response to Question 226 were therefore searched, with a particular focus on the Information Governance Team and Health Records Department. Keywords from the documents requested were used to search for relevant information.

227(a).17 The keywords include, but are not limited to: documents management, records management, policies, procedures, guidance, access to records, processing records, storage of records, retention of records, records retention policies.

227(a).18 Part F - Previous investigations into Mr Eljamel (Request 28 to 30)

227(a).19 This section of Appendix C covers previous investigations into Mr Eljamel. All areas listed in response to Question 226 were therefore searched, with a particular focus on the offices of the Executive and Board Members and the PLRT Repository. Keywords from the documents requested were used to search for information relevant to the documents requested. Keywords from the documents requested were used to search for relevant information.

227(a).20 The keywords include, but are not limited to: reviews, investigations, reports, papers, including the names and titles of all reports/ reviews/investigations listed in this witness statement request, as well as the authors of the reports/reviews/investigations.

227(a).21 Part G - Complaints and Legal Claims (Request 31)

227(a).22 This section of Appendix C covers complaints and claims relating to Mr Eljamel. All areas listed in response to Question 226 above were therefore searched, with a particular focus on the offices of the Executive and Board Members, the complaints and legal teams and the PLRT Repository. Keywords from the documents requested were used to search for relevant information.

227(a).23 The keywords include, but are not limited to: complaints, claims, concerns, feedback, legal, patient experience.

(b) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of NHST, please identify what these are;

227(b).1 The majority of documents requested under Appendix C were already identified through the work carried out in response to Appendix B. For this witness statement request, NHS Tayside has explained where gaps remain, specifically where documents were believed to exist but could not be located. Full details of these gaps are provided in Appendix B, Part E, Questions 114 to 117.

227(b).2 In regard to the requests made in Appendix C that were not covered by the questions in Appendix B, the areas identified as gaps are detailed in our response to Appendix C, specifically in Appendix B, Part E, Questions 114 to 117.

(c) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of NHST, please identify broadly what has happened to them (including whether they have been lost or destroyed and, if so, when and why); and

227(c).1 Please see the response to Question 227(b) above. In addition to this, if it is known what has happened to the relevant documents, this information is indicated within this witness statement response and/or in response to Appendix C. See Appendix B, Part E, Questions 114 to 117.

- (d) **If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of NHST and NHST is aware of these being held by or on behalf of another party, please indicate the nature of these documents and by whom GMC believes them to be held.**

227(d).1 In the last line of the question, NHS Tayside has assumed that the Inquiry means NHS Tayside, rather than the GMC as stated in the question.

227(d).2 Throughout this witness statement, where it is thought that other individuals or organisations hold information that may be relevant to the questions asked, NHS Tayside has indicated this in the response to the specific question.

228. Please certify that the documents which have been produced in response to this rule 8 request are, to the best of NHST's knowledge and belief, all documents held by NHST, on its behalf or under its control.

228.1 NHS Tayside certifies that the documents which have been produced in response to this witness statement request are, to the best of its knowledge and belief, all documents held by NHS Tayside, on its behalf or under its control.

Appendix C – Request for documents to be produced to the Inquiry

General disclosure request

- 1 In addition to any documents which you have exhibited to your witness statement in response to the questions posed at appendix B above, the Chair requests the general disclosure of the following all documents held by you or on your behalf relating to the matter raised for you to address in the witness statement requested above.
 - 1.1 Please see response to Appendix B above, and responses to requests below.
 - 1.2 NHS Tayside has indicated below the Inquiry inventory number(s) for the documents that we have provided that are relevant to each request in Appendix C of the Inquiries witness statement request (ref: NHS Tayside/061125). If there is documentation that NHS Tayside does not hold or is unable to provide, if not already outlined in the responses to the questions in Appendix B, this information is also included below where known.

