IN THE BIRMINGHAM AND SOLIHULL CORONER'S COURT

HIS HONOUR RICHARD FOSTER

NOMINATED PURSUANT TO SCHEDULE 10 CJA 2009

INQUESTS TOUCHING UPON THE DEATHS OF PATIENTS OF MR IAN PATERSON FOR TREATMENT OF BREAST CANCER

Ruling upon Application on behalf of Mr Ian Paterson concerning MDT Bias and Objectivity

Background

1. In April 2017, Mr Ian Paterson was convicted of 17 counts of wounding with intent and 3 counts of unlawful wounding. He was sentenced to a 20-year custodial term. Following those convictions, West Midlands Police asked HM Coroner for Birmingham and Solihull to review a number of cases where patients had died from breast cancer and were previously treated by Mr Paterson. HM Coroner carried out preliminary inquiries into those cases under Section 1(7) of the Coroners and Justice Act 2009. She did this by setting up a multi-disciplinary team (MDT) of medical experts to review all those cases where former patients of Mr Paterson had died, in order to identify where there is any evidence to give reason to suspect an unnatural death as a result of his potentially substandard treatment. Initially, the MDT looked at 23 cases selected at random, but this was later expanded so that the MDT have reviewed all those cases where it is known that former patients of Mr Paterson have died of breast cancer. For these purposes, breast cancer must have been shown as the cause of death in Part 1 of the death certificate, or where there was a clear link between the cause of death in Part 1 to the cause of death as being breast cancer in Part 2. The MDT have reviewed, so far, 586 cases, 62 of which have resulted in Inquests being opened. A small number of cases are still being reviewed.

2. On 1st April 2023, I was nominated to conduct the investigations and Inquests pursuant to Schedule 10 of the Coroners and Justice Act 2009. At a Pre-Inquest Review Hearing on 9th June 2023, I ruled that I will sit without a jury and that Article 2 of the European Convention of Human Rights is engaged, and so by virtue of Section 5 (2) of the Coroners and Justice Act 2009, the scope of the Inquest will include:

   (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) Systemic failings 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 be considering Reports to Prevent Future Deaths pursuant to Section 5, paragraph 7 of the Coroners and Justice Act 2009.

3. The substantive hearings commenced on 7th October 2024 and have been divided into five modules as follows:

1. The cause of death;
2. Systemic issues;
3. Regulatory and other NHS bodies;
4. The patient recall process; and
5. Prevention of Future Deaths.

4. Module 1 is anticipated to continue until early 2026.

5. Where Inquests have been opened, the reports prepared by the MDT for the purposes of considering whether or not there has been reason to suspect unnatural death have been used as the basis for the evidence to be provided to the individual Inquests. I directed that it was neither proportionate nor necessary for those medical experts to provide any further or fuller reports.

6. The five core members of the MDT are:

Professor Nigel Bundred (now retired, but previously 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)
Mr Rick Linforth (Consultant Oncoplastic Breast and Reconstructive Surgeon at the Bradford Teaching Hospitals)
Professor David Dodwell (Consultant Clinical Oncologist at Oxford University Hospitals NHS Trust and Senior Clinical Research Fellow at the University of Oxford)
Professor Simon Russell (Consultant Clinical Oncologist at Addenbrookes Hospital, Cambridge)

Background to Mr Paterson's Application

7. On 26th February 2024, the solicitors on behalf of Mr Paterson made detailed submissions criticising the approach of the MDT on eight of the Inquests.

8. The letter of 26th February 2024 predated disclosure to Interested Persons (IPs) of certain emails passing between members of the MDT and the Solicitors to the Inquests (STI). The contents of those emails are set out at paragraphs 53 to 54 of the submissions by Counsel to the Inquests (CTI) dated 6th January 2025. For ease of reference, I repeat them here:

Email from Professor Mike Dixon, dated 2nd February 2024:

