

Report of the Independent Inquiry into the Issues raised by Paterson

Chairman: The Right Reverend Graham James

February 2020

Return to an Address of the Honourable
the House of Commons
dated 4 February 2020 for

Report of the Independent Inquiry into the Issues raised by Paterson

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An opening statement by the Chair of the Paterson Inquiry

The Rt Revd Graham James

This report is not simply a story about a rogue surgeon. It would be tragic enough if that was the case, given the thousands of people whom Ian Paterson treated. But it is far worse. It is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were the victims of Paterson's malpractice were let down time and time again.

They were initially let down by a consultant surgeon who performed inappropriate or unnecessary procedures and operations. They were then let down both by an NHS trust and an independent healthcare provider who failed to supervise him appropriately and did not respond correctly to well-evidenced complaints about his practice. Once action was finally taken, patients were again let down by wholly inadequate recall procedures in both the NHS and the private sector. The recall of patients did not put their safety and care first, which led many of them to consider the Heart of England NHS Foundation Trust and Spire were primarily concerned for their own reputation. Patients were further let down when they complained to regulators and believed themselves frequently treated with disdain. They then felt let down by the Medical Defence Union which used its discretion to avoid giving compensation to Paterson patients once it was clear his malpractice was criminal. Only by taking their cases to sympathetic lawyers did some patients find themselves heard. By that stage many others found their exhaustion was too great and their sense of rejection so complete that they scarcely had the emotional or physical strength to fight any further. Even today, many patients, especially those treated within Spire hospitals, have no individual care plan. Thousands of people are still living with the consequences of what happened. It is wishful thinking that this could not happen again.

The Inquiry team were told by regulators and other witnesses that procedures and processes had tightened up considerably in the past decade. We were informed that the regulatory system was more vigilant, and patient safety was now given a much higher priority so that another Paterson would be unlikely. We acknowledge many areas of improvement in processes and procedures. But in Paterson's years of practice, there were many regulations and guidelines in place which were disregarded or simply ignored, and not just by him. It was striking that regulators testified to major improvements which they thought would identify another Paterson, while the clinicians we met believed that, despite the changes, it was entirely possible that something similar could happen now. The testimony of those on the front line is telling.

It is tempting for inquiries to recommend fresh layers of regulation. But our healthcare system does not lack regulation or regulators. The resources they possess, both human and financial, are very considerable. There is no process, procedure or regulation which can prevent malpractice on its own. This report is primarily about poor behaviour and a culture of avoidance and denial. These are not necessarily improved by additional regulation. The sheer

number of regulatory bodies and the complexity of their areas of responsibility meant that Paterson's patients thought the system unfocused and scarcely possible to navigate, while many clinicians seemed to feel the same, and so avoided engagement with it.

We were told that if there was more accessible data about a consultant's whole practice, then the events described in this report would have been stopped more quickly. We have made a recommendation in this area, but it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used, and then made available to the public, which determines its value. Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.

This capacity for wilful blindness is illustrated by the way in which Paterson's behaviour and aberrant clinical practice was excused or even favoured. Many simply avoided or worked round him. Some could have known, while others should have known, and a few must have known. At the very least a great deal more curiosity was needed, and a broader sense of responsibility for safety in the wider healthcare system by both clinicians and managers alike. However, some seem to have been inhibited from complaining because they had seen colleagues appearing to get nowhere by doing so (and in some cases finding themselves under investigation). A few of Paterson's more junior colleagues commented that the unusual character of his surgical practice (compared with other breast surgeons) was well known. To a surprising degree he was "hiding in plain sight".

While patients have been our focus, the impact of what is described in this report has been enormous for many clinicians and others who either worked with Paterson or came into contact with him. Those who did take action but were then poorly served by those to whom they reported, have themselves been traumatised. Some who should have taken action now live with the guilt. Others are in a state of denial. Many patients felt that some of those who worked closely with Paterson should answer for their actions or negligence. In conducting this Inquiry, I have reported five health professionals to either the General Medical Council or the Nursing & Midwifery Council and referred one matter for investigation by the West Midlands Police.

There are two other issues that concerned some patients and their families, and which other agencies have the legal competence to pursue. The first relates to those Paterson patients who have died and whose families are left wondering if they would not have done so if treated by another surgeon. This is a task for the Coroner. The Inquiry team did not have the authority to pursue individual cases, but we engaged with the Birmingham and Solihull Coroner on this question. I am confident this serious and distressing matter will be rigorously pursued.

The second matter raised with us concerned the belief among patients that at his criminal trial, Paterson was in receipt of legal aid, despite his high earnings over many years. I have reported this claim to the Legal Aid Agency and asked that it is investigated.

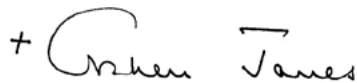
The regular restructuring of healthcare and its agencies, regulators and organisations meant that some of our corporate witnesses noted that their own organisation did not exist when Paterson was practising. The reluctance to take responsibility for predecessor bodies may be understandable, but it leads to a significant loss of corporate memory, together with an offloading of responsibility, and thus undermines accountability. As it is, only just over eight years have passed from the day Paterson was suspended from practice to the publication of this report. We are not speaking of a different age. This tragic story would not have been told in its fulness were it not for a relatively small number of Paterson patients who were

determined to prevent other people suffering as they had done, and who pressed for an Inquiry. I pay tribute to their brave and resolute determination. If patients in the future are safer in both the NHS and the independent sector as a result of this report, it will be due largely to their efforts, and to the many patients who gave such detailed and frequently harrowing testimonies. Their courage and nobility in the face of so much suffering has been an inspiration. It is to them and their families that this report is dedicated.

Acknowledgements

The Inquiry team has been a small and extremely hard-working one. I have also been very well served by three independent advisors and by a separate clinicians' panel. Their names are found in appendix 2. Several hundred evidence sessions have been held with patients, families and other witnesses during the course of the Inquiry. The independent advisors participated in many of them and their insights have helped to shape the report and recommendations. The clinicians met as a group and were valuable in helping me and the Inquiry team explore some of the clinical and medical issues which arose. The way in which a substantial amount of evidence was systematically recorded and analysed has been a key element in being able to complete the report in good time. Only the sheer number of witnesses, and then later the General Election, has caused us to overshoot the intended aim of reporting within 18 months of establishing the Inquiry.

The Inquiry team's dedication to the task, and their capacity to handle a large amount of work and to compile such a detailed report is a testimony to the ability of everyone within it. It also reflects their excellent teamwork under the leadership of Rebecca Chaloner, who has been instrumental in enabling every aspect of the Inquiry's work to be fulfilled well. I am immensely grateful to her and to every member of the team, the independent advisors and the clinicians' panel for all they have contributed to this report.

A handwritten signature in black ink that reads "Graham James". The signature is written in a cursive style with a small cross at the beginning.

Bishop Graham James

CHAPTER ONE – Introduction

In April 2017, Ian Paterson, a surgeon in the West Midlands, was convicted of wounding with intent, and imprisoned. He had harmed patients in his care. The scale of his malpractice shocked the country. There was outrage too that the healthcare system had not prevented this and kept patients safe. At the time of his trial, Paterson was described as having breached his patients' trust and abused his power.

In December 2017, the Government commissioned this independent Inquiry to investigate Paterson's malpractice and to make recommendations to improve patient safety.

This report presents the Inquiry's methodology, findings and recommendations. More importantly, it tells the story of the human cost of Paterson's malpractice and the healthcare system's failure to stop him, and something of the enduring impact this has had on the lives of so many people.

Chapter two describes how the Inquiry was set up and how we did our work. It also tells the story of how we reached out to former patients of Paterson and their families, to make sure that they were at the heart of all we did.

A summary of the experience of each patient who gave evidence to the Inquiry is included in chapter three. Two hundred and eleven patients, or their relatives, gave evidence to the Inquiry and we are grateful to them for their courage in coming forward. We urge that chapter three is read in detail to understand the scale of Paterson's malpractice and its impact on patients and their families.

Chapters four, five, six and seven present the Inquiry's findings in four key areas: safety and quality of care; responding when things go wrong; working with others to keep patients safe; and governance, accountability and culture. Our findings are based on the evidence we heard from patients, their relatives and other witnesses. All the evidence we received has been read, analysed and considered in preparing this report.

The Inquiry's recommendations to Government are at chapter eight.

We begin with a brief introduction to Ian Paterson and the hospitals at which he worked. We also include a note on the regulation of both NHS and private hospitals.

Ian Paterson

Paterson qualified in medicine at Bristol University in 1981. After he graduated, he worked for a time in Manchester before he came to the West Midlands to work at Good Hope Hospital in Sutton Coldfield.

Paterson had been suspended for a time in 1996, while he was employed at Good Hope Hospital, after he had exposed a patient to harm in one of his operations. Good Hope Hospital arranged for Paterson's surgical work to be supervised until there was confidence that he could operate again without such oversight.

Paterson was trained as a general surgeon, initially specialising in vascular surgery, but was nonetheless appointed as a specialist breast surgeon in 1998 at Solihull Hospital, part of the Heart of England NHS Foundation Trust (HEFT).

Paterson also practised as a surgeon in the independent sector. He treated patients at the Bupa Little Aston Hospital from 1993 and at the Bupa Parkway Hospital in Solihull from 1998. Both hospitals were taken over by Spire Healthcare (Spire) in 2007. Over time, Paterson increasingly treated most of his private patients at Spire Parkway Hospital.

There were concerns about Paterson's clinical practice over many years. Clinical colleagues first raised serious questions about his surgical procedures and medical practice in 2003. Ultimately, he was suspended by HEFT in 2011 and Spire suspended his right to practise at its hospitals later that year. We discuss the concerns about Paterson in more detail in chapter five.

In April 2017, Paterson was convicted of 17 counts of wounding with intent and three counts of unlawful wounding relating to nine women and one man, whom he had treated as private patients between 1997 and 2011. Paterson was sent to prison for 15 years. His jail sentence was felt to be too lenient and was increased by the Court of Appeal to 20 years in August 2017.

Heart of England NHS Foundation Trust

Birmingham Heartlands and Solihull NHS Trust was formed following the merger between Birmingham Heartlands NHS Trust and Solihull Hospital in 1995. This became Heart of England NHS Foundation Trust (HEFT) in April 2005 when the Trust achieved foundation status. In April 2007, Good Hope Hospital became part of HEFT. It was then one of the largest NHS Trusts in England and received the highest rating from the Commission for Health Improvement and the Healthcare Commission for the period from 2003 to 2005.

Later, HEFT experienced long-standing difficulties in the quality of care it provided, and in its finance and governance. As a result, University Hospitals Birmingham NHS Foundation Trust (UHB) became responsible for running HEFT, in 2015.

In August 2017, the Competitions and Markets Authority approved a merger of the two Trusts. HEFT formally became part of UHB in March 2018.

Spire Parkway and Little Aston

Parkway Hospital in Solihull and Little Aston Hospital are private hospitals where Paterson practised.

Until 2007, they were part of Bupa, which at that time was a private healthcare organisation that provided both private medical insurance and hospital services. In 2007, Bupa sold its hospital services to Cinven, a global equity firm, resulting in the formation of Spire Healthcare.

Spire Healthcare became a public listed company in July 2014. It operates a network of 39 private hospitals across the UK and employs 11,700 staff. In addition to its employed staff, 7,700 self-employed healthcare professionals operate within Spire's hospitals. Where we refer to Spire hospitals in this report we mean Parkway Hospital and Little Aston hospital, those now run by Spire.

Regulation of hospitals

Paterson worked in the NHS, at HEFT. He also practised in the independent sector, at Parkway and Little Aston hospitals, run by Spire since 2007. There are differences between how hospital services are run in the NHS and the independent sector, and we explore these differences in our report. However, it should be noted that hospitals in the NHS and the independent sector are both inspected by the same regulator, the Care Quality Commission. This is examined in more detail in chapter six.

CHAPTER TWO – The Inquiry

On 7 December 2017, Philip Dunne MP, Minister of State for Health, announced that there would be an independent, non-statutory inquiry into the malpractice of Paterson and associated issues. The Inquiry was to be chaired by The Right Reverend Graham James, then the Bishop of Norwich.

In this section, we describe how the Inquiry was set up and how we carried out our work. We do this by looking at the following four areas:

- setting up the Inquiry
- reaching out to patients and their families
- the Inquiry’s terms of reference
- how we did our work.

Setting up the Inquiry

In April 2017, Paterson was convicted of wounding with intent. He was sentenced to 15 years in prison. Later that year, Paterson’s sentence was increased to 20 years.

Despite the conviction of Paterson, many of his patients felt that there were still unanswered questions about his malpractice and called for a public inquiry into the case. On 5 October 2017, a group of 11 former patients of Paterson met Philip Dunne MP, Minister of State for Health, to ask him to set up an inquiry. The Inquiry was announced in Parliament on 7 December 2017, under the chairmanship of Bishop Graham James. It was not established under the Inquiries Act 2005. The Inquiry was a non-statutory inquiry and did not have the power to compel people to give evidence. It was commissioned and funded by the Department of Health and Social Care but was independent from the Department.

There have been previous inquiries into Paterson’s malpractice. In 2013, HEFT commissioned Professor Sir Ian Kennedy to review the Trust’s response to concerns about Paterson’s surgical practice. In 2014, the board of Spire commissioned Verita, a management consultancy, to review the governance arrangements at its Parkway and Little Aston hospitals in light of concerns raised about the surgical practice of Paterson. These reviews reported to the boards of HEFT and Spire, respectively. This Inquiry was different. It was patient led. In addition, rather than focus on one organisation, we looked across both the NHS and independent sector. We also considered the role of other organisations such as the Care Quality Commission and private medical insurance companies. Perhaps the most significant difference from the Kennedy and Verita reports is that this Inquiry is making recommendations to Government rather than to the board of one organisation. The Inquiry’s recommendations, if accepted and implemented by the Department of Health and Social Care, have the potential to improve patient safety in all NHS and independent sector hospitals in England.

Following his appointment as Chair of the Inquiry, Bishop Graham James set up a team to work with him. Details of the Inquiry team are at appendix 2. Members of the team had experience of working on other independent inquiries, including the Hillsborough Independent Panel, the investigation into Jimmy Savile at Leeds Teaching Hospitals, The Independent Inquiry into Child Sexual Abuse and the Gosport Independent Panel.

The Chair was supported by three independent advisors, who had expertise in areas within the Inquiry's terms of reference. He also appointed a clinical panel to advise him on matters of clinical practice that emerged through the course of the Inquiry. Details of the independent advisors and members of the clinical panel are found at appendix 2.

Paterson worked in the West Midlands area, and it was important that the Inquiry was easily accessible to those who had been affected by him. The Inquiry set up its hearing centre in central Birmingham, so that it was relatively local for former patients of Paterson. The Inquiry carried out most of its work there, including hearing evidence from patients and other witnesses.

Reaching out to patients and their families

On his appointment, the Chair made a public commitment that the Inquiry would be informed by the concerns of former patients of Paterson and that they would be at the heart of the Inquiry. The first task for the Inquiry was to reach out and engage with former patients and their families to ensure our work was informed by what was important to them and to give them opportunity to present evidence if they wished to do so.

In February 2018, through articles and features in the local media, and through community groups, for example, the local branch of the Women's Institute and church newsletters, we invited patients and their relatives to get in touch with the Inquiry.