Specific disclosure request

Appendix C – Part B – Structures and systems

- 2 All documents, for the avoidance of doubt including all guidance, policies, frameworks practices or operational documents relating to the system within NHST from the relevant period showing or tending to show:
 - 2(a) The nature of any policy or practice within NHST relating to the allocation of work to neurosurgeons, insofar as relevant or potentially relevant to the practice if (*sic*) Mr Eljamel;

NHST-01522, NHST-01543, NHST-01547, NHST-01521, NHST-01505, NHST-01504, NHST-01604, NHST-01505, NHST-01541, NHST-01603 and NHST-01540.

- 2(b) The nature of any policy or practice within NHST relating to the management of the workload of neurosurgeons, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHST-01522, NHST-01543, NHST-01547, NHST-01521, NHST-01505, NHST-01542 and NHST-01548.

- 2(c) The nature of any policy or practice within NHST relating to management of neurosurgeons' commitments to (i) private practice (ii) research (iii) study leave or (iv) teaching commitments, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHST-01511.

- 2(d) The nature of any policy or practice within NHST relating to the training or supervision of junior neurosurgeons by consultant neurosurgeons within NHST, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHST-04467.

- 2(e) The nature of any policy or practice within NHST relating to liaison with private hospitals connected to the practice of consultant neurosurgeons, in particular but not limited to patients treated in both systems, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHS Tayside holds no evidence for the above document request.

- 2(f) The nature of any policy or practice within NHST relating to referral of patients between NHS and private care, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHST-01521.

- 2(g) The nature of any policy or practice within NHST relating to the clinical governance (including corporate and professional oversight) of the practice**

of neurosurgeons, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;

NHST-01605, NHST-01606, NHST-01552, NHST-04353 and NHST-04354.

- 2(h) The nature of any policy or practice within NHST relating to risk management of the practice of neurosurgeons, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHST-01615, NHST-01616 and NHST-01617.

- 2(i) The nature of any policy or practice within NHST relating to the whistleblowing systems connected to the practice of neurosurgeons, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel;**

NHST-00237, NHST-00236, NHST-00238, NHST-01693 and NHST-01694.

- 2(j) The nature of any policy or practice within NHST relating to the systems for formal complaints or feedback connected to the practice of neurosurgeons, insofar as relevant or potentially relevant to the practice if (sic) Mr Eljamel, including (for the avoidance of doubt) policy or practice relating to the investigation of such formal complaints or feedback and to learning lessons from the outcome of such investigations;**

NHST-01526, NHST-01684, NHST-01645, NHST-01527, NHST-01528, NHST-01529, NHST-01530, NHST-01531, NHST-01700 and NHST-01532.

- 2(k) The nature of any policy or practice within NHST relating to the interaction with (i) NHS Education for Scotland or its predecessors (ii) Healthcare Improvement Scotland or its predecessors or (iii) the Scottish Executive/ Scottish Government, insofar as relevant or potentially relevant to the practice if Mr Eljamel;**

NHST-04411, NHST-04393, NHST-04394, NHST-04395, NHST-04396, NHST-04397, NHST-04398 and NHST-04399.

- 2(l) The nature of any policy or practice within NHST relating to the clinical supervision of neurosurgeons insofar as relevant or potentially relevant to the practice of Mr Eljamel;**

NHST-01579. Further documents are provided in response to Request 8(n).

- 2(m) The nature of any policy or practice within NHST relating to the suspension of neurosurgeons insofar as relevant or potentially relevant to the practice of Mr Eljamel;**

NHST-01579, NHST-00242, NHST-00243 and NHST-00244.