> "*We have to be consistent, but at times that is difficult because Paterson's surgery was performed to a terrible standard. The number of nodes in his clearances was so variable. I have a very similar case I will present on Monday. Paterson was also a liar and I rarely make such a statement. To do the mastectomy when the margins were clear was potentially an assault. I note that this was done privately.*
>
> *Axillary clearance is not well described. In the Supremo study we defined it as removing more than 10 nodes. By this definition then Paterson did clear nodes sufficient to classify it as a clearance. It is impossible on a single case to define a surgeon as incompetent but the amount of data we have is such that his surgery can be shown to be incompetent.*
>
> *I am not sure where that takes us with this case though. If we accept this case as more than minimally affecting outcome, then we need to go back to the other cases where nodal recurrence followed an inadequate axillary clearance which seems to be the norm for Paterson...*
>
> .....
>
> *Studies have however very clearly shown that leaving involved nodes behind does not appear to alter the prognosis.*
>
> *So despite huge concerns about Paterson's practice, I am clear in this case that an expert witness from the other side would be able to show the fallacy of Nigel's argument that the extent of axillary surgery affected the outcome. This is despite the fact that Nigel's case is well argued. I just do not think the available evidence supports that the extent of surgery affects survival. On this basis I do not feel a case based on the failure to remove more than 12 nodes merits referral to the Coroner. We need to find someway though of exposing Paterson as a liar and an incompetent surgeon who should never have been doing this surgery. He lied in the case I will present on Monday saying the margins were clear when he knew there was ink on DCIS.*"

Email in response by Professor Dodwell, 3rd February 2024:

> *"I fully agree with Mike. Why treatment to the axilla doesn't improve breast cancer mortality is a slight mystery, since there is RCT evidence that local treatment to the breast, post-mastectomy chest wall, and other (IMC and SCF) lymph nodes does!*

Consistency is key and I am worried about this because if we articulate different principles on different cases in the Autumn our credibility will take a serious hit.

Some key principles requiring consistency are:

- *The effect of treatment delay*
- *Poor local treatment doesn't negatively affect breast cancer mortality unless this is local recurrence*

And now

- *Inadequate axillary treatment doesn't affect breast cancer mortality."*

9. Those emails arose in the context of a review by the MDT of their findings in the Inquest of Janice Prescott which came about as the result of them having to review further medical records. As a result of these emails, CTI advised that the members of the MDT should reply to a detailed questionnaire, which advice I accepted. I gave directions for this and at paragraphs 56 to 58 of CTI's submissions of 6th January 2025, there is set out the relevant responses.

10. On 27th September 2024, Leading Counsel then instructed by Mr Paterson (Mr Hodivala KC) made submissions which were principally concerned with an application for funding for legal representation and the obtaining of expert evidence which I refused as I had no power to do so. Within those submissions there was a representation that the MDT should review all its reports in respect of the 62 opened Inquests.

11. As I have said, the resumption of the Inquests commenced on 7th October 2024, but the first two weeks were set aside for various generic issues which included each member of the MDT being made available for questioning in connection with any concerns about their objectivity bearing in mind those emails. Arising therefrom, I gave a preliminary ruling on 16th October 2024. I ruled as follows:

"*My provisional view, subject to representations, is that the members of the MDT have approached the cases which they have reviewed with independence and objectivity and have done so in accordance with their obligations as experts as set out in Part 35 of the Civil Procedure Rules. I am conscious of the background against which these Inquests arise. In expressing this preliminary view, I wish to make it clear to all Interested Persons that I will have uppermost in my mind, when assessing expert evidence in the individual Inquests, the potential for unconscious bias.*"

12. Thereafter, the resumption of the Inquests proceeded, and following my provisional ruling on 16th October 2024, no further applications, representations or submissions were received until a letter from Mr Paterson's solicitors, dated 29th November 2024, which included a detailed critique of three of the resumed Inquests: Gladys Currall, Christine Baker and Christine Gould. The letter raised questions about the objectivity of the MDT and the rigour of CTI in the questioning of the MDT at the Inquests which had been resumed. That letter did not seek any remedy, and therefore following submissions to me

by CTI, I gave directions for Mr Paterson and other IPs to provide submissions as to the way forward.

13. Further submissions were then received on behalf of Mr Paterson from Mr Robert Dacre of Counsel in which it was submitted that I should attach no weight to the evidence of the MDT and/or decline to hear further evidence from MDT members, that I should instruct an expert in evidence-based medicine to consider the literature and research upon, particularly, the issue of causation, and to instruct Mr Douglas Macmillan, Consultant Breast Surgeon and Professor Pat Price, Consultant Oncologist, to conduct a review of the MDT reports in all the cases not involving Spire Healthcare. These two experts had been instructed by Spire Healthcare in the eleven Inquests involving Mr Paterson's practice at the Spire private hospitals.