Two local support groups had been set up by former patients of Paterson. They were instrumental in helping the Inquiry reach patients through their membership and networks. A third group, Solihull Breast Friends, a charity supporting local women with breast cancer, was equally helpful in circulating information about the Inquiry to its members. The Chair and the Secretary to the Inquiry were invited to meetings of all three groups to inform members about the purpose of the Inquiry and to invite participation in its work. We are grateful to these local support groups and their Chairs for all they have done to help us to reach out to patients and their families.

UHB got in touch with former patients of Paterson, to ask permission to pass their contact details to the Inquiry. Spire forwarded a letter from the Inquiry to patients Paterson treated at Spire who had since claimed compensation, giving them details of how to contact the Inquiry. Two firms of solicitors who had represented patients in compensation claims, Thompsons and Slater and Gordon, wrote to their clients to pass on contact details for the Inquiry.

The Chair of the Inquiry wrote to MPs in the Solihull area, so that they had details of how their constituents could get in touch.

When the Inquiry was announced in December 2017, the Department of Health passed contact details of 14 people to the Inquiry who were either former patients of Paterson or relatives of former patients. Through the efforts described above, by the end of March 2018, around 180 patients and their relatives had met with us in groups to talk about the things that were important to them that the Inquiry needed to consider in its work. In total, 211 patients or their relatives gave evidence to the Inquiry.

The Inquiry's terms of reference

When the Inquiry was announced in December 2017, it was given broad themes to explore. Consultation with patients and others was necessary to shape the terms of reference and make sure they reflected what was important to patients.

We held seven closed meetings in Solihull and invited patients and their relatives to come and talk with us about what should be included in the Inquiry's terms of reference, and whether the Inquiry's hearings should be held in public or in private. Those meetings were held at different times of the day, including evenings, to accommodate people's working patterns and other personal commitments. In addition, when the Chair and Secretary to the Inquiry went to the meetings of the local patient and family support groups, they sought views on the Inquiry's terms of reference. Patients and family members who were unable to meet the Inquiry team in face-to-face meetings were asked to let us have their views in writing. Around 180 former patients of Paterson and their relatives contributed to the Inquiry's terms of reference in some way.

Others with an interest in the case, including the hospitals where Paterson worked, and professional regulators, were invited also to send their written observations on the draft terms of reference.

Final terms of reference, based on what we had heard from patients and others, were published on the Inquiry's website on 27 March 2018. The Inquiry's terms of reference are at appendix 1.

It became clear very quickly in our discussions with patients and their relatives that many felt there were others who had colluded with Paterson's malpractice and that these individuals should be held to account. No inquiry has powers to "punish" individuals for their actions, or lack of action. However, we understood patients' distress that they believed some professionals had not acted in line with their duty of care. Hence, we included a clause in the terms of reference that we would report anyone whom we considered may have committed disciplinary or criminal offences to the relevant authority concerned. As the Chair indicated in his opening statement, we have referred three individuals to the General Medical Council (GMC), two to the Nursing and Midwifery Council (NMC) and one case to West Midlands Police.

How we did our work

Patients of Paterson, and their families, were at the heart of the Inquiry and so we began with them. They were invited to private evidence sessions at the Inquiry's hearing centre in Birmingham to tell us about their experience. If patients were unable to come to the hearing centre, they were offered an evidence session by telephone. In two cases, we visited patients at home to listen to their evidence. Two members of the Inquiry team were present at each patient evidence session. Patients were invited to tell their experience in their own words. The Inquiry team restricted themselves to asking questions to prompt them to do so. Patients, family members and former members of staff had access to a counsellor during their evidence session if they wished. A counsellor was also available to them immediately after their session. Sessions were recorded and transcribed. People were then asked to check the transcript of their session to make sure it was accurate.

The information gathered in patient evidence sessions was used to help us frame the right questions for other witnesses, and also to inform the Inquiry's findings and recommendations. Where patients did not want to give evidence in person, they were invited to give a written statement instead. Patients and their relatives also had the opportunity to send documentary evidence to the Inquiry if they wished. Two hundred and eleven patients and family members gave evidence in 172 sessions, and five gave written statements.

When we refer to patient evidence in this report, patients are identified by a unique number, rather than by their name. By this means, we protect them from being identified.

Following the patient evidence sessions, other witnesses, for example, representatives of the hospitals where Paterson worked, his ex-colleagues, and professional regulators, were invited to give evidence to the Inquiry. These sessions were also held in private since patients had said they thought people would be more open and candid in private than they would be in public. These evidence sessions were attended by three members of the Inquiry team, including one of the independent advisors. Witnesses were asked questions in line with the Inquiry's terms of reference and informed by evidence we had gathered from patients. As with the patients, these sessions were also recorded and transcribed, and witnesses were similarly asked to check the transcript for factual accuracy. Some witnesses provided written statements, in addition to or instead of attending evidence sessions. Witnesses were also able to send documentary evidence to the Inquiry. One hundred and five witnesses gave evidence in 113 sessions; an additional 13 witnesses did not attend an evidence session but provided written evidence statements. A list of witnesses who gave evidence to the Inquiry is at appendix 3.

We invited Paterson to give evidence to the Inquiry. Paterson declined to be interviewed. However, he did provide a written statement.

When we refer to witness evidence in this report, individual witnesses are identified by a unique number rather than by their name. This is to offer a degree of anonymity to those who gave evidence, and which we hoped would encourage them to be open and candid with us. The only exception to this is where individual witnesses held or hold positions which carry public or legal accountability for the organisation they represented at the Inquiry, such as members of boards. In these cases, witnesses are named. Where witnesses were giving evidence on behalf of an organisation or corporate body, that organisation is named.

The Inquiry had no powers to compel people to give evidence, but the overwhelming majority of those whom we invited came and did so. A small number of organisations and individuals refused to give evidence. These are listed in appendix 3. Individuals who were in breach of their professional code of conduct by not cooperating with the Inquiry have been reported to their professional regulator. In the case of four witnesses, we invited them to give evidence but had no response from them and no certain means of knowing if they received our invitation. We do not believe there is any further action to be taken in these circumstances.

All the evidence we gathered was analysed against the Inquiry's terms of reference and checked against existing (and in some cases, earlier) policy and guidance to the NHS and independent sector. Advice was sought from the Inquiry's independent advisors and clinical panel, where necessary. The Inquiry's findings and recommendations are based on the analysis of the evidence we received and grounded in the experiences of patients and their relatives who shared their accounts with us.

CHAPTER THREE – Patient Accounts

A central objective of the Inquiry was to give former patients of Paterson and their families an opportunity to tell of their experiences, and to be heard.

In total, 211 people told us about their experience as a patient of Paterson or about the experience of a member of their family who had been treated by him, in 172 evidence sessions and five written statements. Of the patients themselves, 80 were treated in the NHS, 92 were treated in the independent sector and five were NHS patients treated in the independent sector.

Summaries of each of the accounts we heard are presented in this chapter. They are presented in date order, by when patients were first treated by Paterson. Some of the longer accounts are the most recent, perhaps because people's recollections of events were clearer. The summaries have been anonymised. We refer to each patient by a code number. In a very small minority of cases, patients or their relatives did not want us to publish a summary of what they told us. These have not been included.

In presenting these summaries, the evidence of patients and their families has been recounted as it was told to us. We have not investigated individual patient accounts. However, we used their evidence to identify themes and concerns which were then explored with other witnesses and which are discussed in chapters four to seven.

Although most of those treated had breast procedures and were women, Paterson performed other procedures and also operated on men. The term "cleavage sparing mastectomy" is mentioned in some of the patient accounts. This procedure has no definition and is not a recognised practice. Paterson would leave tissue behind following mastectomies. Even though the term cleavage sparing mastectomy may not have been first used by Paterson, it has become associated with him. In listening to patient's accounts, we were surprised by Paterson's recklessness. Even after he knew he was under surveillance he did not appear to modify his practice. Some patients who spoke to us believed that they had good treatment from Paterson, while others now wonder if they had the correct treatment.

We would like to thank those who shared their experiences with us. We were struck by their courage and candour and were moved by what they told us. Many who came forward to give evidence to the Inquiry were motivated by a desire to do what they could to prevent something similar to their experience happening to someone else.

In trying to understand what happened while Paterson practised in the NHS and independent sector, it is important to take the time to read these accounts. It is also important to remember that for the majority, the experiences they shared with us happened at a time in their lives when, as patients, they were vulnerable.

Mid 1990s

Patient 485

Patient 485 found a lump in her breast, was referred to her local hospital and was told that it was nothing to worry about, but to “keep an eye on it”. She saw her GP about a year later about a breast lump and he referred her to Paterson at Good Hope Hospital as an NHS patient. Paterson told her the lump was not cancerous but that it was best to remove it as a precaution. Following her operation to remove the lump, the nurse at her GP’s surgery remarked how Paterson had stitched the wound tightly, so she would not have a scar. However, the stitches were difficult to remove and patient 485 came close to passing out with the pain.

Patient 485 has not been recalled by the Hospital and wonders whether she needed the operation and if Paterson was qualified or trained to do it.

Patient 355

In the 1990s, patient 355 was referred to an NHS hospital by her GP, as she had breast pain. She had private medical insurance and so Paterson advised her to see him privately at Little Aston Hospital every 12 to 18 months for regular checks.

Two years later, Paterson carried out a lumpectomy as he felt there was ‘something sinister’ (no biopsy was carried out beforehand).

In mid-2000s, Paterson did a biopsy on patient 355’s cleavage, as he felt the skin thickening looked ‘sinister’. Paterson then operated to remove a lump from her breast, followed by a further operation as the “margins” (area) around the lump were not clear of cancer. This was followed by a mastectomy.

Patient 355 had been seeing Paterson regularly for 12 years and said “it was like meeting up with an old friend”. However, she commented that “there was no discussion about options, it was him asserting what needs to happen”. Patient 355 had two small children and her own business, and was keen to get on with the surgery as quickly as possible.

Patient 355 was referred for chemotherapy, being told that it was an “insurance policy”. Prior to the treatment Paterson said he didn’t like the look of the veins in her legs and five weeks after the mastectomy, and still being in considerable pain, Paterson stripped the veins from patient 355’s legs. Until this point she had not had any problems with her veins.

Soon after this procedure, patient 355 had 12 sessions of chemotherapy, losing her hair. She has since discovered that the chemotherapy was unnecessary, as was the stripping of her leg veins.

A year after chemotherapy, Paterson removed a lump from her shoulder, suspecting secondary cancer. The results from the biopsy showed that the lump was fatty tissue. Again, patient 355 has since discovered that this surgery was also unnecessary.

The impact on patient 355 has been considerable. She feels her children, her husband and her business have all been affected. She was terrified of the chemotherapy and was under significant pressure, having a young family and a successful business. Patient 355 started to experience panic attacks as a result of her experience.

Patient 341

Patient 341 found a lump in her breast and was referred by her GP to Good Hope Hospital as an NHS patient. Her GP advised her to contact Paterson's secretary as she would be seen quicker. She saw Paterson two days later. He examined her and carried out tests. She said he was "very reassuring and kind".

Patient 341 had the lump removed one week after receiving the test results. Paterson then told her she needed a mastectomy as the cancer had spread, including to her lymph nodes. Following surgery, the breast care nurse explained that Paterson had left some flesh to make a cleavage. Patient 341 was content with her treatment.

Around 2011, following reports about Paterson in the press, patient 341 went to see her GP who reassured her that her treatment had been satisfactory. However, she was recalled by Solihull Hospital.

At the recall appointment, patient 341 had a mammogram and scan. The breast surgeon confirmed he had found nothing of concern but offered to remove the remaining flesh. As the surgery was some time ago she declined.

Patient 341 said she was grateful that Paterson saw her so quickly after referral as she feels at the time having cancer was "like a death sentence" and she had very young children. She said the short amount of time between diagnosis and surgery made a big difference and "all her fears and worry went".

Late 1990s

Patient 139

Patient 139 noticed a lump on her breast and went to see her GP the next day. She referred her to Solihull Hospital as an NHS patient, where she saw Paterson. He did a biopsy, sent her for an X-ray. Paterson saw patient 139 a couple of hours later, where he told her “it is definitely a cancerous lump” and that she needed a mastectomy. Patient 139 had the operation, and while she noticed that the tissue had not been removed back to the rib cage, she “thought that was the way they did it”, particularly as at no point was she asked by Paterson if she would prefer to have anything other than a full mastectomy. She had radiotherapy and chemotherapy after her surgery. After a few years, patient 139 considered reconstruction and saw a cosmetic surgeon in the NHS.

About five years ago, patient 139 noticed an article in the paper about Paterson and cleavage sparing mastectomies and contacted the hospital where she saw a different breast surgeon. He sent patient 139 to have a mammogram and told her she had had a cleavage sparing mastectomy. Patient 139 decided to have the remaining breast tissue removed. The hospital offered no explanation or apology for what had happened under Paterson’s care.

Patient 139 told us, “We do not want it to happen to anybody else, that is the thing. It is bad enough it has happened already.”

Patient 174

Patient 174 found a lump in her breast. Her GP referred her to see Paterson privately at Little Aston Hospital, on the basis that he was the “best in the area”. Following a biopsy on the lump, Paterson told patient 174 everything was fine but suggested six-monthly check-ups would be a good idea, which she had, privately. In the early 2000s, an abnormality was found at her check-up. Paterson told her that this was “pre-cancerous” cells. He advised her to have a biopsy in a different part of her breast and told her that this also contained “pre-cancerous” cells. He told patient 174 the situation was “a ticking time bomb” and gave her the option of more frequent check-ups or a mastectomy and breast reconstruction. She chose to have the mastectomy and reconstruction.

There were complications with the surgery to reconstruct her breast (which was carried out by a plastic surgeon) and patient 174 was in theatre for more than 13 hours. On waking from the operation, she was told that an ambulance was on standby in case she needed to be transferred to an NHS hospital for intensive care. She spent the night in Little Aston Hospital’s high dependency bed. Patient 174 had several operations over the course of the next two years to reconstruct her breast.

Patient 174 continued to have six-monthly check-ups with Paterson for ten years after she had found the initial lump, at which point he suggested she switch to check-ups every 18 months, and then have mammograms every three years as part of the NHS breast screening programme.

When news about Paterson doing cleavage sparing mastectomies broke in the media, patient 174 asked Spire for a review of her case. She was told that none of the seven operations she had were necessary. Patient 174 instructed solicitors to act on her behalf and was awarded compensation. She said of the compensation, “I would rather have a breast.”

Patient 174 and her family have been greatly affected by her experience. Her children were taking exams when she had surgery. Patient 174's husband had health issues which she feels were attributed to the stress he was under when she had surgery, which has since been found to have been unnecessary. She told us, "I cannot trust anything medical now. I have to be dragged to the doctors now if I am ill."

Husband of patient 37 (described as X)

X's wife was referred to Little Aston Hospital as a private patient with a lump in her breast. Her GP has described Paterson as "the top cancer specialist in the country".

Paterson recommended a cleavage sparing mastectomy followed by a breast reconstruction, carried out by a cosmetic surgeon he worked with. During the reconstruction operation, X received a call from the cosmetic surgeon asking for a decision as the surgery had gone wrong. X felt very uncomfortable and not qualified to make such a decision regarding his wife's emergency treatment. A vein had been severed during the reconstruction surgery and, as a result, X's wife was rushed (sedated) to the A&E department of a local NHS hospital. X described his wife's treatment as a "catalogue of disasters".

Paterson had also removed lumps from her back, carried out gallbladder surgery and a procedure on an intimate part of her body. X said Paterson saw his wife "as a cash cow".