- 2(n) The nature of any policy within NHST relating to the resignation of neurosurgeons insofar as relevant or potentially relevant to the practice of Mr Eljamel;**

There is no policy within NHS Tayside relating to the resignation of neurosurgeons. Clause 8 of Mr Eljamel's appointment letter dated 9 October 1995 [*NHST-01540*] specifies that the employment is subject to three months' notice on either side and is subject to the provisions of the National Terms and Conditions of Service of Hospital Medical and Dental Staff. As stated earlier, NHS Tayside does not hold any handbook that was used prior to April 2003. However, the Hospital Medical and Dental Staff Terms and Conditions of Service Handbook, published by the Scottish Executive in April 2003 has been provided [*NHST-01574*]. Those provisions merely confirm that Consultant grade employee contracts are subject to three months' notice of termination on either side. (See, for example Hospital Medical and Dental Staff and Doctors in Public Health and The Community Health Service (Scotland) Consultant Grade Terms and Conditions of Service, paragraph 10.5.1 [*NHST-01698*])

- 2(o) The nature of any policy or practice within NHST relating to the removal from the General Medical Council's medical register of the names neurosurgeons, insofar as relevant or potentially relevant to the practice of Mr Eljamel;**

NHS Tayside holds no evidence for the above document request.

- 2(p) The nature of any policy or practice within NHST relating to undertaking reviews or investigations into the professional practice of neurosurgeons, insofar as relevant or potentially relevant to the practice of Mr Eljamel;**

NHST-04378, NHST-00243, NHST-00244 and NHST-04381.

- 2(q) The nature of any policy or practice within NHST relating to the systems relating neurosurgeons, such as Mr Eljamel, sharing information with their patients, their professional colleagues, NHST or regulatory bodies (including the General Medical Council) relating to sub-standard or potentially sub-standard professional practice; and**

NHST-04355 – NHST-04361. Other documents of relevance here have been provided in response to Requests 8(m) and 8(n).

- 2(r) The nature of any policy or practice within NHST relating to the systems for NHST for itself information relating to sub-standard or potentially sub-standard professional practice on the part of neurosurgeons, such as Mr Eljamel, with the neurosurgeon's patients, regulatory bodies (including the General Medical Council), the Scottish Government or the police.**

Please see above response to Request 2(q).

- 3 All documents showing or tending to show how and why any such system changed in the relevant period.**

Any relevant documents have either been provided in the responses above, or in NHS Tayside's response to Appendix B. NHS Tayside has no further information to provide.

- 4 NHS Scotland circular entitled Clinical Governance NHS MEL (1998)75 (as updated in the year 2000).**

NHST-00231.

5 NHS Tayside Clinical Governance Strategy 2013-2016 (November 2013).

NHST-01623.

6 All documents showing or tending to show the nature, policy behind and operation of information sharing systems between NHST and other bodies with responsibility for the oversight of Mr Eljamel, including but not limited to:

- 6(a) Insofar as relevant to the provision of healthcare over the relevant period, the UK Government;**
- 6(b) NHS Education for Scotland and its predecessor organisations;**
- 6(d) The Royal College of Surgeons (Edinburgh) and other relevant Royal Colleges;**
- 6(e) The Royal College of Surgeons;**
- 6(f) The General Medical Council;**
- 6(g) The British Medical Association;**
- 6(h) The Health and Safety Executive; or**

NHS Tayside holds no evidence for the above document requests.

6(c) The University of Dundee;

NHST-01598.

6(i) The Police

NHST-01613 and NHST-01614.

7 All documents showing or tending to show the nature, policy behind and operation of information sharing systems between NHST and former patients of Mr Eljamel or their representatives.

NHST-01488, NHST-01489, NHST-01490, NHST-01491, NHST-01492, NHST-01493, NHST-01494 and NHST-01495.

8 Any guidance, handbooks, codes, best practice guides or other similar documents issued by or available to the NHST relating to matters covered in the Inquiry's Terms of Reference over the relevant period, including but not limited to those relating to:

8(a) Appraisal, validation or revalidation requirements pertaining to medical professionals;

NHST-04374, NHST-04375, NHST-04376 and NHST-04377.

8(b) Reporting or self-reporting requirements pertaining to medical professionals;

NHST-04355, NHST-04356, NHST-04357, NHST-04358 and NHST-04359.

8(c) Neurosurgery generally but, in particular, spinal surgery, the use of radiology in neurosurgery and surgical marking;

NHST-01543 and NHST-01547.