14. It should be mentioned that in those 11 Inquests which concern BUPA or its successor Spire Healthcare where Mr Macmillan and Professor Price have been instructed there has been expressed a different view to those expressed by the MDT on the issue of causation. Mr Macmillan has also provided different evidence to any other witness as to what constitutes a normal or standard mastectomy.

<u>The Causation Issue</u>

15. As a general principle, the MDT have adopted an approach to causation which can broadly be summarised as follows in cases where it is suggested that there was a partial or incomplete mastectomy:

    (a) The recurrence occurs in breast tissue which would have been removed in a properly performed mastectomy;
    (b) The local recurrence causes or more than minimally, trivially or negligibly contributes to the deceased developing metastatic disease; and
    (c) The deceased dies of metastatic disease.

16. Mr Macmillan and Professor Price (who for ease of reference I will refer to as the Spire instructed experts) take a different view on causation and, in particular, rely upon a number of research papers and medical literature to support the view that breast conserving treatment where breast tissue remains does not increase the risk of recurrence or mortality.

17. The above is a simplified summary of what is a complex issue and I have already ruled that there will be a need for several days of generic evidence dealing with this issue. For the purposes of this ruling it is not necessary for me to explore the detail of the medical literature or the divergence of views amongst the experts, save to recognise the complexity of the issues raised, the existence of the literature and the differing views upon it.

<u>Submissions by Other Interested Persons and the Hearing on 10th January 2025</u>

18. Submissions from other interested persons are summarised at paragraphs 13 to 16 of CTI's submissions to me of 6th January 2025. Although Spire had previously expressed "*a*

degree of concern" about objectivity arising from the emails, no other IP supports Mr Paterson's applications.

19. At a hearing on 10th January 2025, Counsel for Mr Paterson, as well as on behalf of a number of the families of the deceased and on behalf of University Hospitals Birmingham NHS Trust (UHB - the successor Trust to that which formerly employed Mr Paterson) expanded their written submissions orally. Sixteen families of the deceased have the benefit of legal aid and are represented by Counsel. Counsel for the families criticised the strident nature of some of the submissions on behalf of Mr Paterson which it was submitted was inappropriate in the context of a Coroner's Inquest. Criticism was also made of Mr Paterson only attending Court (remotely from the prison where he is serving his sentence) upon the days when he actually gives evidence and declining to appear on other days to exercise his rights as an IP. It is submitted that it is then inappropriate for him to criticise the conduct of the Inquests when he has failed to exercise those rights. Counsel for the families and also Counsel for UHB highlighted the sentencing remarks of Mr Justice Jeremy Baker (as he then was) when sentencing Mr Paterson following his criminal convictions which made repeated references to Mr Paterson's dishonesty. Counsel for UHB also stressed the importance of an early resolution of the generic issues concerning causation.

The Substance of Mr Paterson's Applications

20. The submissions on behalf of Mr Paterson can be summarised as follows:

(a) As evidenced by the email sent by Professor Dixon, the MDT have shown actual bias such that I should decline to hear their evidence.
(b) Further or alternatively, there has been unconscious bias and a lack of objectivity.
(c) The evidence from the MDT is so unreliable that I should decline to consider it.

The Test for Bias

21. The law in relation to the duties of an expert and bias are set out fully by CTI in their submissions of 6th January 2025 at paragraphs 37 to 42 and I do not repeat them here.

22. Clearly, I must consider all types of bias, whether this be actual or intentional bias (as is alleged here), or subconscious bias. Bias means a preconceived opinion that is not based upon reason or actual experience. It is also important to separate bias (actual or subconscious) from a difference of opinion or a disagreement with other experts of a similar discipline.

23. Although the wording of the emails from Professor Dixon is unfortunate, clumsy and inappropriate, in themselves I am satisfied that they cannot be the decisive test for bias. Indeed, Mr Paterson has been proved to have told lies to the criminal standard of proof, and there is evidence of at the very least inaccuracies in letters written by Mr Paterson to General Practitioners when reporting upon test results and the like.