Patient 37 was recalled by Spire. At her recall appointment, X and his wife discovered that the surgery on her breast had been unnecessary. X said for 20 years he has lived with the vision of his wife waiting to be transported in an ambulance and fearing he would lose her. His wife survived but the experience has been devastating for the whole family and they went through what X described as some "very black moods".

Patient 53

Patient 53 is deceased. Her husband and daughter told us of her experience. Patient 53 had a lump in her breast and was referred by her GP to Solihull Hospital as an NHS patient. Following a biopsy, Paterson told her she had cancer. He said patient 53 could have the lump removed but would need chemotherapy afterwards, or she could have a mastectomy, which had a higher chance of getting rid of all the cancer. Patient 53 chose to have a mastectomy and was operated on by Paterson.

Five years later, patient 53 became very ill and died. She had secondary liver cancer. Her family wonder if the secondary cancer was caused by Paterson leaving breast tissue behind following patient 53's mastectomy. When the news about Paterson's malpractice broke, they contacted solicitors to try to find out if patient 53 had had a cleavage sparing mastectomy. However, there are not enough details in her medical records to confirm this or not. Patient 53's family are troubled by this unanswered question: "there is no proof that he done it, but then there is no proof that he did not". They feel strongly that others working with Paterson would have known that what he was doing was wrong.

Patient 486

Patient 486 was a semi-professional sportsman. He was referred by his GP to Little Aston Hospital for a hernia in the groin, as a private patient. Patient 486 was seen by Paterson who examined him and said that he needed a bilateral hernia operation.

Patient 486 attended early for his operation, to find Paterson impatiently waiting for him, with blood spots on his gown. Patient 486 had an “old fashioned” (rather than keyhole) operation and was discharged the next day but had pain in his left testicle. He made another appointment with Paterson a week later but was told that “it’s perfectly fine” and Paterson sent him away in “unbearable pain”.

Patient 486 went to see his GP who said that he had an infection. He referred him back to Paterson who agreed and said that the testicle needed to be removed. Paterson did this and replaced the testicle with a prosthetic one. However, patient 486 was still in pain and as a result Paterson removed the prosthesis, leaving him with one visible testicle.

It would be 10 years before patient 486 was able to play the sport he loved again.

Patient 318

Patient 318 had a lump in her breast and her GP referred her to Paterson at Heartlands Hospital as an NHS patient. Paterson carried out tests and scans and told patient 318 that the lump was not cancerous but decided to review her after six months. At that review, he recommended a biopsy and a full mastectomy because of the position of the tumour, to be followed later by reconstruction. Patient 318 had the operation three months later, followed by chemotherapy, radiotherapy and the removal of her ovaries to make sure there was no chance of any cancer.

Two years later, the patient was contacted by the Priory Hospital to have the reconstruction carried out as an NHS patient. She was very pleased with the results.

In late 2017, the patient was contacted by University Hospitals Birmingham. They told her that she may have had a cleavage sparing mastectomy, but that they could not tell because of the poor medical records and her breast reconstruction.

Patient 318 said, “It is just the shock, I suppose, to be part of something that has made such national news, and every time it came up it sort of brought it all back.”

Patient 176

Patient 176 is deceased. His son gave evidence on his behalf. Patient 176 saw Paterson as a private patient at Little Aston Hospital, for a procedure to improve his hearing by unblocking an artery. Patient 176’s hearing did not improve, and his voice became faint and squeaky as a result of the procedure. His son told us that his father thought the procedure had been a waste of time and money. He described how patient 176 lost confidence in speaking following the procedure and that this contributed to him feeling isolated for the remainder of his life.

Patient 41

Patient 41 was first diagnosed with breast cancer in the mid-1990s and had two lumps removed from her breast by a surgeon other than Paterson. Following this, she saw Paterson at Heartlands Hospital as an NHS patient. At the appointment, Paterson said that he didn’t need to see patient 41 and called his registrar. The registrar found a breast lump and took a biopsy of it.

Patient 41’s husband accompanied her for the results. Patient 41 found Paterson’s attitude had altered from being pleasant to “exceedingly arrogant” towards her husband. She said Paterson “shot down” her husband every time he asked a question or voiced an opinion; Paterson was dismissive to him and said “this concerns your wife, not you”.

Patient 41 and her husband had jointly decided on a mastectomy due to her age and already having had two breast lumps removed. She said Paterson was reluctant to carry out a mastectomy and wanted to remove the lump instead. Patient 41 asked that clips were used instead of stiches as she was prone to infection. Paterson refused.

Following her mastectomy, patient 41 did not see Paterson as he was on holiday. She developed an infection and during his absence had to have her wound drained three or four times.

When patient 41 was later called back to the hospital, she discovered that she had had a cleavage sparing mastectomy rather than the full mastectomy she had expected. Patient 41 decided to have the excess breast tissue removed as she felt she was “living with a time bomb”.

Patient 41 felt that she wasn’t listened to by Paterson, was treated “like a piece of meat” by him and found his behaviour towards her husband upsetting.

Patient 356

Patient 356 had discharge from her nipple and decided to see Paterson privately at Parkway Hospital.

Following a mammogram and scan, Paterson told patient 356 she had pre-cancerous cells and that she needed incisions under both nipples, her nipples lifting and the removal of her milk ducts. He told her that she would then be free of cancer. Patient 356 told us she believed everything he said and “thought he was a wonderful man”.

Patient 356 was rushed back to theatre following surgery as she was bleeding heavily. She remembers experiencing a choking feeling. She told us that she had haemorrhaged as Paterson hadn’t tied up one of her veins. One of patient 356’s breasts healed well but she discovered a small piece of plastic in the other breast. She removed this from her wound which then healed.

Patient 356 had six-monthly checks with Paterson, including mammograms. Her health insurance was a work-based scheme with BUPA. BUPA refused to continue to cover her and she was referred to Solihull Hospital as an NHS patient. The doctor patient 356 saw at Solihull Hospital was concerned about the number of mammograms she had had, particularly as she wasn’t at risk of developing breast cancer. She was discharged from Solihull.

Patient 356 was not recalled by Spire. Following local press articles about Paterson she contacted Spire and asked to be reviewed. At the review, she was told that all the tests she had before her surgery were clear and that her surgery had not been necessary.

Patient 356 feels she is “one of the lucky ones”. Although she had unnecessary surgery and has been left with no sensation in her nipples, she has healed and got on with her life.

Patient 218

Patient 218 was treated by Paterson, as was her mother.

In the late 1990s, patient 218’s mother, who was in her 70s, was diagnosed as having breast cancer, and had a mastectomy. At that point, patient 218 said “generally everybody felt very lucky to see him, you know he was best of breed”. Her mother was content with her surgery but very unhappy with the scar, which was described as a “mess” by the oncologist. Patient 218 has since wondered whether Paterson rushed the surgery. Paterson offered her mother

the opportunity to become part of a free trial and undergo a full body CT PET scan at a private provider, which patient 218 thought was a “holistic approach”. She was grateful as the scan identified her mother had colon cancer.

Patient 218 had a family history of breast cancer and opted to have regular check-ups with Paterson at Parkway Hospital as a private patient. Early in the 2000s, patient 218 discovered a golf ball sized lump under her arm. Paterson said he thought it was a lymph node and advised her to leave it for three months. Due to her family history, patient 218 was very anxious about the lump and asked Paterson to remove it. She said she didn't feel put under pressure by Paterson and considered him to be “reflective and reassuring”. Patient 218 told us her diagnostic imaging was always given to her as Paterson said it would be useful if she ever wanted a second opinion.

Patient 218 commented that she and her family felt that Paterson was “thoroughly engaged and a decent family bloke” due to his involvement with Breast Friends and the park runs he attended.

Paterson wasn't present at one of patient 218's routine appointments and the breast care nurse said she had taken over his clinic for a while which patient 218 found “completely weird”. Patient 218 found Spire's recall process “thoroughly random” as her mother was recalled but she wasn't. Her mother chose not to attend the recall appointment as she was content with her treatment. Patient 218 contacted Spire Parkway and queried why she hadn't been recalled. She felt Spire were “trying to hush the whole thing up”.

Despite being pleased with the treatment she had from Paterson, patient 218 said later that the Paterson case has left her with a lack of trust in the medical profession and a lack of confidence in the private sector.

Patient 186

Patient 186 chose to have hernia surgery as a private patient, as his GP had told him that waiting lists in the NHS were long. Patient 186 was self-employed and was worried about the impact of waiting a long time for treatment. He asked the receptionist at Little Aston Hospital who the best surgeon was, and she responded that “Paterson is very well known”.

Patient 186 had seven groin hernia procedures over a period of 20 years, five of these as a private patient and two as an NHS patient. He told us that each operation done by Paterson “went wrong”. Patient 186 said that the benefits of each procedure lasted about 12 to 18 months before the “muscle burst through again”. He wondered if Paterson purposely didn't operate correctly to ensure he returned for further surgery.

In the late 2000s, Paterson told patient 186 he had increased his prices from £1,600 to £2,400. Patient 186 queried this and said he couldn't afford any further treatment at that price. Paterson explained the increase was due to the hospital investing in new equipment but said, “I'll tell you what I'll do, you do me a favour and I'll do you a favour. I'll do it for £1,600 on condition that if anybody asks about your scars or who operated, only if they ask, you say you don't know and cannot remember who operated.”

Patient 186 continued to have pain and problems in his groin and saw a different consultant, who told him, “Oh my god it's a real mess down there.” He advised patient 186 to not have any further procedures despite the pain and told him that he still had stitches in his stomach.

Patient 186 has had significant financial loss as a result of being a patient of Paterson, as he paid for the majority of treatments and medication himself. He has also been refused private medical insurance due to the number of procedures he has had.

Patient 334

Patient 334 went to see Paterson at Little Aston Hospital following a recommendation from a colleague. She had been suffering with throat problems for several years. Paterson examined her and scanned her throat. He told her “I am going to tell you exactly how it is. You are going to die.” Paterson told her that she needed surgery. Patient 334 asked if it would be possible to delay the operation as she had a relative to care for and other personal matters to attend to. Paterson encouraged her to have the operation urgently, and in the private sector to avoid NHS waiting times. She did not have health insurance and paid for the surgery herself.

Paterson removed one of patient 334’s thyroid glands. She was pleased with the care she received at the time and was relieved that the tissue that was removed was not found to be cancerous.

Several years later, patient 334 went to Parkway Hospital as a private patient for a neck scan. When Paterson reviewed the scan, he told her she might need to have the other thyroid gland removed. She delayed surgery at this time and returned six months later for a further review. At the review, Paterson told patient 334 that she wouldn’t need the second thyroid removed and put the earlier advice down to the machinery being new and the radiographer “having a bad day”.

Patient 334 was surprised and in disbelief when stories about Paterson appeared in local news. She had found Paterson to be charming and professional. After some time, and following his suspension, patient 334 contacted Spire to ask for a review of her treatment. She was told she would be put on a list for review, but Spire did not contact her again. Following Paterson’s conviction, patient 334 contacted solicitors to try to find out more about the care she had received. She was reviewed by a clinical expert who found that Paterson had not performed the correct tests or surgery and was wrong to tell her that she might die from the lump in her throat.

Patient 334 told us that she thinks she has been one of the “lucky ones” compared to some patients, but said, “I do not think I will ever trust anybody again. I am not good with the medical profession anyway.”

Patient 246

Patient 246 is deceased. Her sister and father gave evidence to the Inquiry on her behalf.

Patient 246 had private health insurance through her employer. She was referred to Parkway Hospital where she was diagnosed as having breast cancer. Paterson carried out a mastectomy on patient 246 and recommended she have chemotherapy and radiotherapy.

When patient 246 returned for an operation to reconstruct her breast, it was discovered she had cancer cells on her scar. The cells were removed prior to the reconstruction. Following the delayed reconstruction, patient 246 had a lot of muscle damage to her back and returned frequently to Parkway Hospital as she suffered with neck problems. She thought this was a result of the reconstruction.

A tumour was later found at the top of patient 246’s spine and removed by another consultant. Cancer was also found in her breast bone. She transferred to the Priory for ongoing treatment by her oncologist.

Patient 246 saw the same oncologist, who worked with Paterson, for fourteen years. He told her that she had cancer in her bones, but that they could “keep on top of it”. Her family feels that she wouldn’t have received that amount of treatment or care in the NHS and therefore she wouldn’t have been alive for an additional fourteen years. Patient 246 was not recalled by Spire.

The on-going media activity in relation to Paterson has been very difficult for the family and the many years patient 246 received treatment “took its toll” on the whole family.

Patient 84

Patient 84 had a history of breast lumps and had already had surgery to have these removed by a different consultant. When further lumps developed, she was referred to Paterson as a private patient at Parkway Hospital. Following a scan, Paterson recommended that the lumps should be removed “because they could develop into something not very nice”. After surgery, a biopsy of the lumps showed that they were not cancerous.

Patient 84 was not contacted for a recall appointment by Spire. She trusted that the medical profession would get in touch if they thought she was at risk. However, she knew of two people who had been Paterson patients who had died of secondary cancers and became increasingly worried that her treatment may not have been necessary. Patient 84 contacted solicitors and then Spire, to arrange a recall appointment.

The consultant who carried out the recall appointment did not make patient 84 feel comfortable and appeared to be defensive. It was some time before he wrote to her to tell her his opinion. The letter told patient 84 that her mammogram now showed no abnormality. She was also sent the radiologist’s report from the time of her surgery in which the radiologist had commented, “I cannot see any suspicious calcification.”

Patient 84 remains unclear to this day as to whether the treatment she had from Paterson was necessary. The experience has “seriously impacted” on her ability to trust people.

Patient 275

After discovering a lump in her breast, patient 275 was referred by her GP to Little Aston Hospital to see Paterson as a private patient. He told her that she had “clustered calcification” in her breast and operated on her. Following that, a relative had a lump in her breast and patient 275 suggested she see Paterson, because her own experience was good. The relative had mammograms and X-rays, and then Paterson carried out a biopsy which showed breast cancer. Paterson suggested a double mastectomy, which was done by a different surgeon. Patient 275 and her relative have both had confirmation that they received appropriate treatment from Paterson.

Patient 348

Patient 348 had her baby in Solihull Hospital and following this, found a lump under her arm. Paterson came to see her and asked her to come and see him privately at Parkway Hospital after patient 348 told him she had health insurance. He removed the lump. A year later, patient 348 had discharge from her nipple and her GP referred her to Paterson at Parkway Hospital as a private patient. Paterson advised her to use primrose oil. The discharge continued for a year, and patient 348 saw Paterson again who told her that her condition was “pre-cancerous”, operated the following week and put her on a surveillance programme. In the early 2000s, patient 348 had discharge from the other nipple. Paterson again operated. Five years later, the discharge returned, and she had further operations.

In total, patient 348 had seven operations in ten years. Patient 348 was recalled by Spire. At her recall appointment, she was told that “there was no pathological proof that I had the pre-cancerous condition” and therefore concluded that the operations were not necessary. Patient 348 feels “complete and utter disbelief that he did it to me”.

Patient 154

Patient 154 was referred by her GP to Solihull Hospital for a mammogram to check a breast lump. She was seen by Paterson who told her that the lump required further investigation. Patient 154 asked whether this would happen more quickly if she saw him privately, which he confirmed. She saw Paterson at Parkway Hospital as a private patient. Patient 154 had a further mammogram and ultrasound scan, following which, Paterson operated to remove the lump from her breast.

