IN THE BIRMINGHAM & SOLIHULL CORONER'S COURT

BEFORE HM CORONER HIS HONOUR RICHARD FOSTER
NOMINATED PURSUANT TO SCHEDULE 10, CORONERS AND JUSTICE ACT 2009

In the matter of multiple Inquests touching the death of patients of Mr Ian Paterson for treatment for breast cancer

OPENING REMARKS BY HIS HONOUR RICHARD FOSTER

1. Today is the date fixed for the resumption of the Inquests into the deaths of 62 former patients of Ian Paterson who were treated by him either at Solihull Hospital, then part of the Heart of England Foundation NHS Trust and now part of University Hospitals Birmingham NHS Trust, or in the private sector principally at hospitals in Solihull and Sutton Coldfield run by BUPA until August 2007 and thereafter by Spire. Ian Paterson was appointed as a Consultant Surgeon at Solihull Hospital in 1998 and practised there until his exclusion in May 2011. In the private sector he was granted practising privileges by BUPA in 1993 and suspended by Spire in August 2011. He was suspended by the General Medical Council in 2012.

2. These hearings, which are likely to take several months, are the next phase in what has been a long journey. That journey commenced shortly after the criminal convictions of Ian Paterson for Inflicting Grievous Bodily Harm with Intent and Unlawful Wounding in 2017 when West Midlands Police referred a number of deaths to HM Coroner for Birmingham and Solihull. In 2023 it was decided that these should be judge-led Inquests, and I was nominated for this purpose.

3. Preliminary enquiries have been carried out into all former patients of Ian Paterson where Breast Cancer was shown to be the cause of death in Part 1 of the death certificate as well as those cases where the cause in Part 1 appears to be linked to breast cancer shown in Part 2. Every case has been referred to a multi-disciplinary team of medical experts which has considered a total of 562 deaths so far. That team has reported having applied a two stage test in each case – first to identify whether there appears to have been any culpable human or system failing in the medical management of a deceased's breast cancer, and secondly whether, on the balance of probabilities, that failing has more than minimally, trivially or negligibly contributed to death. The report from the multi-disciplinary team has informed me or my predecessor as to whether there is reason to suspect that the deceased has died an unnatural death, thus triggering the statutory duty to conduct an investigation (and ultimately an Inquest) pursuant to section 1 of the Coroners and Justice Act 2009. As a result of those reports the 62 Inquests the hearings of which begin today were

opened. A small number of deaths are still being considered and so it is possible that further Inquests will be opened.

4. The purpose of these inquests is for me to hear evidence so that I can make findings of fact and come to a conclusion about each death. The inquest is simply a way of establishing facts about the deaths. My role is to answer four main questions in each case. Who was the deceased? When, where, how (and, if appropriate, in what circumstances) did she come by her death? I am also required to record particulars for registering the death, such as date and place of birth and occupation. Evidence was heard at the opening of each Inquest to answer these questions apart from how and, where necessary, in what circumstances. I am not allowed to express an opinion on any other matters.

5. Article 2 of the European Convention on Human Rights (the "right to life") is engaged in these Inquests. Section 5(2) of the Coroners and Justice Act 2009 therefore applies and so the scope of the Inquests will include where necessary the following:

(a) Any failings in the recruitment and supervision of Mr Paterson by his colleagues, management and corporate governance. This will include considering whether Mr Paterson's clinical colleagues should have been put on notice that Mr Paterson was treating patients improperly and informed the appropriate authorities.

(b) Any systemic failing by the hospital management and corporate governance in addressing and responding to concerns raised about Mr Paterson.

(c) Any inaction or failure of supervision by the regulatory agencies and other NHS bodies.

(d) Any failings in the culture at the hospitals where Mr Paterson worked in addressing and preventing substandard medical treatment while Mr Paterson worked at each hospital.

(e) Any failings in the establishment and scope of the respective recall systems adopted.

I will also consider Reports to Prevent Future Deaths.

Module 1 which begins today will deal with the medical cause of death of each deceased and will consider the role not just of Ian Paterson but also his clinical colleagues. The subsequent modules will deal with the systemic and other wider issues.

6. Nobody is on trial here – whether they are an individual or an organisation. An inquest does not decide matters of criminal or civil liability. There is no question of attributing blame. Indeed, I am not permitted to frame any conclusion in such a way as to appear to determine any question of criminal liability on the part of a named person or civil liability.

7. The bereaved families will be at the heart of these Inquests. They have the right to participate in this process and they will be listened to, whether they are represented or not, as I endeavour to establish the facts. At the same time these proceedings must and will be conducted fairly. Fairness applies to all Interested Persons, and that includes Mr Paterson.