24. I find far more helpful the six tests proposed by CTI in their submissions to me dated 6th January 2025 contained at paragraph 47 which are as follows:

(a) Whether the MDT has approached the individual Inquests in an objective and forensic manner.
(b) Whether there are reasonable grounds for reaching the conclusions that they reached in respect of the cases.
(c) Whether, if there was a range of opinion, the MDT consistently chose the opinion which was contrary to Mr Paterson's interests.
(d) Whether the MDT has distorted, misrepresented or otherwise manipulated the available literature contrary to the interests of Mr Paterson.
(e) Whether the MDT has deliberately and unfairly mis-stated the medical notes or the literature in a manner contrary to the interests of Mr Paterson.
(f) Any other matters which might suggest a prejudice or bias against Mr Paterson.

25. I will deal with each test in turn.

Has the MDT approached the individual inquests in an objective and forensic manner?

26. The MDT have reviewed 586 cases, from which only 62 have met the evidential threshold to require an Inquest to be opened. By way of further examples of this, there are approximately 30 cases which have been reviewed by the MDT when it was found as a fact that there had been an incomplete mastectomy (for which the MDT chose to use the nomenclature of a "cleavage sparing mastectomy") where Inquests have not be opened because, upon the view of the MDT, there was, on the balance of probabilities, no causative link between that incomplete mastectomy which was criticised and the eventual outcome.

27. There have been differences of opinion within the MDT which have been expressed in evidence. Most noticeably in the Inquest on Isobel Chandler, Professor Dixon did not criticise the treatment and gave evidence that, in his view, there had been metastases at the time of diagnosis and prior to the mastectomy. In the same Inquest, Professor Bundred and Professor Dodwell expressed a different view that the most likely course of the disease was the metastatic spread of cancer from a local recurrence in the breast.

28. The change of view by the MDT in the Inquest of Janice Prescott is also telling whereupon the review of further medical records (although these were not the cause for the change of view), Mr Linforth and Professor Dodwell differed from the initial views expressed by Professor Bundred and opined that the failure to achieve node clearance was not causative of the death.

29. If a further example of objectivity and forensic analysis is required, this can be obtained from the Inquest into the death of Shionagh Gough, where Mr Linforth and Professor Russell took a different view from Professor Bundred. Professor Bundred had initially criticised the operative treatment carried out by Mr Paterson which he thought was indicative of an incomplete mastectomy, leaving behind breast tissue. On the other hand, Mr Linforth gave evidence that all breast tissue had been excised within a timely manner and Professor Russell made no criticism of the oncological treatment.

Are there reasonable grounds for reaching the conclusions that the MDT reached in each case?

30. In all the Inquests which have been resumed so far, there has been a forensic analysis of the evidence from MDT members when it has been given.

31. In the initial stages of the Inquests, MDT members gave generic evidence which dealt with some of the guiding principles applied by them. This will be explored further in later generic hearings, but there was nothing inherently illogical or unreasonable about those principles. By way of example, which I have already touched upon, an incomplete mastectomy was deemed to be not causative of the metastatic spread of cancer where there had not been a local recurrence in the breast. Some of the guiding principles were also mentioned by Professor Dodwell in his February 2024 email set out at paragraph 8 above.

32. Although in the Inquest into the death of Chloe Nikitas there did develop a conflict in the medical evidence, particularly between Professor Bundred and Mr Douglas Macmillan, the Consultant Breast Surgeon instructed by Spire Healthcare whom I agreed should be called. Again, this is a dispute which will be explored further in later generic hearings when a closer analysis of the research material and medical literature will be required. However, Professor Bundred, by way of example, quoted research material from Nottingham and Stevenage in support of his contention of a causative link between incomplete mastectomies, local recurrence and metastatic spread, whereas Mr Macmillan, relying upon other research material, opined that there was no causative link between incomplete mastectomies and recurrence and mortality. This is a conflict in the medical expert evidence, which is commonplace in the civil courts, but in my judgment can never by itself be indicative that one expert or set of experts are biased or held their views unreasonably.

Where there is a range of opinion, has the MDT consistently chosen the opinion which was contrary to Mr Paterson's interests?

33. The examples which I have already given from the Inquests into the deaths of Janice Prescott, Shionagh Gough and Isobel Chandler all indicate views being expressed by the MDT when there is a range of opinion and where the concluded views are not contrary to the interests of Mr Paterson.

34. Again, as I have already pointed out, there were a number of cases reviewed by the MDT where, despite criticism of the operative technique by Mr Paterson, the MDT came to the view that there was no causative link to the eventual outcome.