In the mid-2000s, patient 154 developed “dimpling” in the other breast and was referred by her GP to see Paterson at Parkway Hospital as a private patient. She had the same tests as before and Paterson recommended surgery and in a letter to her GP said that she had suspected cancer. Paterson removed tissue from patient 154’s left breast which he told her was pre-cancerous and she was kept under review for several years.

When concerns started to emerge in the media, patient 154 contacted Spire and asked for another doctor to review her care. Most of her earlier patient notes were missing, but he told her that since the late 1990s the recommendation was that surgery should not take place without a biopsy. He also told her that the condition she had – enlarging of the cells, particularly around the milk ducts, was normal for a woman of her age. So, most, if not all, of the surgery patient 154 had was unnecessary.

Patient 154 told us “I go into a doctor’s now and I certainly don’t trust them on first conversation, because, you know, I trusted him on first conversation... And I really have to remind myself on a regular [basis] that one bad apple doesn’t mean that everybody is the same. But that makes me lose confidence in myself.”

Patient 7

Patient 7 was initially seen by a colleague of Paterson’s at an NHS hospital because she had breast lumps, before Paterson took over responsibility for her care. Following a scan, he told her that her lump was getting worse and that he needed to act. Patient 7 was reluctant to have surgery and asked whether there was an alternative course of action. Paterson told her that if she did not have an operation “it will start to deform your breast, very quickly”. Paterson also refused patient 7’s request for a second opinion and told her, “mine is the greatest opinion”. He also told her that there was no time to be seen on the NHS as the lump was growing rapidly and therefore he had to see her as a private patient at Parkway Hospital.

Patient 7 was seen at Parkway Hospital in preparation for surgery but had no further test prior to her operation. On the day of the surgery, patient 7 was asked to sign a consent form for the operation while lying on the trolley. She was also asked to consent to a mastectomy if Paterson found during the operation that any cancer had progressed. Patient 7 had the lump in her breast removed, but afterwards noticed that Paterson had also removed tissue from a different area. When asked about this, his response was that he was able to remove the lump through a different route and argued that he left patient 7 with a “nice scar”, which she disputed.

Patient 7 saw her GP in the early 2000s, when he examined her breasts and found a large lump. The GP referred her immediately to Paterson at Parkway Hospital. Paterson told patient 7 that the lump had returned and was bigger than ever. She refused to have a further operation, and Paterson backtracked, saying, "People who are quite skinny, it's always difficult to tell what the lumps are like", and agreed no further surgery was needed.

Patient 7 was recalled by Spire but told us that their response to her questions about her treatment were wholly inadequate. She has since found out that the surgery she had was not necessary.

Patient 337

Patient 337 went to her GP with a large lump in her breast but no pain. Her GP referred her to Heartlands Hospital as an NHS patient. She saw a specialist who thought it was a blocked milk duct and booked her in for a follow-up mammogram. After that, she saw Paterson who took a sample of cells from her nipple, hitting her breast bone while he did it. She returned a few days later and Paterson told her that, because there was no fluid in the sample, she had cancer. Paterson told her he would need to operate within three days. Patient 337 pointed out that she was waiting for an operation on her varicose veins and Paterson said he would do those at the same time. When she returned home, she received a call from a clinical colleague of Paterson's who said: "You're not having your leg operated on by Mr Paterson. If you have your breast and your leg operated on at the same time you will die." He cancelled her leg operation.

Patient 337 arranged the appointment for her surgery and was told by the hospital to come in the night before because "Mr Paterson's organised that you come in the night before". When she arrived, the hospital said that there was no need and that she was to return the next day. Patient 337 had the operation and when she came round, realised that she still had her breast. She was surprised at this, as she had expected to have her breast removed. The breast cancer nurse told her that she would have to wait for the results of the biopsy before knowing whether she had cancer. She received those a month later, when she found out that Paterson had not operated on her, it had been a different doctor who had removed a non-cancerous growth from her breast. When patient 337 asked the breast cancer nurse to explain why she was initially informed she had cancer by Paterson, she was told: "Well, you can complain but you don't stand a hope in hell." The patient was so frightened that she did not complain.

Patient 337 said of her experience "I'll never get over it. My husband knows I'll never get over it. It was devastating."

Patient 366

Following the birth of her child, patient 366 found a lump on her right breast. She visited her GP who referred her to Parkway Hospital as a private patient. Patient 366 had a mammogram and scan then saw Paterson who offered her the option of taking a biopsy of the lump but told her he thought it would be better to have the lump removed as he implied that the biopsy would reveal cancer. He operated on patient 366 about a week later. Patient 366 recalls that after the surgery, he sent the nurse who was attending to her away to get some dressings and then told patient 366 that she should expect bad news once the lump had been tested. When patient 366 returned to see Paterson, she felt his demeanour changed when he saw she had her husband with her. He told her that she had had a "lucky escape". Patient 366 had a serious infection following her surgery.

Almost 20 years after she was treated by Paterson, patient 366 found she had breast cancer. While she was being treated for this, she was told that her original operation had not been necessary. She was shown a radiologist's report from her scan at the time, that stated that no further action was needed. The patient feels that Paterson operating unnecessarily was unforgiveable, especially having been told to prepare herself for cancer when her children were so small, which was "so cruel".

Patient 366 continues to be "very up and down, emotionally". She has lost her ability to trust other medical professionals and despite assurances that she will get over this by professionals, patient 366 doesn't think she ever will.

Patient 283

Patient 283 visited her GP for a postnatal examination following the birth of a child. The examination revealed a lump in her right breast which the GP thought was likely to be a blocked milk duct. Patient 283 continued to experience problems and was referred to Solihull Hospital where she saw Paterson.

Paterson also thought the lump was a blocked milk duct, but organised a scan. He told patient 283 he thought the scan showed a type of cancer and took a biopsy of the lump. When she returned for the results of the biopsy, Paterson told her that she needed to have a lump removed from her breast and suggested that she might want to pay to be treated privately to avoid waiting. Patient 283 had the lump removed by Paterson as a private patient at Parkway Hospital. A few days after her surgery, she had a follow-up appointment with Paterson who told her the lump was cancerous and that she needed a mastectomy.

Following her mastectomy, patient 283 was surprised to see that she had been left with some cleavage. She developed a serious infection after her operation which required further treatment. Patient 283 told us that her family had to battle with Spire to treat the infection without charging more money.

Patient 283 only learned of Paterson's malpractice on a news feature on local radio and has never been recalled by Spire. The experience of being treated by Paterson has left her with overwhelming anxiety and she believes that Paterson has made her feel unsafe and unable to "enjoy lovely times with her family". Patient 283 was subjected to "frightening statements" made by Paterson resulting in her later being diagnosed with post-traumatic stress disorder.

Patient 302

Patient 302 found a lump in her breast. Her GP referred her to Solihull Hospital where she saw Paterson as an NHS patient.

Paterson told patient 302 that the lump needed to be removed and she queried whether this was necessary. After the operation, she asked if the lump was benign and Paterson confirmed that it was fatty tissue. He was insistent that the lump had needed to be removed, but this left patient 302 feeling unhappy at the outcome. Paterson's manner during this time made her feel subservient and it took her a long time to regain her confidence. She also felt uncomfortable at some of the personal comments he made to her and felt that he "was predatory".

Patient 302 had another operation by Paterson when she discovered a further lump in her breast. She was curious as to why the lumps kept returning and asked Paterson for his opinion. He was unable to give a plausible explanation and told her “that these things can turn nasty later”. This left her feeling confused and unhappy, especially when she experienced problems after this operation.

Patient 302 was referred to Paterson for a third time and queried how specialised he was in breast surgery as he had the title “general surgeon”. She didn’t receive a satisfactory response to this question. Patient 302 was recalled by the hospital but found this to be unsatisfactory and felt that “they wanted to absolve themselves, not themselves – but the NHS – of any wrongdoing”.

Patient 34

Patient 34 had a routine mammogram and was recalled to Solihull Hospital. She met Paterson who said there was something that looked cancerous and took a biopsy. She transferred to Parkway Hospital as a private patient and Paterson operated to remove a lump from her breast and also removed some lymph nodes.

At first Paterson said the lump was the size of a pea and that patient 34’s cancer had been caught early. Patient 34 had radiotherapy after her surgery. This caused some bleeding which she described as “traumatic” and which required further surgery. She started taking the drug tamoxifen but three years later stopped as it was damaging her liver.

Patient 34 continued to see Paterson as a private patient for five years. She had several other non-breast related operations with Paterson. She said, “So I did not really go through the GP. Just on my routine visits to him, I would say, you know, ‘Can you do this and that?’ So, he did.” With each procedure, patient 34 did not heal correctly, or had problems afterwards. She said she felt comfortable with Paterson and that she had a rapport with him. Patient 34 gave an example “I mean, little things like when I was waiting for the operation, I would be lying on the thing and he could come in and tickle my feet, which was all part of him.”

Patient 34 said her insurance company “used to moan about him – that he charged too much”. She also said that she noticed he had coded a procedure incorrectly and wonders if he inflated it.

Patient 34 was not recalled by Spire.

Although Patient 34 feels happy with her treatment by Paterson she does wonder if all the scans she had were necessary. She also said, “And then I think every time I had another operation it was more money for him. I feel now a little bit – I don’t know what the word is – that I was just helping him to make more money.”

Patient 131

Patient 131 visited her GP as she had a lump in her breast. She was told there was a waiting list in the NHS and as she had private medical cover, she was referred to Paterson at Parkway Hospital. Her GP told her Paterson was one of the best breast surgeons in the area.

Patient 131 found Paterson charming and he put her at her ease. He said the lump should be removed as soon as possible. When patient 131 was admitted to Parkway Hospital, she was told for the first time that she required a “needle location” which needed to be carried out at an NHS hospital some distance away. She was transported there in the hospital minibus. Patient 131 had a needle inserted into her breast and was transported back to Parkway Hospital in significant pain, feeling vulnerable and angry.

Patient 131 was taken into theatre and Paterson removed the lump. When she came round from surgery Paterson told her there was a further lump behind the original one. She was discharged home and after a few days her breast was very sore, swollen and hot. Patient 131 returned to Parkway Hospital where Paterson said he would “sort it out”. A few days later she had further swelling and more pain. Paterson inserted a drain to try to reduce the swelling. Patient 131 said everything felt rushed and she experienced significant pain throughout and after the procedure.

Patient 131 later received a call from Paterson who said, “You will be very relieved to know that thanks to your operation you are no longer at risk of developing breast cancer”. She mentioned the severe pain she experienced during the operation to Paterson who said this will have been due to “delirium or confusion”. Patient 131 said throughout her treatment with Paterson she trusted him and believed him, as he was a respected consultant.

The pain in patient 131’s breast has continued, and she has since received treatment from clinical pain specialists who have said this is due to nerve damage during her surgery. She has had to fund all pain relief treatment herself.

When the news broke regarding Paterson’s malpractice, patient 131 said she wondered if she had misjudged him. Spire wrote to her saying there were inconsistencies in her notes and invited her in for a recall appointment. The radiologist had stated in her medical notes from her initial appointment that she needed to be reviewed in a year and no treatment was necessary.

At the recall appointment patient 131 found the clinician “remote and disinterested”. She wasn’t offered any support. She found it difficult to comprehend that she had been living in pain for fifteen years when her surgery, which had caused the nerve damage, had been unnecessary.

She feels betrayed by the medical profession and now mistrusts what she is told. When referring to Spire Parkway she said, “What kind of standards does this place operate to? A glossy brochure, lovely photographs etc. This is not what it’s about.”

Patient 299

Patient 299 had a lump in her breast and was referred to Good Hope Hospital as an NHS patient by her GP. She had scans and a biopsy. Paterson told her she had breast cancer.

Patient 299 first discovered the lump when she was pregnant and was concerned she could pass the cancer onto her baby. Patient 299 said she found Paterson kind. He reassured her that she wouldn’t pass cancer on and that her baby would be monitored. After her baby was born, patient 299 had a mastectomy, carried out by Paterson. She said she couldn’t fault him. Patient 299’s sister asked Paterson how long she would have lived for if she hadn’t had surgery. He said 18 months.

Patient 299 said when the news broke regarding Paterson’s malpractice she was shocked and could not believe the accusations being made against him. She was recalled and was told that “everything was fine”.

Patient 299 said she is grateful to Paterson as she feels he saved her life. She said he cared about her and her family.

Patient 346

Patient 346 was referred to Paterson by her GP as an NHS patient in the late 1990s as she had a lump in her breast. She was very anxious as her mother had died from breast cancer, and she found him to be reassuring. Patient 346 had an ultrasound scan and mammogram. Paterson told her the lump was a cyst but to return to him if she had any problems in the future.

Early in the 2000s, patient 346 found another lump and saw Paterson at Spire as a private patient. Again, he said the lump was a cyst. A year later, patient 346's GP referred her to Paterson at Spire as she was concerned about lumps in her breast. The radiologist she saw said he thought there was no cause for concern. However, Paterson said there was an area "he didn't like the look of" and carried out what he described as a biopsy. On returning for the results of the test, Paterson told her there were "some abnormal cell formations" and the lump should be removed.

Paterson removed the lump and at a follow-up appointment he told patient 346 he had taken "a very wet, squidgy lump type thing".

Patient 346 said she was in total disbelief when the news broke regarding Paterson's malpractice. She said she thought he was "brilliant, reassuring and a gentleman" and that the reports must be wrong. The more she read in the newspapers the more she thought: "he said that to me".

Patient 346 was recalled by Spire and learnt that her test results had not been conclusive. She was told that the surgery had been unnecessary. Patient 346 said Spire did not offer any support and that their view was "that he was a consultant who rented a room, so they had nothing to do with it". She said "that if you mentioned Mr Paterson nobody said anything. It's all a bit of a closed shop. I feel as if all the ranks are closed in the medical world."

Patient 346 said, "I would never go down the private healthcare route again." The impact on her was "horrible". She said her husband had been affected too. She said that he would always ask for a second option if she required surgery as she has lost her trust.

Patient 323

Patient 323 found a lump in her breast and was referred to Paterson as an NHS patient. Paterson removed the lump and six or seven weeks later operated again to remove more tissue.

Some years later, patient 323 had bleeding from her nipple. She again saw Paterson as an NHS patient. He operated to identify the problem and told patient 323 that she had cancer and needed to have a mastectomy, which she did, followed by immediate breast reconstruction. Patient 323 said that she was aware that she was going to have a cleavage sparing mastectomy and that she wasn't given a choice about this.

A short time later, patient 323's GP referred her to Paterson as her reconstructed breast had started to "crinkle up". She still had cancer in her breast. Paterson performed a further cleavage sparing mastectomy on the reconstructed breast. He told her she could not have her breast reconstructed this time as the cancer was "too acute". Following her surgery, patient 323 had chemotherapy and radiotherapy. Three years after her original cleavage sparing mastectomy, a different surgeon operated to remove the breast tissue that had been left behind.

Patient 323 was recalled by Solihull Hospital. When she went to the hospital for her recall appointment she was told it had been cancelled. Patient 323 was told at her rearranged recall appointment that she didn't have cause for concern and would be invited for routine breast screening appointments.

Patient 323 was treated over a ten-year period. She said she now realises that her illness and treatment by Paterson has had an impact on her family.

Patient 228

Patient 228 had a lump in her breast and was referred to Paterson at Little Aston Hospital as a private patient. Her GP recommended Paterson as he was considered the best breast care surgeon.