8(d) The use of products or devices in surgery, including licensing considerations;

NHST-04388.

8(e) Medical ethics including but not limited to informed consent or patient communication more generally;

NHST-04360 and NHST-04361.

8(f) Consultant appointments, including qualifications;

NHST-01574, NHST-01575, NHST-00232 and NHST-01577.

8(g) The management of workload, including commitments to private practice and teaching commitments;

NHST-01518, NHST-01604, NHST-01520, NHST-01519, NHST-01516, NHST-01524, NHST-01609, NHST-01610, and NHST-01611.

8(h) Supervision and teaching of junior colleagues;

NHS Tayside holds no documentation in relation to the above request.

8(i) Medical research;

NHST-01515 and NHST-01514.

8(j) Professional governance, including compliance generally and, in particular with whistleblowing systems;

NHST-04402, NHST-01694 and NHST-04401.

8(k) Compliance with corporate of clinical governance processes more generally, including but not limited to mortality and morbidity meetings, multidisciplinary meetings, adverse incident or near miss reporting, serious clinical event analysis, audit requirements, internal assessments, continuing professional development;

NHST-00022, NHST-00040, NHST-00203, NHST-00204, NHST-00226, NHST-00231, NHST-01506, NHST-01509, NHST-01510, NHST-01512, NHST-01513, NHST-01537, NHST-01552, NHST-01553, NHST-01554, NHST-01623, NHST-01646, NHST-01648, NHST-01649, NHST-01650, NHST-01703, NHST-01706, NHST-04362, NHST-04363, NHST-04364, NHST-04365, NHST-04366, NHST-04367, NHST-04368, NHST-04369, NHST-04370, NHST-04371, NHST-04372 and NHST-04373.

8(l) Handling complaints, concerns and feedback;

NHST-01526, NHST-01527, NHST-01528, NHST-01529, NHST-01530, NHST-01531, NHST-01532, NHST-04411, NHST-04412, NHST-04384, NHST-04385,

NHST-04386, NHST-04387, NHST-04451, NHST-04389, NHST-04390, NHST-04391, NHST-04392, NHST-04415 and NHST-04414.

- 8(m) Candour on the part of surgeons or health boards, in particular with their patients, patient representatives, employer, regulatory bodies or the police;**

Documents provided in response to Request 2(q). See also below response to Request 8(n).

- 8(n) Standards of professional conduct when things go wrong, including self-reporting;**

NHST-01552, NHST-01553, NHST-01554, NHST-01579, NHST-04353, NHST-04354, NHST-04355, NHST-04356, NHST-04357, NHST-04358 and NHST-04359.

- 8(o) Clinical supervision or suspension;**

NHST-01574, NHST-01575 and NHST-01579.

- 8(p) Compliance with external reviews;**

NHS Tayside holds no evidence for the above document request in relation to compliance with external reviews

- 8(q) Document management; and**

NHST-01502; NHST-01589; NHST-01590; NHST-01591; NHST-01486; NHST-01454; NHST-01455; NHST-01456 and NHST-01484

- 8(r) Any other matter falling within the Inquiry's Terms of Reference or provisional List of Issues.**

NHS Tayside has no further information to provide at this time to the Inquiry, other than information it has provided previously or is providing as supporting evidence for this witness statement.

Appendix C – Part C – The NHS Tayside neurosurgical service and the work of Mr Eljamel

- 9 All documents showing or tending to show the nature of the professional work undertaken by Mr Eljamel during the course of his employment with NHST, including, for the avoidance of doubt, all neurosurgical theatre lists, theatre logs and on-call logs for the relevant period.**

NHST-01522, NHST-01547, NHST-01521, NHST-01587, NHST-01541 and NHST-01546.