35. There have also been many occasions during the medical evidence in the resumed Inquests when MDT witnesses have not criticised clinical decisions taken by Mr Paterson.

Have the MDT distorted, misrepresented or otherwise manipulated either the available literature or medical notes in a manner contrary to Mr Paterson?

36. There is a clear conflict which has developed in these Inquests with a range of medical literature and research material concerning, in particular, the recurrence and mortality rates following breast conserving treatment with adjuvant therapy, compared with a standard or normal mastectomy.

37. The Spire instructed experts have drawn upon that material to express views doubting the causative link between incomplete mastectomies and recurrence or mortality. On the other hand, members of the MDT, drawing upon the same and other available material, have taken a different view.

38. As I have already said, these are important issues which will have to be explored forensically in future hearings, but the existence of that conflict in the medical evidence and the interpretation of the available material is nothing unusual in the civil courts.

39. I have seen no evidence of manipulation or distortion. Furthermore, it should be borne in mind that I have heard other evidence from clinicians supportive of the views expressed by the MDT on causation and on the criticism of some of Mr Paterson's operative techniques. Such evidence has been given by, amongst others, Professor Kirby and Mark Sibbering, both former Presidents of the Association of Breast Surgery, as well as Mr Martin Lee, a Consultant Breast Surgeon who also practised in the West Midlands at the material times.

40. As regards to the interpretation of medical records, a close forensic analysis has taken place of the available records upon which members of the MDT giving evidence have been questioned, and I have seen no indication of the interpretation of those records as having been manipulated or misinterpreted.

Any other matters which might suggest prejudice or bias against Mr Paterson

41. There have been differences of opinion within the MDT expressing different views upon any culpable, causative failings by Mr Paterson. Furthermore, other clinicians of the same discipline have supported the views of members of the MDT.

42. There has been what could be regarded as a healthy disagreement between medical experts which the courts are familiar with having to resolve. Such a disagreement, based upon sound principles, can in my judgment never, by itself, be indicative of bias or prejudice.

Conclusions as to bias and reliability

43. For there to be actual bias, it seems to me that I must be satisfied on the balance of probabilities that either a witness has conducted himself in such a way as to indicate bias or prejudice, or that the views expressed by such an expert are so irrational or unreasonable that they can only be due to such bias or prejudice.

44. The emails from Professor Dixon, in my judgment, cannot by themselves be indicative of such bias or prejudice. It is to be noted that the criticism on behalf of Mr Paterson is against Professor Dixon's emails rather than the follow up email from Professor Dodwell. However, taken separately or together, those emails do not evidence actual or unconscious bias. They can do no more than, as has happened here, be the catalyst to explore the issue further.

45. As I have indicated in the course of this Ruling, any views expressed by members of the MDT cannot be said to be irrational or unreasonable, being supported as they are by other clinicians and relying as they do upon available literature and research material.

46. Insofar as there has developed a difference of opinion with other experts, in particular with the Spire instructed experts, the forensic process in these Inquests will explore and examine these further to enable me to reach conclusions where it is necessary so to do. I will be giving further directions in this regard.

47. As I have said in a previous Ruling, I am conscious of the background against which these Inquests arise, namely an investigation into the practices of a Consultant Breast Surgeon who is now serving a 20 year prison sentence for wounding with intent and unlawful wounding in the course of his professional practice. However, nothing I have seen or heard in these investigations or Inquests has indicated to me any unconscious bias by the MDT. Nevertheless, I, as the tribunal of fact, will have the potential for such bias uppermost in my mind when assessing evidence in these Inquests. My task is to fully, fairly and fearlessly investigate all relevant facts. Fairly includes fairness to Mr Paterson as well as to every other party.

48. The other limb of Mr Paterson's application deals with the alleged unreliability of the MDT evidence such that I should not rely upon it. As I have already said, although there is a difference of views on important aspects arising in these Inquests, particularly that of causation, I can find nothing irrational or unreasonable in any views expressed by the MDT. Some of the detailed criticisms of evidence to date are dealt with fully in the appendices to CTI's submissions of 6th January 2025.

<u>The way forwards</u>

49. My conclusion that there is no actual or unconscious bias or prejudice on the part of the MDT, nor any other matter which should render their evidence inadmissible, is not the end of the matter.

50. Nothing in this finding takes away my discretion to give directions and make decisions concerning the future conduct of the Inquests.