Paterson did a biopsy on the lump and told her that the lump was benign. Patient 228 said it was a "great relief", as her mother had died from breast cancer. She decided to have the lump removed as Paterson told her it was "better to be safe than sorry". Patient 228 was due to have surgery on her back at another hospital and Paterson said he "could do the top at the same time" as her back surgery. Patient 228 and her husband took him to be completely serious. Her back surgeon "was quite horrified" at this suggestion.

Following surgery, patient 228 was surprised that Paterson had removed about a third of her breast, particularly as he had said the lump was benign.

Patient 228 has suffered from breast pain since surgery. She has not been recalled by Spire but has had her breast checked at an NHS hospital and was told that the pain is due to "stretching scar tissue". She takes morphine for back pain but says she can still feel the pain in her breast despite the morphine.

Patient 228 said she is very angry, particularly as the lump was benign and she wonders if the surgery was unnecessary. She has been left "disfigured" with a dent and scar from surgery that she shouldn't have had. Patient 228 feels angry that she has also been left with constant breast pain.

Patient 340

Patient 340 was referred to the breast clinic at Solihull Hospital as an NHS patient, as she frequently suffered with cysts and lumpy breasts, coupled with a history of breast cancer in her family. She saw Paterson every 18 months to have the cysts drained and always found him "fantastic" and "that he had a great sort of personality". However, she was advised by her GP that regularly draining the cysts could lead to tissue damage.

Some years later, patient 340 went on to discover a painful lump in her breast and was sent to Solihull Hospital for an urgent mammogram and to have biopsies. She was informed that same day that she had breast cancer. Paterson operated to remove the lump and some of the surrounding tissue, despite patient 340 telling him she wanted to have a mastectomy. He was unable to remove all the cancerous cells and operated three more times to "shave" the tissue away. Paterson told patient 340 that he needed to operate again to remove further tissue. The nurse present at the consultation told patient 340 that if she agreed to further surgery, "these sort of operations" would continue. Patient 340 insisted on having a mastectomy rather than further "shaves".

Patient 340 was recalled by Solihull Hospital and given assurances that the treatment she had was necessary and had been correct. Following her experience, patient 340 has no trust in what doctors say to her and records every appointment she attends. She spoke about the impact of having cancer and being a patient of Paterson, "It is almost like these are the things that you see that happen to other people, not to yourself."

Patient 27

Patient 27 had pain in her breast. Her GP referred her as a private patient to Paterson at Parkway Hospital. Paterson told her that she had "teenage breasts" and advised her to take evening primrose oil. That seemed to work for a while but later she thought something looked odd, returned to Paterson who, after a scan, said she needed surgery to remove her milk ducts. Patient 27 had the operation, which seemed to fix the problem.

In the mid-2010s, when articles about Paterson appeared in the media, patient 27 wondered whether her operation was necessary and asked Spire to review her case. They told her that Paterson "grossly exaggerated the findings of the scan, giving him justification to do the operation". Spire did not think that the operation should have been the first choice of treatment and that there were no clinical reasons for it.

When patient 27 found out she was operated on for no good reason it was "a hard blow to take". One of the worst things for her was "knowing I was deceived and betrayed by a medical professional who should be totally trustworthy".

Patient 99

Patient 99 is deceased. Her husband spoke to the Inquiry on her behalf. Patient 99 had a mammogram, which showed no problems, but two weeks later she was taken ill. She saw her GP, who referred her to Paterson at Solihull Hospital. He examined her and, after some tests, told her she had breast cancer. He told her that he needed to do a biopsy, but because there was a long waiting list in the NHS, suggested he did it at Parkway Hospital within two days. Patient 99 agreed to this and paid to have the biopsy as a private patient. While patient 99 was recovering from the anaesthetic after the biopsy, Paterson told her that she definitely had cancer. He told her that he had removed most of it with the biopsy, but that she still needed a mastectomy, which took place two weeks later in the NHS. This was followed by chemotherapy and radiotherapy. At her check-ups, Paterson urged patient 99 to have a breast reconstruction. She saw the reconstruction surgeon but decided not to have it.

Patient 99 was recalled to Solihull Hospital in the early 2010s, where she found out for the first time that she had a cleavage sparing mastectomy. Paterson had told her previously that she had undergone a full mastectomy and he had removed some glands from under her arm. Patient 99 was offered further surgery at her recall appointment, but she declined as she was feeling well at that point. The hospital said they would review her annually for three years. In fact, they only reviewed her once, two years later. Two years after that, patient 99 was taken ill again, was admitted to hospital and sadly died of cancer three months later.

Patient 99's husband has been left wondering if there was any connection between the cancer that she died from and her cleavage sparing mastectomy. The clinical team treating patient 99 before she died have not been able to answer this question for him.

Patient 26

Patient 26 had severe stomach pains and went into Good Hope Hospital, where she was told she had gastritis and to “go home, you’ll get over it”. She saw her GP the next day, who told her she had gallstones and referred her as a private patient to Little Aston Hospital, where she had a scan. The doctor there advised her that the gallstones should be removed. Patient 26 was referred to Paterson who operated to remove her gallstones. A few days later, patient 26 had stomach pain again. She was seen at the Nuffield Hospital by Paterson, who removed a bile duct. Over time, patient 26 developed irritable bowel syndrome and had problems with her diet but did not think it was connected to the operation.

In the mid-2010s, patient 26 had severe abdominal pain and was admitted as an emergency patient to Good Hope Hospital, who told her that her common bile duct was blocked. She was kept in hospital for ten days and had an operation to clear it. Patient 26 was told that the blockage was caused by one of the gallstones remaining from the original operation, which had caused sepsis.

Patient 26 described how the experience has affected her trust in medical professionals: “I cannot say that at the time when all this happened I was particularly feeling in charge, but since then...I find myself thinking ... I will look up the person.”

Early 2000s

Patient 303

Following a routine mammogram, patient 303 was referred as an NHS patient to Solihull Hospital with a suspected cancerous condition. She saw Paterson there who arranged for her to have biopsies of her breast, which he told her confirmed that she had cancer. Paterson told patient 303 that she needed an operation to remove the cancer and may need a mastectomy, but that he wouldn't know that until he began the surgery. Paterson operated to remove the cancer from her breast and discharged her from hospital the same day. Patient 303 became very ill following her surgery and had to be re-admitted to hospital the following day. She had developed an infection which took a month to treat with daily dressings, antibiotics and strong painkillers.

The pathology results following patient 303's operation showed that not all the cancer had been removed and she had to have a second operation, which Paterson did. Patient 303 told us that she did not like Paterson's attitude towards her and felt belittled by him. She began to take other people to her appointments with him to support her. Shortly after her second operation, patient 303 asked to change to a different consultant. Her new consultant was very attentive to patient 303, accompanying her to scans, and with hindsight, she wonders if he had concerns about Paterson's treatment of her.

Patient 303 wasn't recalled by Solihull Hospital, which she thought may have been because she was under the on-going care of a consultant at the hospital. When news of Paterson's court case broke, patient 303 complained to the hospital about her treatment by him. She did not feel that the hospital's response to her complaint addressed the issues she raised.

Patient 303's treatment by Paterson has significantly affected her life. She was dismissed from her job on the grounds of ill-health as she needed to have so much time off work as a result of the complications she had following her operation. She feels that her relationship with her daughter has been affected by her illness. Patient 303 told us, "This man's hands had touched me and that's the bit I find hard. Not just once, but twice, and they've been inside my body."

Patient 326

Patient 326 found a lump in her breast. She had previously had her other breast removed and insisted on seeing a specialist. She was referred to Solihull Hospital as an NHS patient, where she saw Paterson. Following tests, he told patient 326 that she had breast cancer and that she would have to have another mastectomy.

Patient 326 had expected a full mastectomy and had discussed this with Paterson before her surgery. However, after the operation she discovered that flesh had been left behind. Paterson assured her that there was no breast tissue left and the skin was left behind in the case she wanted a reconstruction.

Patient 326 was recalled by Solihull Hospital who examined her and found that there was still breast tissue present and that she required another operation to remove it.

Patient 326 considered Paterson to be charming and convincing and does not hold any resentment towards him. However, she told us she felt "that he could have put me in danger" and felt that "he obviously had a God complex or something because he did some terrible things to some people."

Patient 159

Patient 159 found a lump in her breast. She had private medical insurance and her GP referred her to Paterson at Parkway Hospital on the basis that he “was the best person for the job”. Paterson operated to remove the lump from patient 159’s breast and told her that it was benign but that there had been some abnormal cells present, which he had removed.

Seven years later, patient 159 had a routine medical examination. The doctor examining her thought they could feel a lump in her breast and advised her to get this checked. Patient 159 asked to be referred to Paterson again. She had an appointment with him at Parkway Hospital. He examined her and reassured her that it was just a fatty lump which needed no further treatment. Patient 159 has always found Paterson to be charming and reassuring.

When news of Paterson’s malpractice broke, patient 159 initially thought she was alright and that her treatment had been appropriate and was surprised to be recalled by Spire. At her recall appointment, patient 159 was told that her original operation had not been necessary, the lump was just fatty tissue and did not contain any abnormal cells. She told us, “I felt like somebody had hit me over the head with a brick.” She does not remember being offered any follow-up support by Spire.

The experience has shaken patient 159’s confidence and left her with a mistrust of the medical profession, she said; “I just know if somebody is on the take and they are conning me, and I just know, because I have got this intuitive gift, I thought. And I met Ian Paterson, who was charm itself, and I was totally fooled.”

Patient 73

Patient 73 had problems with one of her breasts. She was aware of Paterson’s good reputation locally and arranged to see him as a private patient at Parkway Hospital.

Paterson operated to remove some of the tissue from patient 73’s breast. He told her that it looked suspicious and persuaded her to have a lump removed from her breast. She required further surgery to tidy up scarring from the operation.

Patient 73 became aware of concerns around Paterson’s practices and was recalled by Spire. At her recall appointment she was told that Paterson had exaggerated her condition in her medical notes and that her operation had not been necessary. Patient 73 told us that no support or counselling was offered by Spire when these facts emerged.

Patient 73 expressed her anger and frustration and believes “it’s spoilt the last few years”.

Patient 249

Patient 249 had been bleeding from her nipple. She was referred to Paterson as an NHS patient. Following a mammogram, Paterson told her that there was a problem as he couldn’t find anything but would like to “open” her up to check. Thinking she may have cancer, patient 249 agreed; she told us, “I’d have probably agreed to a camping trip with Saddam Hussein at that moment in time.”

Paterson operated on patient 249. He told her that the bleeding was due to an infection and discharged her. Patient 249 told us that the nursing staff who were changing her dressings at her GP’s surgery, appeared confused that she had been discharged with no follow-up appointments. She later found out that Paterson had not written to her GP, letting them know what had happened.

When news of Paterson's malpractice broke, patient 249 contacted a solicitor to see if she had had the right treatment. She was told that she did not need to have the surgery. Paterson had recorded in her medical notes that patient 249 had asked him to operate rather than adopt a "wait and see" policy. This was not true, she had not been offered the "wait and see" option.

Patient 249's experience with Paterson has made her question her judgement and left her a bit distrustful of the medical profession. Whilst she feels she hasn't suffered as a result of her treatment other than having an unsightly scar, patient 249 feels "very, very angry for people whose lives have been destroyed".

Patient 365

Patient 365 had a lump in her breast removed by a surgeon other than Paterson. She was an NHS patient and saw Paterson at her check-up appointment at Solihull Hospital. He told patient 365 she had cancer and that her breast needed to be removed. A breast care nurse she saw at her appointment reassured her that Paterson was a "marvellous surgeon. He does a cleavage sparing mastectomy, you know, for ladies".

A few years later, patient 365 was diagnosed with cancer in her other breast. Paterson carried out a mastectomy which was followed by an immediate breast reconstruction. It took patient 365 18 months to recover from the operation. Following her second operation, a breast care nurse told her that they couldn't give her the "all clear" as Paterson hadn't removed any of her lymph nodes.

Patient 365 was recalled by the hospital and told that Paterson had not removed all her breast tissue in the first mastectomy. The consultant she saw was unable to tell her how much breast tissue was left as Paterson's note keeping was poor. Patient 365 opted to have regular mammograms and an MRI scan. Fifteen years after her original surgery, patient 365's breast cancer returned. She had further surgery followed by radiotherapy.

Patient 365 told us that she now lives in "limbo" and doesn't want other women to go through what she'd been through. She said, "Well, I hope it doesn't happen again. That's the only thing. I mean, that's why I've come along, to save other women."

Husband of patient 353 (described as Y)

Patient 353 was referred by her GP to Solihull Hospital as she had a lump in her breast. Following tests, she was called into a consulting room and saw Paterson, who told her that she had aggressive breast cancer which needed to be treated as soon as possible. He then asked patient 353 if she had private medical insurance. Y, who was with her at her appointment, confirmed that they did, provided through his employment. Paterson told them that in that case, he would be able to operate the following week at Parkway Hospital.

Paterson discussed treatment options with patient 353 and her husband. Patient 353 was very clear that she wanted a double mastectomy to get rid of the cancer in her affected breast and to prevent the spread of cancer to her other breast. Paterson arranged for her to be assessed to make sure she understood the psychological impact of the decision she was making. Following her operation, patient 353 had chemotherapy, radiotherapy and a breast reconstruction. Over the course of the next few years, patient 353 had other non-breast related procedures by Paterson as a private patient.

When articles about Paterson began to appear in the local press, Y asked Paterson if he had performed a cleavage sparing mastectomy on patient 353. Paterson denied that he had and dismissed the articles as being due to a patient acting maliciously to try to get free treatment.

Patient 353 was not recalled by Spire, however, she asked to be reviewed. The consultant she saw told her that she had had an incomplete mastectomy and had breast tissue left. Y told us that Paterson had “played Russian roulette” with his wife’s health.

Y described how stressful the whole experience had been for the family. Y told us that patient 353 had agreed that he should speak to the Inquiry but that she has been left drained by her experience of being a patient of Paterson.

Patient 328

Patient 328 had some irritation in her breast. She had private medical insurance and her GP referred her to Paterson at Parkway Hospital on the basis that he was the “lead person”, locally. Following an ultrasound scan, mammogram and biopsy, Paterson told 328 she had cancer and booked her in for surgery.

Patient 328 had surgery to remove a lump in her breast. A short time later she had to return for further surgery as the margins around the lump were not clear of cancer. She needed chemotherapy, and asked Paterson if she could have a Hickman line inserted, which is a central line into a vein to make the administration of chemotherapy easier. Four days after Paterson had inserted the Hickman line, patient 328’s arm started to change colour. She went to hospital on the advice of her oncologist. The Hickman line had not been properly inserted into the vein, this had caused a blood clot and patient 328 had to stay in hospital for a week while this was treated. She has ongoing health problems resulting from the incorrect insertion of the Hickman line.

Patient 328 was not recalled by Spire. When news of Paterson’s malpractice became known, she contacted a solicitor to find out if her treatment had been necessary. Patient 328 was told that the diagnosis of cancer was correct but that she may not have required all the surgery she had had. Her experience has left her wary of being treated in the independent sector again.

Patient 46

Patient 46 had a lump in her breast and was referred to the NHS. She asked for an onward referral to Parkway Hospital, as test results were taking six weeks in the NHS.