8. I make it clear from the outset that I come to each Inquest with an open mind and that it is open to me to reach a conclusion of death by natural causes without any culpable failings, if appropriate, on the evidence. On the other hand, I must also consider whether any death was caused by neglect, if appropriate. If death was from natural causes, I will need to consider whether any failings in the deceased's treatment contributed to death. If they did, I will need further to consider whether there were any systemic failings which allowed that to happen. I emphasise that these Inquests are not criminal or civil trials, but rather an investigation into the relevant facts to enable me to reach conclusions

9. There have been previous inquiries and investigations. University Hospitals Birmingham commissioned the report by Professor Sir Ian Kennedy. Spire commissioned its own report. The government set up the non-statutory inquiry chaired by the Right Reverend Graham James. However, apart from the GMC proceedings which related to limited issues only, these Inquests will be the first opportunity for evidence to be gathered from witnesses on oath, questioned by and on behalf of me as well as by Interested Persons, and where witnesses can by statute be forced to provide evidence. Those who declined to cooperate with previous investigations can now for the first time be made to provide evidence and answer questions. My investigation will be thorough and detailed. Module 1, dealing with the medical cause of death in each Inquest, will last until well into next summer, and the subsequent modules will not conclude until 2026. Those modules will cover if necessary the systemic issues, the role of the regulatory and other NHS bodies, the patient recall process and reports to prevent future deaths

10. I would like to take this opportunity to explain what will take place in the opening days of the Inquests. Ian Paterson has made an application to adjourn the Inquests and to seek to persuade me that I have the power to grant him public funding for legal representation. I must give those applications appropriate consideration. This I will do today with the intention of delivering my decision this afternoon.

11. If I do not accede to Mr Paterson's application then I will proceed this week and into next week to deal with certain generic matters.

12. Tomorrow I will hear evidence from Dr Andrew Stockdale, a Consultant Oncologist who worked closely with Ian Paterson and who first raised concerns about Mr Paterson's practices in 2003. I will also hear evidence from individuals who at the material times were part of the West Midlands Cancer Intelligence Unit.

13. On Wednesday I will hear evidence from two members of the multi disciplinary team of medical experts who have been advising me – David Dodwell (Consultant Clinical Oncologist at Oxford University Hospitals NHS Trust and Senior Clinical Research Fellow at the University of Oxford) and Rick Linforth (Consultant Oncoplastic Breast and Reconstructive Surgeon at the Bradford Teaching Hospitals). Their evidence will assist us all – and in particular the bereaved families – to understand the medical science surrounding the treatment of breast cancer. It must be understood that although my legal team has worked closely with these medical experts I have never met or spoken to them.

14. On Thursday of this week I will be calling Mr Paterson. It is intended for him to answer some generic questions about his clinical practice and procedure at the material time rather than speak about individual patients. I will call him on other occasions for that purpose.

15. On Monday of next week, I will hear evidence from Dr Mark Sibbering, who was at the material times President of the Association of Breast Surgery. I will also hear evidence about the policies at the hospital concerned for adopting new surgical procedures.

16. Certain IPs have expressed concern about the process adopted by my multi disciplinary team of medical experts as well as about potential bias. It is important that I and those engaged in these Inquests have confidence in the integrity of those processes. Accordingly, on Tuesday of next week I have arranged to hear from the other members of the team: Professor Nigel Bundred (Professor of Surgical Oncology and Consultant Surgeon at University Hospital, South Manchester), Professor Mike Dixon (Professor of Breast Surgery and Consultant Surgeon at Western General Hospital, Edinburgh) and Simon Russell (Consultant Oncologist at Addenbrooke's Hospital, Cambridge). This will ensure that CTI and IPs will have had the opportunity to explore with all members of my multi disciplinary team any concerns about the processes adopted by them.

17. It is planned on Wednesday of next week – so 16th October – to move on to the first Inquest.

18. I want to now address some remarks for the benefit of particular participants in the Inquest process.

19. First and foremost to the bereaved families. I know that some of you have the benefit of legal representation. Your lawyers will have contact with CTI in the same way as the legal teams of all other IPs. I wish to make it clear that all bereaved families have access to CTI to raise concerns or questions which they feel need answering and this can be done through Higgs LLP, the STI, who will be at court at every hearing.

20. Many of you will find some aspects of these Inquests distressing. You will find on the investigation website details of special arrangements with CRUSE which have been set up, together with useful guidance. A leaflet is also available at court.

21. I also recognise the importance of you knowing when the Inquest for your family member will take place. I will do my upmost to ensure that the time-table is adhered to, but this is not straightforward as some cases may take unexpectedly longer than others and hearings have to fit in with the clinical work of busy NHS practitioners.

22. To the press and media outlets. Fair and accurate reporting of these proceedings is encouraged, but at the same time the bereaved families deserve sensitivity and respect for their privacy. The STI will assist the media in every appropriate way. All material referred to in court will be made available apart from that of a personal or sensitive nature – the most obvious example being medical records. I will follow the Chief Coroner's Guidance No. 25 a copy of which can be made available to you and will in due course appear on the website. I understand the immediacy of modern journalism and STI will endeavour to respond to media enquiries accordingly.

23. Finally, a few words for the benefit of the legal teams to IPs. I have been grateful to you for your assistance with my investigations and I have no doubt that this will continue. However, I do please ask you to bear in mind at all times the bereaved families who have waited so patiently for the resumption of the Inquests and so to seek to manage legal submissions in such a way so as to minimise disruption to the Inquest time-table. This is not litigation but an investigation into to the relevant facts.

24. Around 56,000 people in the UK receive a breast cancer diagnosis each year. *"Patients rightly expect to be safe in the hands of the clinicians that treat them. They expect the regulatory system that wraps around the healthcare system to protect them"*. Those are not my words but the words of the then Secretary of State for Health and Social Care when responding to the Inquiry Report by Bishop James. Mindful of this in these Inquests I will ensure that all the relevant facts are fully, fairly and fearlessly investigated.

His Honour Richard Foster
HM Coroner
7th October 2024