51. I need to consider what medical evidence I should hear and how the resolution of the important generic causation issues should be resolved.

52. It should also be borne in mind that I will not necessarily have to make a decision on the balance of probabilities on every issue which arises in these Inquests. Obviously, I will do so where this is possible and appropriate, but it might be that in some Inquests I am

unable to reach such conclusions but instead will express some issues as a possibility rather than a probability. These Inquests are not civil litigation trials where a Judge has to either find the case proved or dismissed.

Medical expert evidence going forwards

53. As I have already said, the February email from Professor Dixon was unfortunate, inappropriate and clumsy, although by itself it is not indicative of actual or unconscious bias for the reasons I have set out. Insofar as he has given evidence or been the author of reports, I am satisfied that his evidence is properly admissible.

54. However, the matter does not end there. I have to consider whether going forward it would be appropriate, necessary or in the best interests of the conduct of these Inquests for Professor Dixon to continue to give evidence and be part of the MDT.

55. Of course, Professor Dixon nor any other medical expert is not the tribunal of fact – I am. A medical expert does no more than provide me, the Coroner, in these Inquests with expert opinion outside my knowledge. It being then for the Coroner to, where necessary, make decisions based upon all the evidence in the Inquest.

56. Although Professor Dodwell was also involved in an email exchange where he was expressing concerns about the credibility of the MDT being maintained, I note that the thrust of the criticism on behalf of Mr Paterson is in connection with Professor Dixon's email and not that of Professor Dodwell.

57. The well-known test for bias and the need for recusal for a Judge or Juror is that of bias or the appearance of bias (my emphasis). Certainly, applying this enhanced test, Professor Dixon, if he were a Judge would have to recuse himself and if a Juror, would be discharged.

58. The authorities are quite clear that I have a wide discretion to determine what evidence I should or should not hear. This is perhaps best summarised in the dicta of Toulson LJ (as he then was) in *R (Mack) v HM Coroner for Birmingham and Solihull [2011] EWCA Civ 712*:

"9. There is clear authority and it is not in dispute that this gives to the coroner a wide discretion – or perhaps more appropriately a wide area of judgment – whom it is expedient to call. The court will only intervene if satisfied that the decision made was one which was not properly open to him on Wednesbury principles."

59. Before I came to any final conclusions on how I should exercise that discretion I sought the advice of CTI and submissions from other IPs upon the following question:

"Whether having concluded an expert was not actually or subconsciously biased would it be a lawful and proper exercise of a coroner's discretion to nonetheless exclude that expert's evidence going forwards in order to allay concerns as to fairness held unilaterally by one Interested Person but not shared by other Interested Persons"

60. Advice from CTI dated 28th January 2025 concluded that to exclude the evidence of an MDT member in these circumstances would be a Wednesbury unreasonable exercise of my discretion for the reasons set at paragraphs 23 to 28 of that advice which I do not

repeat here. The only submissions from an IP are those on behalf of Mr Paterson dated 4th February 2025 in which it is submitted that to exclude such evidence going forwards would be a lawful exercise of my discretion for the reasons summarised at paragraph 38 of those submissions.

61. There are five core members of the MDT: Professor Dixon, Mr Linforth, Professor Bundred, Professor Russell and Professor Dodwell. The first three are consultant breast surgeons, and the latter two consultant oncologists.

62. I have concluded that it would be in the best interests of the future conduct of the Inquests if Professor Dixon withdrew from the MDT for the purposes of the ongoing inquiries to see if any remaining cases being reviewed need to have Inquests opened. In so doing, I make it clear that I make no criticism of his professional integrity. I also conclude for the same reasons that his role as a witness in the Inquests going forwards should be limited in the manner which I set out below.

63. I accept that the offending email could give the appearance of bias. Although such an appearance is not the test for bias when considering an expert witness, I can well understand why Mr Paterson might feel a sense of unfairness about Professor Dixon continuing as an expert witness. The core MDT will still then consist of two breast surgeons and two oncologists. Although I am not excluding Professor Dixon as an expert witness in the Inquests going forwards, I am limiting his involvement to those Inquests where his evidence is necessary in order for me to carry out a full and fearless investigation.