Patient 46 saw Paterson. He told her that the lump was a concern and that most people would opt to have it removed, which she did. Paterson later removed a further lump in the same place, describing it as a “hormone hotspot”. At a follow-up appointment, Paterson carried out a needle biopsy without any pain relief. Patient 46 described Paterson as “vicious”. She said “he hurt me so much, it felt like an attack”, and that the experience felt very different to previous encounters where he had always been charming.

When Paterson’s malpractice was reported in the press, patient 46 asked Spire for an appointment as she had been recalled. She was told that the surgery had been unnecessary, and Paterson had lied to her. She was also informed that there was no such thing as a “hormone hotspot”. Patient 46 recalls that the female chaperone who was in the room during her review appointment tried to discourage her from taking further action.

Patient 46 has been left with a distrust of the medical profession. She told us, “And sometimes if you think they are really good, and you really like them you think, ‘How good are they really?’ Because he was obviously such a really good conman.”

Patient 158

Patient 158 felt a lump in her breast while she was on holiday and went to see her GP when she returned home. She referred patient 158 to Paterson because she knew and liked him when they had previously worked together. Patient 158 saw Paterson as a private patient. He arranged for an ultrasound and mammogram. Paterson took a needle biopsy and in doing so punctured her lung, which he excused by saying that she was slim and “it was quite a common thing with the needle to do that”.

Paterson removed a lump from patient 158’s breast at Little Aston Hospital. He then told her she had cancer and that he would have to operate to take away more tissue, which he did at Parkway Hospital. Patient 158 had chemotherapy following her surgery.

Patient 158 continued to see Paterson as a private patient for regular checks for ten years. In the late 2000s, he told her that the cancer had returned and recommended a cleavage sparing mastectomy. Because she wanted to avoid an operation, she asked for further tests. Paterson agreed, and booked her in for an ultrasound in the morning, where the technician could not find anything. Patient 158 was booked in for exploratory surgery that afternoon, where Paterson removed more tissue from the same area, despite the ultrasound showing that there was no problem.

When patient 158 heard about the recall in the news in 2012, she contacted Spire and was seen by a doctor there. She was assured by him that her treatment was appropriate, but it was unclear whether the final operation was necessary.

Patient 158 told us, “The sad thing is that I have lost all trust in the people that of all you should be able to trust.”

Patient 311

Patient 311 had some discolouration on her breast. Her GP referred her to Solihull Hospital as an NHS patient, where she saw Paterson. Paterson told her he was 99 per cent sure she had breast cancer but confirmed this by extracting “a dark liquid”. Patient 311 believed she had had a full mastectomy within ten days of her initial appointment. She understood he did this so that she could have a reconstruction. Patient 311 had radiotherapy and chemotherapy following her surgery.

Patient 311 has been recalled by the Hospital and has discovered that Paterson had carried out an incomplete mastectomy. She has chosen not to have the remaining breast tissue removed.

Patient 311 feels grateful to Paterson that she is still alive. She said he was “a lovely man, I could not fault him”.

Patient 35

Patient 35 returned from holiday and noticed a small mark on the side of her breast. She visited her GP twice who told her there was nothing to worry about. Patient 35 had a family history of breast cancer. She had private medical insurance and asked to be referred as a private patient. Her GP sent her to see Paterson at Parkway Hospital, as he had a “good name”.

At patient 35's appointment, Paterson arranged for her to have a mammogram and ultrasound. When the X-rays returned, Paterson told her that she had "abnormal tissue" and that she could either have a needle biopsy, but he said: "I am not quite sure what that would show", or he could operate in two days' time. In the light of Paterson describing the tissue as "abnormal" she decided to have the operation.

Paterson operated to remove some of patient 35's breast tissue. He told her that he did not think she had cancer, but that he would send it for analysis. When she returned for her results, Paterson told her to "put some Nivea cream on and that will smooth it out a bit". Patient 35 asked him for the results, and he said that it was abnormal, but was not cancer. Later, patient 35 had a mammogram which showed something Paterson said "they were not happy with", which could be a cyst. Patient 35 wished to return to the NHS and was reassured by Paterson that he would see her at Solihull Hospital.

Patient 35 was seen at Solihull Hospital by a different doctor, who had none of the notes from her spell of private patient care, despite her having asked that they be transferred. Patient 35 had at least two mammograms and was told she would be discharged.

Patient 35 was recalled by Spire. She was told that there was never anything wrong with her. Her notes were limited, but the ultrasounds and mammograms were all clear. Patient 35's operation had not been necessary. The tissue removed was normal.

For 12 years, all the stress patient 35 and her family had been put under, had been for no reason. Patient 35 said, "I feel as though 12 years of my life has just been wiped out."

Patient 148

Patient 148 was referred as an NHS patient to the breast clinic at Solihull Hospital by her GP following a routine mammogram. She had a biopsy and then saw Paterson. Patient 148 found Paterson to be "charming", he explained that he was going to carry out a cleavage sparing mastectomy, which at that stage she had no reason to doubt was usual practice. No other options were discussed. Patient 148 had six months of chemotherapy following her surgery.

Patient 148 contacted the hospital following local publicity about Paterson. She saw a breast consultant who told her that she had 20 per cent to 25 per cent of breast tissue remaining and that this should be removed. Her notes stated she had a full mastectomy and that the options offered to her were "lumpectomy, mastectomy or cleavage sparing mastectomy". This was not the case.

Patient 148 had a recurrence of cancer in her right shoulder which she believes is secondary cancer from the operation carried out by Paterson. Her diagnosis is terminal.

Patient 87

Patient 87 found a lump in her breast. She had private medical insurance and was referred to Paterson at Parkway Hospital. Her friends had recommended Paterson and she had seen him at ladies' lunches. Patient 87 told us that he was well known in the area and therefore an obvious choice. Paterson operated to remove the lump from her breast.

Five years later, patient 87 had a further lump in her breast, which Paterson removed. He told her the lump was cancerous, and she had radiotherapy after her surgery. Paterson referred patient 87 for chemotherapy. She was reluctant to have this and asked her GP for advice, her GP encouraged her to go ahead. Patient 87 had chemotherapy as an inpatient as she reacted very badly to the first treatment. She caught an infection while in hospital.

Patient 87 had a number of additional procedures carried out by Paterson as a private patient, including four anal stretches, and she had 12 anaesthetics within 12 months. Patient 87 said that nobody at the Spire questioned the number of general anaesthetics she was having.

Patient 87 was not recalled by Spire. However, she later learned that while the second lump Paterson removed was cancerous, the chemotherapy was unnecessary, as was the removal of the first lump in her breast.

The experience had a huge impact upon the family, particularly patient 87's children who were very concerned about her. She told us, "It was very grim really. And I had many, many operations with Mr Paterson."

Patient 296

Patient 296 was referred to Heartlands Hospital by her GP as she had pain in her breast. She had a lump in her breast which was tested, but the results were inconclusive. The consultant she saw told her she should be monitored for three months. At each appointment patient 296 was told the lump was a cyst until the third appointment when she was told it was a "lump". Patient 296 was very upset by this apparent change in diagnosis. The nurse at the clinic suggested patient 296 transfer to Parkway Hospital using her private medical insurance.

Patient 296 had a mammogram and ultrasound scan at Parkway Hospital. She saw Paterson who gave her a choice, to continue monitoring or have the lump removed. As patient 296 had been concerned for over a year and had a very young child she opted to have the lump removed.

Patient 296 told us the oncologist at Parkway was surprised to see her and suggested her lump was a cyst. She repeated this to Paterson who again said it was her choice whether to have the surgery. Paterson said it was probably a "precursor to something" and may be "high risk". As patient 296 was ready for surgery she opted to go ahead.

When patient 296 returned for her results Paterson told her, "I would not like to say I have saved your life", and recommended he continued to monitor her.

Patient 296 found a small "gristly cartilage sort of lump" in her breast and her GP again referred her to Paterson. She had a mammogram, ultrasound scan and biopsy. Paterson told her it was cancer but as the lump was small he could remove it. He said it was her choice whether to have chemotherapy. Patient 296 found making this decision extremely stressful and after carrying out research decided against it.

After Paterson had removed the lump from her breast, patient 296 had a further operation to remove more tissue that had surrounded it, followed by radiotherapy. Paterson advised her to be monitored every three months with an ultrasound scan.

Patient 296 was a patient of Paterson's for nine years, mostly at Spire but on one occasion she saw him as an NHS patient at Solihull Hospital. She remarked that his manner was different when she saw him at the NHS hospital and he did not seem particularly pleased to see her.

Following Paterson's suspension, patient 296 saw a different consultant who referred her to a lymphedema specialist because of the swelling and discomfort she was experiencing.

Patient 296 contacted Spire as she was concerned about the media reports regarding Paterson. At her recall appointment, she learnt that none of the procedures she had had were necessary. Patient 296 said that her experiences of being treated by Paterson has left her with a distrust of the medical profession and she would always seek a second opinion now. She told us, "I do not think I trust one doctor now."

Patient 316

Patient 316 found a lump in her breast. Her GP referred her to Solihull Hospital breast clinic where she was seen by Paterson as an NHS patient. He told her that she needed to have the lump removed. A few weeks after her operation, Paterson told patient 316 that she would need to return to surgery for a mastectomy. Before the second operation, Paterson told patient 316, "I like to leave my ladies with a bit of cleavage", which she did not question because she thought Paterson would know the best treatment for her.

Patient 316 was pleased with the care that she received at the time, from Paterson and the nurses. She went on to have chemotherapy, and regular follow-up appointments. Several years later, patient 316 was told that she needed a mammogram of the remaining breast tissue, but no explanation was given as to why this was needed.

When news about Paterson had reached local papers, patient 316 called Solihull Hospital and asked to be reviewed. At that appointment, she and her husband were unnerved by someone who looked like a security guard outside the door of the consultation room. No explanation was given as to what his role was, or why he was there. Patient 316 was examined and told that she would need further surgery to remove the remaining breast tissue. She was told that the remaining breast tissue was not cancerous and considers herself "one of the lucky ones".

This experience has had an impact on patient 316's family. She found it difficult to tell them about repeat operations. Patient 316 told us, "And you would see it all in the press. Friends talking about it. Work colleagues, somebody in work and it was all sort of in our face and I just wanted it to go away, to be honest."

Patient 294

Patient 294's GP referred her to Solihull Hospital as she had cysts in her breasts. She had a mammogram and ultrasound scan and then saw Paterson who confirmed there was nothing untoward.

A few years later, patient 294 had further problems with her breasts and again saw Paterson as an NHS patient at Solihull Hospital. Following a biopsy, Paterson diagnosed her with cancer and told patient 294 that he wanted to operate within a month to remove her breast. Patient 294 was shocked and felt rushed into agreeing to the surgery. Instead, she chose to have an alternative treatment, but after a year she found out that the tumour had not reduced and so agreed to have surgery. Patient 294 also subsequently found another small lump on her breast, which was confirmed to be malignant and she agreed to have a double mastectomy.

Patient 294 was waiting in the anteroom before surgery, when Paterson suddenly approached her and "just jabbed a syringe straight into one breast and then straight into the other breast", with no warning. She described this as "brutal", "painful" and "cruel".

Patient 294 chose not to have chemotherapy and tamoxifen following her surgery. Paterson told her that if she didn't have them, her cancer would return. It did not and this was confirmed when she was recalled.

Patient 294 is now mistrustful of doctors. She told us, "Well, actually, every time I go to the doctors, as soon as I step through the surgery door my pulse rate sky rockets and I am a nervous wreck. So, I avoid going to the doctor as much as I possibly can. Yes, it is a real trial for me to go to the doctors now, and I did not have that before actually. No. So, yeah, my heart goes 'boom.'"

Patient 301

Patient 301 went for a routine NHS mammogram test, which showed a small growth in her breast. She was seen by Paterson at Solihull Hospital. He removed some breast tissue for examination, but the results were inconclusive. Paterson then removed a small growth for analysis. This showed that patient 301 had cancer and Paterson recommended she have a mastectomy. Paterson left a flap of skin, for cleavage, behind after the operation. This was pointed out to patient 301 by the nurse who said, "It's his signature."

Patient 301 had six-monthly check-ups. In the mid-2010s, she was recalled by the hospital. At the appointment, the hospital offered to remove the flap of skin and her other breast, but she declined. She has never been given an explanation by the hospital of why she was left with the flap of skin. No health professional patient 301 saw had ever expressed any surprise that tissue was left following a mastectomy.

Patient 324

Patient 324 found a lump in her breast and was referred to Parkway Hospital as a private patient. Paterson examined her and said he didn't believe the lump was of concern, but she could choose to have it removed. Patient 324 now feels she was naïve as at the time she didn't realise that the lump should have been tested.

Patient 324 had the lump removed and six weeks later found several more lumps. Paterson said she should have them removed and after doing so, diagnosed her as having a rare disease. He said there was no known cause or cure and that the condition usually resulted in a mastectomy.

After patient 324 had a further eight lumps removed, Paterson told her she needed a mastectomy. She had two separate mastectomies and immediate reconstructions. Following the second operation, she developed a blood clot in the artery next to her heart and was transferred by emergency ambulance to an NHS hospital. She developed a serious stomach complaint. Patient 324 was convinced she had MRSA as her flesh was going black. In one year, patient 324 had 96 hospital appointments and 23 general anaesthetics.

Patient 324 was recalled by Spire. At her recall appointment she discovered that none of the treatments were necessary and was told by the consultant that it was the worst case of abuse and negligence he had seen. Patient 324 has also found out that she had not had a total mastectomy. The reconstructive surgeon hadn't taken any notes, and something had gone seriously wrong during her surgery causing patient 324 to develop a blood clot. No support or follow-up was offered by Spire. Patient 324 has since discovered that Paterson was using the wrong codes for invoicing her insurance company and over-charging for the procedures.

The impact on patient 324 and her family has been great, particularly during her emergency care. She had a significant amount of time off work and as a result her employer "wanted to get rid of her". Patient 324 is very conscious of her scars from the multiple operations and says that she would always ask for a second medical opinion if she required treatment now.

Patient 287

Patient 287 was told that she had breast cancer following a routine mammogram. She was told at Coventry Hospital that her cancer was unusual and she would need to have surgery at Solihull Hospital. Patient 287 saw Paterson who operated to remove a lump from her breast. Following this, she was told by a different consultant that she needed a mastectomy.

As patient 287 had waited a while and not had an appointment for surgery, her family suggested she have treatment privately as they were very worried about the delay. She has since discovered that she had an appointment at Solihull but didn't receive the notification.

Patient 287 saw Paterson as a private patient at Parkway Hospital. He told her that as the theatre was closed at Solihull Hospital the waiting lists for NHS treatment were at least six weeks. She had a mastectomy at Parkway Hospital the following day. Patient 287 had radiotherapy following her surgery. She has since discovered that Paterson had lied to her and the operating theatre at Solihull Hospital had not been closed.

Patient 287 continued to have follow-up appointments at Solihull Hospital, but on one occasion chose to see Paterson privately as she was waiting at Solihull hospital for over two hours and wasn't prepared to keep on waiting. On this occasion, he sent patient 287 for a scan due to the discomfort she was experiencing from radiotherapy. Patient 287 attended a pain clinic at Solihull Hospital because of the burns and discomfort she was experiencing from radiology. The consultant she saw was surprised by the remaining tissue on her breast but patient 287 thought this was a "new mastectomy".

Two years later, patient 287 elected to have her other breast removed for "safety's sake" and the fact that she couldn't have a reconstruction on her original surgery due to her "burnt and fragile" flesh.