- 10 All documents showing or tending to show statistical information about (a) how many NHS patients were under Mr Eljamel's care over the relevant period, each year and based on the type of surgery being performed or (b) how the number and types of patients under his care over that period compared with the number and types of patient numbers under the care of other consultant neurosurgeons employed by NHST?**

NHST-01587, NHST-01625, NHST-01626, NHST-01627 and NHST-00072.

- 11 In particular, all documents showing or tending to show proportion of professional responsibilities in the care and treatment of Mr Eljamel's patients was undertaken by him and what proportion was undertaken by junior surgical colleagues in training.**

NHST-01522, NHST-01547 and NHST-00072.

- 12 All documents showing or tending to show what impact, if any, this allocation of work between Mr Eljamel and his junior surgical colleagues in training had on outcomes for his NHS patients including the reasons for such impact.**

NHST-01516, NHST-00072 and NHST-01610.

- 13 National Health Service in Scotland Circular Clinical Governance NHS MEL (1998)75 and was subsequent updates.**

NHST-00231.

- 14 All theatre lists from the neurosurgical unit of Ninewells Hospital over the relevant period.**

NHST-01547, NHST-01548, NHST-01587, NHST-01586, NHST-01625, NHST-01628, NHST-01620, NHST-01626, NHST-01627, NHST-01638, NHST-01639, NHST-01651 and NHST-01652.

- 15 All staff rotas from the neurosurgical unit of Ninewells Hospital over the relevant period.**

NHST-01629, NHST-01547 and NHST-01525.

- 16 All documents showing or tending to show the facilities and standard procedures in place in the neurosurgical service of NHS Tayside over the relevant period including but not limited to:**

- 16(a) Those relating to the availability of imaging;**

NHST-00072, NHST-01522, NHST-01583 and NHST-01506.

- 16(b) Departmental guidelines relating to pre-operative marking relevant to the neurosurgical service of NHS Tayside over the relevant period;**

NHST-00072, NHST-01541, NHST-01630 and NHST-04352.

- 16(c) Surgical audit;**

NHST-01547, NHST-01603, NHST-01630, NHST-01534, NHST-01535, NHST-01536, NHST-01537 and NHST-01506.

16(d) Obtaining informed consent from neurosurgical patients;

NHST-01520, NHST-01519, NHST-01603 and NHST-01506.

- 17 All documents relating to the Action Plan commissioned by the NHST Board Medical Director in around June 2019 in response to the recommendations made in Ms Gillies' review and all documents showing or tending to show any action take to implement it.**

NHST-01631.

- 18 The programme of work commissioned by the then Chief Executive and Board Executive Medical Director of NHST since the publication of the Scottish Government review in 2022 and all documents showing or tending to show any action taken to implement it.**

NHST-01632, NHST-01633, NHST-01634, NHST-01635, NHST-01636 and NHST-01637.

Involvement in and impact of commitments to private practice

- 19 All documents showing or tending to show what patterns and types of private work were undertaken by Mr Eljamel over the relevant period.**

NHST-01516, NHST-01564 and NHST-00072.

- 20 All documents showing or tending to show what proportion of the work undertaken by him was in private practice and what proportion was in NHS Tayside in the relevant period.**

NHST-01516, NHST-01564 and NHST-00072.

Appendix C – Part D – Mr Eljamel's appointments

Term of Reference 1 - To investigate the processes leading to the appointment of Mr Eljamel to key positions he held in his professional capacity in Scotland, including (a) Consultant Neurosurgeon, Ninewells Hospital, Dundee on around 9 October 1995 (b) Head of Department /Section for Surgical Neurology, University of Dundee in around 1996 and (c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee in around 1998, including any induction he may or may not have received upon assuming such roles and the adequacy of the systems in place in that regard within NHS Tayside and the University of Dundee.

21 All documents showing or tending to show the process which was used to reach the decision that Mr Eljamel should be appointed to his post as Consultant Neurosurgeon, Ninewells Hospital, Dundee on around 9 October 1995, including but not limited to:

21(a) The way in which the role was advertised;

NHST-01504.