64. Professor Dixon should continue to complete the pro-forma questionnaire on each Inquest so as to ascertain if there was a range of opinion within the MDT and if so whether he had a different view to those expressed in the MDT report. All IPs will see the responses and an application can be made that I should hear evidence from Professor Dixon in a particular Inquest, or I can decide that he should provide evidence. An application can also be made by CTI. However, going forwards, the MDT evidence should be given by the other members of the MDT save in those Inquests when I decide to the contrary. As regards the generic issues this should be dealt with by the remaining members of the MDT, but to ensure that the Inquests are not deprived of relevant evidence Professor Dixon should be asked if he has any different views to those expressed by the remaining MDT members.

65. I am satisfied that to limit Professor Dixon involvement going forwards is a lawful exercise of my discretion for these reasons:

(a) I am not excluding Professor Dixon's evidence but rather limiting it to where it is necessary for my investigation.

(b) I am not ruling that his evidence is inadmissible, but just for pragmatic reasons limiting it to where necessary.

(c) It is not illogical or irrational to so limit his evidence in a situation where, as here, he has already given evidence in a number of resumed Inquests because the concerns placed before me on behalf of Mr Paterson have developed and expanded since the commencement of Module One on 7th October 2024.

(d) I do not accept that the subjective view of Mr Paterson is an irrelevant consideration. I am not excluding any evidence from Professor Dixon which is relevant but simply relying on other members of the MDT, and indeed other expert evidence where necessary, unless I am of the view that Professor Dixon has additional or different expert evidence to give. Such a pragmatic exercise of my discretion is consistent with the concept of "fairness" expressed by Burnett LJ (as he then was) in *R (Wilson) v HM Coroner for Birmingham and Solihull [2015] EWHC 2561* as well as the concept of "practical justice" expressed *in R (LePage) v HM Assistant Deputy Coroner for Inner South London [2012] EWHC 1485 (Admin)*.

(e) I have received no submissions from next of kin on this issue many of whom have legal representation. I do not consider that the directions in this Ruling will have any negative impact on next of kin.

(f) In so far as Professor Dixon has relevant evidence to give then I will hear it.

66. Another submission on behalf of Mr Paterson is that I should instruct the Spire instructed experts in all the NHS cases. I have considered this carefully but have come to the conclusion at this stage that the cross-admissibility of the evidence from the Spire cases together with the generic causation evidence will provide the necessary expert evidence in all the Inquests. As I have already said expert evidence should be kept to the minimum which is necessary to resolve the medical issues in the Inquests. Nevertheless, I will keep this under review on an Inquest-by-Inquest basis and will not hesitate to seek further expert evidence if this is needed – whether that be from the Spire instructed experts or others.

<u>The generic causation issues</u>

67. In the course of his oral submissions to me, Mr Robert Dacre of Counsel, on behalf of Mr Paterson, developed his submissions regarding the medical literature and research material dealing with the issue of causation following breast conserving treatment compared with a normal mastectomy. His argument is that a mastectomy leaving behind breast tissue such as the "cleavage sparing mastectomy" practiced by Mr Paterson gives no greater risk to recurrence or mortality.

68. This is clearly a complex area where there is a considerable volume of literature and research material from not just the UK, but around the world. It is neither appropriate nor necessary for me to seek to understand that material for the purposes of this Ruling and I do not attempt to do so.

69. I also reject Mr Dacre's submission on behalf of Mr Paterson that there is a need at this stage for me to instruct an expert in evidence-based medicine. I am satisfied that medical experts providing evidence to the Inquests can provide me with the expert evidence which I need in connection with the available literature. Again, however, I will keep this under review.

70. It is also important that there is not a plethora of excessive expert evidence, and that such expert evidence as there is, is focused and relevant.

71. Although Mr Macmillan and Professor Price have only been instructed on the 11 Inquests involving Spire Healthcare, their evidence in those Inquests as well as on the generic issues, will be equally as admissible and relevant in all the Inquests.

72. What is needed is a timetable for the generic causation issues to be explored, first of all by the provision of focused and relevant reports, and thereafter by hearings in which oral evidence can be given and the expert witnesses can be questioned by CTI as well as IPs. I accept the submission on behalf of UHB that the hearing of this evidence should take place sooner rather than later.

73. What has emerged in the Inquests to date, in particular that of Chloe Nikitas, is a clear divergence of opinion. These are issues upon which I need to make a finding on the balance of probabilities if that is possible on an Inquest-by-Inquest basis. However, it must be borne in mind that each Inquest is different and specific to its own facts, with different radiology and pathology, as well as a different course of the cancer in each case.