Patient 287 was recalled by Solihull Hospital. She was told that the surplus breast tissue should be removed but was advised against having further major surgery. She has not been recalled by Spire where her original mastectomy took place.

Patient 287 is still receiving care and treatment due to an "open wound" on her original mastectomy.

Patient 6

Patient 6 had a routine mammogram which showed she had five small breast tumours. She was referred to Solihull Hospital as an NHS patient, where she saw Paterson. Patient 6 asked to have a mastectomy, wanting all the breast tissue on that side to be removed. A doctor who she had not met before (and did not see again) obtained consent for the operation from her.

When patient 6 woke from her surgery, she found that she had not had the surgery she had consented for. She had been left with a considerable amount of tissue, lymph nodes had been removed and there was a large and messy wound. She asked Paterson on two occasions why he had left tissue and he told her, "That's the way I do it." Paterson asked if he could do a further operation because it "looked ugly", but she did not want to go through more surgery.

Paterson continued to see patient 6 for her routine mammograms and check-ups. In 2011, patient 6 received a phone call from a nurse at Solihull asking her to come in for an appointment. It was explained that there was a problem with some of the surgery Paterson had done, and she needed to be reviewed. When she later found out that her breast cancer had returned it was frightening because she felt that her life had been "on the line for ten years" and she hadn't known.

Patient 6 raised concerns and complaints with the Trust on multiple occasions. She feels she was let down and lied to, and that promises made by the hospital to resolve the situation were revoked. She later had to seek treatment at a private hospital to get the treatment she needed.

One of patient 6's relatives also gave evidence to the Inquiry about the impact of her treatment on the family, and to share their observations about Solihull Hospital's handling of recall and aftercare processes.

Patient 6's relative told us that their "world fell apart" and they were in utter shock when they found out that that she needed further surgery.

They felt that Solihull Hospital had no idea what was going on and had a "paternalist attitude towards the patient". At an appointment they attended with patient 6, they found the hospital manager had "the effrontery to say that keeping everything quiet had been in the patients' best interest".

Patient 6's relative told us they lived through the horror of the experience and was frightened that patient 6 would have breast cancer again.

Patient 130

Patient 130 was referred by her GP to Heartlands Hospital as an NHS patient about a mark on her breast. She had a biopsy which was inconclusive, and the doctor told her she probably had nothing to worry about. However, she was transferred back to Solihull Hospital to see Paterson. He took some breast cells using a needle and, without waiting for the results, said that it was definitely cancer. A week later, she returned for the results and Paterson offered her a cleavage sparing mastectomy, which she had two weeks later. This was followed by chemotherapy, and medication, which lasted about five years. Patient 130 also had a reconstruction three years after the mastectomy, at Little Aston Hospital as an NHS patient.

Patient 130 was recalled by the hospital and she felt reassured by this. She assumes that she had cancer and received appropriate treatment.

Patient 175

Patient 175 was referred by her GP to see Paterson as a private patient. She saw Paterson at Parkway Hospital where she had a mammogram, ultrasound scan and fine needle aspiration. Paterson recommended patient 175 have a lump in her breast removed as the only option, saying that there was an even chance that she had cancer, referring to it as "sinister". After the operation, Paterson told patient 175 that the lump was not cancerous, and that he would monitor her annually, which he did for seven years. After this, she used the NHS routine screening scheme.

Patient 175 was recalled by Spire. She was told that her surgery had not been necessary, although there was no immediate risk to her.

Patient 175 told us, "I was left believing that I still had something cancer-related for months, if not years... And I had no more risk of cancer than anybody else."

Patient 312

Patient 312 found a lump in her breast and went to see her GP. She had private medical insurance and her GP referred her to Paterson. When he saw her, he removed some fluid and referred her for a scan. After that, he told her that she needed to have the lump removed because there was evidence of cancerous cells. A few days later, Paterson removed the lump at Parkway Hospital.

In the early 2010s, patient 312 found a lump in her stomach and saw her GP who thought it was cancer. The patient was worried because Paterson told her earlier she had cancerous cells. However, the lump turned out to be a hernia.

Patient 312 was recalled by Spire. She was told that she never had cancerous cells and that her operation had been unnecessary.

Patient 312 spoke of the scale of the Paterson case: “I was shocked how many hundreds of people he made horrendous decisions over.”

Patient 339

Patient 339 found a tiny lump under her arm and saw her GP, who thought she needed an operation and referred her to Solihull Hospital as an NHS patient. She saw Paterson who did not examine her but sent her for a scan. On checking the X-ray, Paterson told her that she had no cancer in her breasts. However, he wrote a sick note for patient 339 to take to work which said that she had breast cancer.

Some time later, Paterson removed some of patient 339’s lymph nodes and told her she had cancer. This was followed by chemotherapy and radiotherapy. A month later, she saw Paterson again, who advised further surgery, which she refused. Ten years later, patient 339 saw another doctor, who told her that she was clear.

Patient 339 contacted the recall helpline number in 2012 but heard nothing. She went to the hospital in 2017 and asked what the position was. As a result, she received a letter referring to the review of patients. Patient 339 was told that the diagnosis of breast cancer was correct and that her treatment was appropriate.

Patient 54

Patient 54 found a lump in her breast. She had private medical insurance and her GP referred her to see Paterson at Parkway Hospital. Paterson saw her within a few days and arranged for a mammogram and biopsies. She went to see him a few days later and Paterson told her that she had pre-cancerous cells and that the lump needed to be removed. Paterson operated shortly afterwards, but patient 54 could still feel the lump after the operation. Patient 54 had regular check-ups and although she still had the lump, she was told she was clear.

In the early 2010s, patient 54 developed a lump in the other breast, and her GP referred her again to Paterson at Parkway Hospital. Paterson arranged for the lump to be tested. Following this, he told her that the lump was cancer and that it had to be removed urgently. She mentioned that she had heard concerns about Paterson’s cleavage sparing mastectomies to him and Paterson agreed that, if a mastectomy was necessary, he would remove the whole breast. In the end, he did not remove the whole breast but removed the lump.

A few months later, patient 54 was recalled by Spire. She was told that the biopsy had shown she had normal breast tissue in both lumps and neither of them needed to be removed.

Patient 54 has lost trust in the medical profession: “I actually avoid going to see medical people now.”

Patient 493

Following routine breast screening, patient 493 was recalled to her local hospital for a further mammogram and a biopsy. She was referred as an NHS patient to Paterson at Solihull Hospital. He told her she had cancer, and that he would perform a cleavage sparing

mastectomy. Patient 493 had concerns about cancer being left in the remaining tissue, but Paterson told her that it would just be “fatty tissue”. Paterson operated and told patient 493 that he had also removed some lymph nodes.

Patient 493 was recalled by the Hospital and given the choice of having the remaining tissue removed, or regular check-ups. She chose to have routine scans and has since been discharged from the hospital. Patient 493 has pursued a successful legal claim against Paterson, where she was told by an independent doctor that her original tumour was smaller than Paterson told her, and the operation had not been necessary. She told us that her experience had left her mistrustful of doctors.

Patient 322

Patient 322 had a lump in the side of her breast. She was referred as an NHS patient to Paterson at Solihull Hospital. Patient 322 had previously had a cancerous lump removed from her breast. She had a mammogram and biopsy and was diagnosed as having cancer. Paterson recommended she have a mastectomy.

Immediately prior to patient 322’s surgery, as she was entering the operating theatre, Paterson told her that he would be “leaving a bit of cleavage”. Patient 322 told us she was expecting to lose the whole of her breast but said at that point she wasn’t aware what a mastectomy should look like.

Patient 322 was recalled by Solihull Hospital after news about Paterson’s malpractice became public. She had a mammogram but said she had previously decided not to have further surgery if the investigations did not identify a problem. However, the hospital had categorised her as “high risk” and recommended surgery. Patient 322 had the remaining breast tissue removed.

Patient 322 said she felt like “one of the lucky ones” as she had her surgery in the early 2000s and has been well since.

Patient 292

Patient 292 had a lump in her breast. Her GP referred her as an NHS patient to Paterson at Solihull Hospital. She told us Paterson was really good to her and remembers him saying “we will get you right”.

Paterson carried out a cleavage sparing mastectomy on patient 292. Her husband recalled one of the nurses saying that Paterson would leave a cleavage but at the time they didn’t know any difference to a total mastectomy. Following her surgery, patient 292 had chemotherapy and radiotherapy which she says made her feel very ill.

Patient 292 was recalled by the hospital and had tests which confirmed she had no reason for concern. However, she found the recall appointments extremely traumatic and worrying. Patient 292 said they “sowed seeds of doubt” as she wondered whether the cancer would return.

Patient 248

Patient 248 found a lump in her breast. Her GP referred her to see Paterson at Solihull Hospital as an NHS patient.

She found Paterson to be pleasant and he put her mind at rest. Following a biopsy, he told her that the lump was cancerous. He removed the lump and prescribed the anti-cancer drug tamoxifen as a precaution. At no point did he explain the side effects but said patient 248 could take it for up to 10 years.

Once the news of Paterson's malpractice broke, patient 248 contacted Solihull Hospital and was told that only Paterson's patients who had had a mastectomy were being recalled.

Patient 248 was told that she was prescribed tamoxifen unnecessarily as she hadn't had cancer. There wasn't any record of a cancer diagnosis in her notes. Paterson had written to her GP and said she had "fibrous disease" and that she had no evidence of pre-cancerous nor cancerous cells. She cannot understand why her GP continued to prescribe tamoxifen if she had not had cancer.

Patient 248 says unnecessarily taking tamoxifen for nine years has caused her to require a hysterectomy, have significant dental problems and stopped her donating blood. She has had psychological problems and lost financially due to time off work and having to pay for unnecessary drugs over the nine years. Her family have been affected emotionally too.

Patient 248 says she feels she has been completely ignored by Solihull Hospital.

Patient 320

Patient 320 had a lump in her breast and was sent by her GP to Solihull Hospital as an NHS patient. She had an ultrasound scan but was advised to leave it for three months. As patient 320 could feel the lump getting larger, she contacted the hospital and had a biopsy. Patient 320 was told she had breast cancer. She was given the choice to have her breast removed and a reconstruction at a later date or to wait six weeks and have a mastectomy and immediate reconstruction. She opted to wait for six weeks in order to have immediate reconstruction.

Patient 320 wasn't aware that Paterson had operated on her and didn't meet him until after her surgery. She told us she didn't like Paterson as she thought he had "no heart" and "wasn't interested in her".

Patient 320 was recalled by Solihull Hospital and told there were some concerns about her surgery. Around the same time, she discovered that she had advanced cancer in her other breast. Patient 320 opted for a mastectomy and reconstruction and also asked for her other breast to be removed as she realised that she had remaining breast tissue and assumed that Paterson had performed a cleavage sparing mastectomy. She was not told at her recall appointment that this was the case.

The impact of her treatment has been significant on Patient 320 and her family, she told us, "It's still part of our lives, very, very much part of our life that something horrendously could happen." She said she still has nightmares and has lost her trust in the medical profession.

Patient 310

Patient 310 had a lump in her breast. Her GP fast-tracked her to Solihull Hospital as an NHS patient. She had a scan and X-ray and Paterson extracted fluid from her breast. The same day Paterson told her she had breast cancer.

Four weeks later, patient 310 had a mastectomy. When she came around from the operation she wondered if it had taken place as she had a cleavage. She assumed this is how she should look after a mastectomy. Patient 310 delayed reconstruction for eighteen months as she had

found her original surgery traumatic. She said having the reconstruction “was the worst thing I ever did”. Patient 310 was expected to stay in hospital for 10 days following reconstruction but had to stay there for 10 weeks.

Patient 310 feels she was neglected immediately after reconstruction which resulted in fluid entering her lungs. She said she couldn’t breathe, and her system began to shut down. She was admitted to intensive care.

The reconstructed breast was removed as it was gangrenous and patient 310 had two further operations at Solihull Hospital to reconstruct her breast. She remembers the plastic surgeon saying “I wish he wouldn’t do these type of operations. He does make it very difficult for me.” Patient 310 had chemotherapy and was prescribed tamoxifen but thought it was strange that the oncologist told her to be “vigilant”.

When news broke in the press regarding Paterson’s malpractice, patient 310 realised she hadn’t had a total mastectomy. She said at no point did Paterson nor anyone at the hospital explain she wasn’t having a total mastectomy.

She was recalled by Solihull Hospital. The breast consultant told her he was 99.9 per cent certain “nothing untoward” was going to happen. He said she could have surgery to remove the breast but didn’t recommend it.

Patient 310 contacted a solicitor about claiming compensation but in the meantime began to feel unwell. At A&E she was told she had a migraine, but she later discovered a lump on her head and went to her GP who referred her to Solihull Hospital because of her medical history. Patient 310 began to feel unwell again and went to A&E as thought she was having a heart attack. Following tests, patient 310 was told she had tumours on her skull and chest. The consultant told her the tumours were inoperable and said they hoped to keep her alive for two years.

Patient 310 said, “They tried to worm their way around everything that it was not at the site of the original operation. But it was proved that it was. It was secondaries from him not removing the tissue.”

She said her life and that of her husband have been “turned upside down”. Their lives now revolve around hospital visits. Patient 310’s career ended, and their long term plans for retirement are finished. She said they are trying to lead as happy a life as they can.

Patient 344

Patient 344 was urgently referred as a private patient by her GP to Paterson at Parkway Hospital after finding a lump in her breast. On the day of the initial consultation with Paterson, she had a mammogram, and was told by the radiographer that “it all looked fine”. However, Paterson thought there was a problem and “whatever it was”, needed to “to be removed”. He did a biopsy without a chaperone present, and later called with the results and date of an operation.

Paterson used the words “pre-cancerous” to patient 344 and said he thought the lump needed investigating and removing. She went to Spire for the operation and was told by Paterson that the test results revealed a “fat necrosis” and that it might have developed into something else. He went on to tell patient 344 that she was “more than likely to develop lumps and every one must be investigated”. He was very business-like in his approach and in hindsight patient 344 feels he was “organising his future income”.

When news about Paterson’s malpractice started to appear in the papers, patient 344 thought the cleavage sparing operations were him “trying to be considerate ...and thinking he was doing the right thing”. Around this time, she was recalled to Spire and told that her original mammogram had shown nothing but normal tissue and that her surgery had not been necessary.

Patient 344 found the recall exercise “a bit of a shock” in how it was handled. She told us she wasn’t offered any counselling or any other support service, and said she was angered by Spire’s approach that “it’s nothing to do with them”.

The experience has had an impact on patient 344. She is now “totally suspicious of anything to do with private surgery” and has even doubted her own doctor, someone who she had been with for decades.

Patient 142

Patient 142 was referred as an NHS patient to Solihull Hospital by her GP as she had a breast lump. She had a biopsy and ultrasound scan and saw Paterson for the results. He said she had breast cancer and gave her the choice of having the lump removed or a mastectomy. She saw the breast care nurse and asked for a double mastectomy as her mother had died from breast cancer. Paterson dissuaded her from having a double mastectomy as he felt it was not necessary.

Patient 142 said her surgery was straightforward but can remember Paterson whispering in her ear that all had gone ok. He later told her that the cancer had not spread to her lymph nodes. He advised her to have chemotherapy as a precaution. Patient 142 had her breast reconstructed after the mastectomy.

Around ten years after her surgery, patient 142 was recalled by the hospital. She was really shocked as she didn’t live locally to Solihull so hadn’t seen the local press reports about Paterson’s malpractice.