21(b) The application submitted by Mr Eljamel for the post, including any accompanying documentation;

NHST-01544.

21(c) The interview process, and

NHST-01653.

21(d) The decision-making process relating to the appointment, including but not limited to the assessment of his experience and qualifications, technical ability, training ability and patient communication and care.

NHST-01570, NHST-01544 and NHST-01653.

22 All documents showing or tending to show the process which was used to reach the decision that Mr Eljamel should be appointed to his post as Head of Department/Section for Surgical Neurology, University of Dundee in around 1996, including but not limited to:

- 22(a) The way in which the role was advertised;**
- 22(b) The application submitted by Mr Eljamel for the post, including any accompanying documentation;**
- 22(c) The interview process; and**
- 22(d) The decision-making process relating to the appointment, including but not limited to the assessment of his experience and qualifications, technical ability, training ability and patient communication and care.**

NHS Tayside holds no documentation in relation to the above requests as this was an appointment made by the University of Dundee.

23 All documents showing or tending to show the process which was used to reach the decision that Mr Eljamel should be appointed to his post as Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee in around 1998, including but not limited to:

- 23(a) The way in which the role was advertised;**
- 23(b) The application submitted by Mr Eljamel for the post, including any accompanying documentation;**
- 23(c) The interview process; and**
- 23(d) The decision-making process relating to the appointment, including but not limited to the assessment of his experience and qualifications, technical ability, training ability and patient communication and care.**

NHS Tayside holds no documentation in relation to the above requests.

24 All documents showing or tending to show the nature and extent of the induction which Mr Eljamel received for his appointments as (a) Consultant Neurosurgeon, Ninewells Hospital, Dundee on around 9 October 1995 (b) Head of Department /Section for Surgical Neurology, University of Dundee in

around 1996 and (c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee in around 1998.

NHS Tayside holds no documentation in relation to the above requests

25 In relation to any other positions or employment referred to in part D of appendix B above, all documents showing or tending to show the process which was used to reach the decision that Mr Eljamel should be appointed to them, including but not limited to:

- 25(a) The way in which the role was advertised;**
- 25(b) The application submitted by Mr Eljamel for the post, including any accompanying documentation;**
- 25(c) The interview process; and**
- 25(d) The decision-making process relating to the appointment, including but not limited to the assessment of his experience and qualifications, technical ability, training ability and patient communication and care.**

NHS Tayside holds no documentation in relation to the above requests.

26 All documents showing or tending to show the terms of each of the employments or positions held by Mr Eljamel referred to in part D of appendix b above, including but not limited to:

- 26(a) His responsibilities in each of these roles, including which hospitals these responsibilities covered;**

NHST-01540, NHST-01504, NHST-01542, NHST-01640 and NHST-01543.

- 26(b) What professional standards was he expected to adhere;**

NHST-01579, NHST-00242 and NHST-00243.

- 26(c) What restrictions, if any, applied to his ability to undertake private work in the role;**

NHST-01574 and NHST-01575.

26(d) What shift patterns and on call obligations he had;

NHST-01540, NHST-01542 and NHST-01543.

26(e) What responsibility for the training and supervision of others did he had; or

NHST-01542.

26(f) The way allocation of work to junior colleagues was arranged.

NHS Tayside holds no documentation in relation to the above request.

Appendix C – Part E – Document management within NHS Tayside

Term of Reference 14 - To investigate document management and retention systems within NHS Tayside relating to the professional practice of Mr Eljamel during the course of his employment there (for the avoidance of doubt including medical records and other documentation relating to his practice), including but not limited to the extent to which reviews or investigations into his professional practice during the course of that employment were to any extent undermined by lack of available documents.

27 All documents showing or tending to show the policies, practices or guidance underpinning document management systems in place relating to documents held by or on behalf of NHST related to the professional practice of Mr Eljamel while working in their employment (including for the avoidance of doubt medical records relating to the care of patients of Mr Eljamel and administrative records relating to his work there) including but not limited to those relating to:

27(a) Promoting and maintaining accuracy of records;

NHST-01599, NHST-01600, NHST-01601 and NHST-01602.