74. The MDT has not, at this stage, provided a generic report focusing particularly on these generic causation issues and, in my view, it is essential that they do so. I see no reason why the four core remaining members of the MDT (the two surgeons and the two oncologists) should not do so.

75. Likewise, the Inquest Legal Team (ILT) have been promised generic causation reports from the Spire instructed experts. I am informed by CTI that these reports have now been received although I have not seen them.

76. In order to assist the experts (and thereafter me), it would be helpful for CTI to propose a structure for such reports and the issues which need to be dealt with so that there is some consistency in the approach to providing the expert evidence from both the MDT and the Spire instructed experts. IPs can then make submissions upon CTI's proposals with a view to a finalised document going forward, hopefully in an agreed format and approved by me.

77. I also need to set a timetable for the provision of the generic expert evidence from the MDT and the Spire instructed experts. I will not do so in this Ruling, but direct as a matter of urgency that the ILT in liaison with IPs and their legal teams agree a proposed realistic, but urgent, timetable for my approval but failing agreement returning to me for a ruling.

78. I did, at an early stage in these Inquests, consider with the ILT whether a meeting of experts would be helpful and appropriate in order to ascertain areas of agreement and disagreement. This is of course a familiar procedure in civil litigation and could be of benefit in these Inquests. At that stage, such a proposal or suggestion was rejected by me upon the basis that it would seem to be inappropriate for important issues on the

medical evidence being dealt with outside Court and not in full sight of IPs, particularly the next of kin, many of whom are unrepresented.

79. I do now, however, feel that the stage has been reached that such a meeting would be helpful on these generic causation issues. One way forward might be for such a meeting to take place on Microsoft Teams to be recorded and that recording to be available to IPs. In any event, all IPs would see the fruits of such a meeting in the form of the familiar joint schedule of areas of agreement and disagreement. I seek further submissions on this before I make a final decision.

80. I will also keep under review the need for any further medical or other expert evidence, but as I have already said I need to avoid unnecessary further evidence provided I am satisfied that the existing experts can provide what is required.

81. In summary, therefore, I direct:

(a) There should be an agreed document (or failing agreement, one finalised by me following submissions) upon the questions to be answered and the issues addressed on the generic causation issues.
(b) Reports should be produced from the MDT and the Spire instructed experts on a strict timetable. Although I am informed that generic reports have recently been received from the Spire instructed experts. It might be that these will need revisiting following the agreed document setting out the generic issues to be addressed.
(c) Thereafter, there should be a meeting of the experts, although, as I have said, I will hear further submissions upon this proposal.
(d) Finally, there should be, at the earliest opportunity, adequate court time set aside for an oral hearing of the generic causation issues.
(e) Although I will not, and it would be inappropriate for me to do so, deliver any conclusions on those generic issues at that stage, I will carry forward that evidence as being admissible and relevant in each of the Inquests. In this regard, in no Inquest is the evidence complete or have I reached any conclusions, save for one where Mr Paterson was not the surgeon, and the Inquest was opened under a misunderstanding because of the lack then of available medical records.

<u>The way forward with the Inquests generally</u>

82. There are currently 61 Inquests to complete, only one having reached a conclusion. In addition, the MDT are still considering further cases where Inquests might be opened and so it is likely that this number will increase. It is clear that the hearing of Module 1 dealing with the medical issues will last throughout this year and into 2026.

83. A particular difficulty has been Inquests being adjourned part-heard, sometimes because of the availability of expert witnesses, and in other cases because of further medical records becoming available.

84. It is my intention to seek to conclude (although not deliver conclusions) the primary evidence in the opened Inquests which have been adjourned part-heard as soon as possible, and for Inquests going forwards that, so far as possible, they are heard one by

one to a conclusion of the evidence without the need to be adjourned part-heard. Inevitably, this might have to occur in some Inquests, but it should be avoided if possible.

85. I am grateful to all the participants in these Inquests, by which I mean CTI, and IPs and their legal representatives to include, of course, the next of kin and Mr Paterson. Their cooperation and participation can only add to the quality of my investigation.

86. It is my hope that this Ruling and the further directions which flow therefrom will form the basis for the successful conclusion of the medical issues in Module 1 with which I have to deal upon an Inquest-by-Inquest basis.

HH RICHARD FOSTER

6th February 2025