27(b) Access to medical records, including for patients;

NHST-01500, NHST-01589, NHST-01590 and NHST-01591.

27(c) Making records comprehensible to patients and other users;

NHST-01500.

27(d) Processing records;

NHST-01488, NHST-01489, NHST-01490 and NHST-01491.

27(e) Storage of records; or

NHST-01486, NHST-01488, NHST-01489, NHST-01490, NHST-01491, NHST-01589, NHST-01590, NHST-01591 and NHST-01457.

27(f) Retention of records.

NHST-01486, NHST-01488, NHST-01489, NHST-01490, NHST-01491, NHST-01453, NHST-01454, NHST-01455, NHST-01456, NHST-01457, NHST-01458, NHST-01459, NHST-01460, NHST-01461 and NHST-01470.

Appendix C – Part F – Previous investigations into Mr Eljamel**28 All documents showing or tending to show how and by whom/ which bodies reviews or investigations such as those relating to Mr Eljamel’s professional practice or systems connected the professional practice of Mr Eljamel listed in part F or appendix B above were ordered and conducted.**

NHST-01681, NHST-01680, NHST-01647, NHST-01678, NHST-01679 and NHST-01468. Further documents relating to this question and the reports listed below are included in each question below.

29 Copies of the following reports:

- 29(a) Any interim report of NHS Tayside relating to Mr Eljamel dated October 2013;**

NHST-00073, NHST-01555, NHST-01641, NHST-01642, NHST-01674 and NHST-01675.

- 29(b) Any final report of NHS Tayside relating to Mr Eljamel dated 6 December 2013;**

NHST-00072.

- 29(c) NHST review of spinal cases from 2010 to 2013, a direct recommendation from the RCS review;**

NHST-01663, NHST-01664, NHST-01665, NHST-01666 and NHST-01630.

- 29(d) The NHS Tayside review of complainant cases relating to Mr Eljamel 2014/15;**

Documentation for this request is provided in response to Request 29(c).

- 29(e) The Scottish Government Review of Unresolved and Outstanding Concerns regarding Mr Eljamel, Former Consultant Neurosurgeon at NHS Tayside 2022;**

NHST-04351.

- 29(f) The NHS Tayside Executive Medical Director Response to Patient A on undertaking a detailed review of surgery carried out and matters arising in theatre 2023; and**

NHST-01669, NHST-01670, NHST-01671 and NHST-01672.

- 29(g) The NHS Tayside look back at operative cases during the period of Mr Eljamel's supervision (June 21 2013 to December 10 2013) June 2023.**

NHST-01667 and NHST-01668.

All documents showing or tending to show the investigations undertaken which led to the reports listed in appendix F of appendix B, including the role of NHST in those investigations being commissioned and carried out.

NHST-00239, NHST-01556, NHST-01631, NHST-01632, NHST-01633, NHST-01634, NHST-01635, NHST-01636, NHST-01637, NHST-01578, NHST-01541 and NHST-01677.

- 30 All documents showing or tending to show any other investigations undertaken within NHST relating to the professional practice of Mr Eljamel while in the employment of NHST, other than those listed in the preceding paragraph.**

NHST-01549, NHST-01654, NHST-01655, NHST-01656, NHST-01630, NHST-01549, NHST-01657, NHST-01658, NHST-01593, NHST-01506, NHST-01566, NHST-01564, NHST-01659, NHST-01660, NHST-01556, NHST-00071, NHST-00072, NHST-01661, NHST-01578 and NHST-01662.

Appendix C – Part G – complaints and legal claims

- 31 All documents showing or tending to show the information relating to complaints or legal claims called for in part G of appendix B.**

NHST-01551 and NHST-01584.

Statement of Truth

I believe that the facts stated in this written statement are true.

Signed:

CAT C

Date: 8 June 2026