At the recall appointment, the clinician explained to patient 142 that she may have remaining breast tissue and explained the potential risks of this. She did not want to live with the worry and opted for her reconstructed breast to be removed. She was told that she would need to see a psychologist prior to the mastectomy to “prove that I was sane”.

Patient 142 said the experience has caused her a lot of anxiety and worry, and “made it more difficult to trust and believe when you are told everything is fine”. She said that living with no breast has not been easy for her.

Patient 330

Patient 330 was diagnosed with breast cancer and told that, genetically, she was at high risk of breast cancer. Due to her being at high risk of breast cancer and because members of her family had had breast cancer, patient 330 decided to have a double mastectomy with immediate breast reconstruction.

Patient 330’s consultant recommended she see Paterson and a cosmetic surgeon, with whom Paterson worked, as they carried out both procedures at the same time, which was unusual in the early 2000s. She had her surgery and reconstruction as an NHS patient at Solihull Hospital. Patient 330 felt Paterson was a pleasant man and had the utmost confidence in him.

More than 10 years later, patient 330 received a letter from the hospital telling her it was not clear from her medical notes whether she had had a cleavage sparing mastectomy. She did not live in the area and did not feel it was necessary to travel to Birmingham for review as she felt well. Patient 330 received a further letter from the hospital in 2015. She again responded saying that she did not feel it was necessary to travel to Birmingham for scans and tests. The hospital replied to her, to let her know that she could be reviewed if she changed her mind.

Following later media reports about Paterson, patient 330 said that she “panicked” and arranged to have an MRI scan. The results confirmed that she did not have any retained breast tissue.

Patient 330 feels her experience of being treated by Paterson was a positive one.

Patient 293

Patient 293 was referred as an NHS patient to Solihull Hospital, as a routine mammogram had identified she had a lump in her breast. She saw Paterson, who told her it was cancerous and that she either needed the lump removing or a mastectomy. Patient 293 chose to have a mastectomy as she didn’t want to carry the risk of the cancer returning. When she was about to go into surgery, Paterson told her that he would leave her a cleavage. Patient 293 said she thought that was the “norm”. She had one third of her breast remaining after surgery.

At patient 293’s follow-up appointment, Paterson told her the cancer had spread to her lymph nodes. She had chemotherapy followed by radiotherapy. Patient 293 said that the chemotherapy nearly killed her. She was admitted to intensive care for a week as it had destroyed her white blood cells.

Patient 293 was due to see Paterson at a follow-up appointment but it was cancelled, and no alternative was given. As she was having pains in her back she chased the appointment. She saw one of Paterson’s team at her appointment but wasn’t concerned about this as she found Paterson “quite arrogant” and didn’t like him. Patient 293 was diagnosed as having secondary cancer in her bones, which is incurable.

Patient 293 wasn’t recalled by Solihull Hospital but asked to be seen when there were reports about Paterson’s malpractice in the media. At the appointment, the consultant said she could have the remaining breast tissue removed but patient 293 refused. She said she had “had enough of Solihull Hospital”. She said, “I have got no faith in Solihull Hospital at all.”

Patient 293 saw her medical records when she claimed compensation. The specialist she saw as part of that process said that if Paterson had done a complete mastectomy, she would not have needed chemotherapy nor radiotherapy.

Patient 293 said that she doesn’t talk about her experiences, particularly to her children, but said, “It plays over and over in my mind” and that she is “really, really angry at times.”

Patient 43

Patient 43 asked her GP to refer her to Paterson as she had lumps in her breast. Paterson had been recommended to her as being “fantastic”. She had private health insurance and saw Paterson at Little Aston Hospital.

Patient 43 had a mammogram and X-ray. Paterson reviewed the results and said she had a cyst and offered to remove it immediately, which she agreed to. She saw Paterson as a private patient regularly for over nine years. On one occasion, he said he didn’t like the look of a lump and that the lump should be removed, which he did.

Although patient 43 moved out of the area she continued to see Paterson for regular checks. She ignored invitations for NHS breast screening as she thought they were unnecessary as she was seeing Paterson regularly. However, on one occasion she did attend for NHS breast screening and saw a large 'C' on her notes, but didn't understand at the time what that was.

Patient 43 started to realise that her experience of being treated by Paterson was similar to those being reported in the press. She was recalled by Spire and learnt that all her surgery had been unnecessary. Paterson had performed and charged her insurance company for cancer surgery when she did not have cancer. Her medical notes state she had breast cancer, which is incorrect.

Patient 43 said she was really affected when Paterson was convicted. She said she started to realise the impact he had had on her. She felt uncomfortable about her body and lost faith in the medical profession. Her husband had to persuade her to get a breast lump checked. Patient 43 said she became aggressive when sat in the waiting room and confrontational with the breast consultant, a direct result of being treated by Paterson.

Patient 255

Patient 255 had a routine mammogram which diagnosed non-invasive breast cancer. She saw an NHS consultant who said that treatment for her condition was a mastectomy.

Patient 255 knew Paterson's breast care nurse and discussed her condition with her. The nurse described Paterson as "wonderful" and told patient 255 she could have reconstruction at the same time as a mastectomy. She then saw Paterson as a private patient and he agreed with the diagnosis. Patient 255 was quickly admitted to Parkway Hospital and had a mastectomy and a reconstruction. The reconstruction surgeon said she would get a tummy tuck as well, as with a reconstruction flesh would be taken from her stomach. Patient 255 said she found Paterson "charming" and felt cared about. She said, "He held your hand and would say 'You'll be alright'".

Patient 255 couldn't straighten her arm after surgery and Paterson's breast care nurse said she needed physiotherapy, but that Paterson could perform a "special procedure" called "tendon splitting". She went ahead and had surgery but is left with no sensation down the back of her arm as a result.

At a follow-up appointment, Paterson told patient 255 she had some lumps under the other arm. At a later appointment he said the lumps had got bigger and recommended they be removed, which he did. Patient 255's wound from this procedure became infected. She had the same issue as with her other arm – that she couldn't straighten it. Paterson performed the "tendon splitting" surgery but patient 255 has since discovered that he should not have operated on an infected wound.

Patient 255 was recalled by Spire. At the meeting, the consultant said that "it was crazy, I've got ten minutes to review these notes and tell you the result." She was told that the operation to remove the lump under her arm, together with the surgery to straighten her arm, were unnecessary.

Patient 255 claimed compensation. The specialist who reviewed her case found that she hadn't had a complete mastectomy. Paterson had left breast tissue and performed a cleavage sparing mastectomy. She was advised that as she had remaining breast tissue, she should have mammograms on both of her breasts. Patient 255 discovered that the cancer had

returned in her reconstructed breast. As a result, she needed to have her reconstructed breast removed and further surgery to rebuild it. She discovered from her insurers that Paterson had claimed for procedures he hadn't carried out.

The impact on patient 255 has been significant. She told us she lost a year of her life and said, "I hated him, I really hated him."

Patient 242

Patient 242 was planning a breast augmentation. She mentioned bleeding from her nipple, but the surgeon said it was nothing to worry about. She later discovered a lump in her breast. Her GP referred her as a private patient to Paterson at Parkway Hospital. Paterson told her that any nipple discharge was as worrying as lumps and he recommended a biopsy.

The results confirmed that the lump was cancerous and patient 242 had a mastectomy and reconstruction. She said that she was "more than happy with the results and the fact that the cancer had been removed."

As patient 242 was in her mid-30s, Paterson said he needed to keep a close eye on her and he prescribed tamoxifen. She reacted badly to the drug and decided to stop taking it. She said that she found Ian Paterson and his team like an extended family.

Four years later, patient 242 was suffering from back pain and her GP prescribed anti-inflammatory drugs. She made an appointment to see Paterson as she was convinced the pain was sinister. He referred her for a scan. The results confirmed that she had a secondary malignant growth. Paterson told her that back pain is an early sign of secondary cancer, something her GP had missed. She had six months of chemotherapy and radiotherapy on her spine. Patient 242 has had surgery on her spine to slow down the bones collapsing.

Patient 242 said, "I have no doubt that without Ian and his team's expertise I would no longer be alive and able to write my story."

Patient 28

Patient 28 is deceased. Her husband gave evidence to the Inquiry on her behalf. He said his late wife went to her GP in the early 2000s as she found a lump in her breast. Patient 28 had private health insurance and was referred to Paterson at Parkway Hospital.

Patient 28 met Paterson who was "super charming, smarmy almost". She had biopsies and a scan. The results indicated that she needed the lump removing. Paterson removed the lump, but she needed two lots of further surgery as he hadn't removed enough tissue around it. She had chemotherapy and radiotherapy, but Paterson told her that her treatment wasn't sufficient and that she would have to have a mastectomy.

Following surgery, patient 28 saw Paterson every six months for "a number of years", and she would often have a PET or MRI scan. Paterson referred her to another surgeon at Spire Parkway as she had problems in the region of her breast bone. The specialist identified patient 28 had a tumour but said it would be too dangerous to remove as it was very close to her vocal chords. Patient 28 had further surgery which involved opening her chest, similar to open-heart surgery, and had the tumour partially removed, followed by chemotherapy.

Patient 28 had further reoccurrences of cancer and was diagnosed as having a tumour on her brain. She had surgery but didn't fully recover. Patient 28 was confined to a wheelchair and later couldn't eat. She was rushed to Solihull Hospital. Her husband said, "Her body said, 'I've had enough', and that was it."

Patient 28 was under the care of Paterson for nine years and during that time there was only one appointment her husband didn't attend. Paterson said, "Oh the Rottweiler's not here today?". Patient 28's husband told us Paterson hated being challenged and avoided answering questions about this wife's treatment. He said, "It was Paterson's treatment and he wouldn't deviate in any way, shape or form."

Spire recalled patient 28. Her husband said the recall appointment was pointless as all the consultant did was look at her body. They never discovered whether she had a cleavage sparing mastectomy but patient 28 always believed all her health problems were caused by her mastectomy.

Patient 28 and her husband raised their concerns about her treatment with Spire. Her husband told us that Spire's response was that they didn't have any responsibility, that Paterson rented the facilities and "whatever Paterson has done, it's not our fault". They also raised their concerns with the GMC. Patient 28's husband said, "It's a closed shop, they won't talk to anyone like me."

Patient 28's husband said he wouldn't now have any treatment without a second opinion. When news broke regarding Paterson's malpractice, his late wife had wanted to "string him up". She wanted to know what he had or hadn't done, not just to her but to his other patients.

Patient 28's father also spoke to the Inquiry about Paterson's treatment of his daughter, and his great sadness at what had happened. He told us, "And, you know, the problem is the grief is exaggerated by anger, because I really am very angry about Paterson."

Patient 25

Patient 25 discovered a lump in her breast. After seeing her GP, who told her they didn't think the lump was serious, patient 25 contacted Parkway Hospital who gave her Paterson's name.

Patient 25 saw Paterson as a private patient and had a needle biopsy, mammogram and ultrasound. Paterson told her she needed a mastectomy and that they would have the results from the biopsy in a few days. When patient 25 returned for her results, she was told by Paterson's breast care nurse that she had breast cancer. She was booked in for a mastectomy two weeks later, when Paterson returned from his holiday. He told her he would carry out the surgery in a way that would help the plastic surgeon reconstruct her breast.

Following surgery, patient 25 thought it was strange that Paterson and his nurse said she did not require chemotherapy but the oncologist she saw told her that she did. She also had radiotherapy after her surgery.

Patient 25 was recalled by Spire. She said that Paterson's breast care nurse was present and looked "gaunt" and a "worried woman". Patient 25 had a mammogram and ultrasound and was told she was clear of cancer. She told us that if she had known then what she knows now she would have asked if she ever had cancer.

Patient 25 had further surgery as her reconstructed breast was too large. Following this, she was still left with one breast bigger than the other but now lives with it as she did not want further surgery, nor to incur further costs.

Patient 25 feels she has dealt with the experience well, although found it difficult to see constant reminders in the media. She feels that her partner has been affected more than she has.

Patient 499

Patient 499 died some time ago. Her husband gave evidence to the Inquiry on her behalf. Patient 499 had a mammogram which picked up something was wrong. As they had private health insurance, she was referred to Little Aston Hospital. Patient 499 had a biopsy and Paterson confirmed she had breast cancer. Paterson said, "Don't worry, you will not lose your breast, you will not die."

A couple of months later, patient 499 had a mastectomy and breast reconstruction, followed by chemotherapy and radiotherapy. Paterson told her that he had "removed every last piece of breast tissue from that side, there is no way you will get breast cancer on that side of your body again". Twelve months later the cancer had returned on the same side. Paterson's explanation was that she must have had a lymph gland which was "deeper down than was normal". Patient 499's husband said they had no way of knowing whether this was true – they had to take Paterson's word for it.

Patient 499's husband said she had further chemotherapy and various cannulas inserted, as her veins had collapsed. Every 12 months, the cancer returned. It eventually spread to patient 499's bones and brain. The oncologist told her she had only a couple of weeks to live. Patient 499 died four years after cancer was first diagnosed.

Patient 499's husband said at the time they didn't have any misgivings about Paterson and said he was "charming, he was confident, he was assured and supportive". He hasn't been able to access his late wife's medical records but someone working with Verita, who undertook the review of Paterson that was commissioned by Spire, told patient 499's husband that they couldn't confirm whether his late wife had a cleavage sparing mastectomy nor whether a mastectomy had been necessary. Patient 499's husband has not received any other communication from Spire.

Patient 499's husband now wonders if he hadn't had private medical insurance whether his late wife would have gone down a different route and could have survived. He feels he would like some answers for his children who have had to grow up without their mother.

Patient 50

Patient 50 saw her GP about a lump in her breast. Her GP spoke highly of Paterson and, because she had medical insurance, referred her to him as a private patient at Parkway Hospital. She had a biopsy on the Friday, and returned on Monday, when Paterson told her she had cancer. Patient 50 had an operation to remove the lump and Paterson told her that the cancer had not spread. This was followed by radiotherapy and an anti-cancer drug, tamoxifen. After two years, she saw Paterson again because she was having problems with tamoxifen and he changed it to another drug. After five years, a scan showed that she was clear of cancer.

Patient 50 contacted the recall helpline and was told at the recall appointment (which Spire charged for) that, although the initial biopsy showed that she had a malignant cell, Paterson should have undertaken a larger biopsy before operating. She has received no follow-up from Spire.

Patient 50 told us that while her own experience has not affected her hugely and that she was lucky to be well supported by her family, she is conscious that other patients have been very affected by their treatment by Paterson.

Patient 216

Patient 216 is deceased. Her family gave evidence on her behalf. Her husband told us that patient 216 discovered a lump on her breast. She went to her GP who immediately suspected breast cancer and referred her to Solihull Hospital as an NHS patient, where she saw Paterson, who was very reassuring. He took a biopsy and discussed the results at a further appointment, where he confirmed that it was breast cancer and discussed the options for operating. Paterson preferred to remove the lump, but patient 216 preferred a full mastectomy, with no reconstruction. She had a mastectomy and the removal of some lymph nodes six weeks later, followed by chemotherapy and radiotherapy. Two or three years later, patient 216 had an irregular mammogram on the breast which had been removed, but it was shown to be clear.

Patient 216 developed a persistent cough and went to see her GP. Tests showed that she had extensive and aggressive lung cancer, which was secondary to the original breast cancer, and was terminal. Patient 216 was never recalled by the hospital in relation to her treatment for breast cancer.

Her husband spoke of the impact on his late wife, having been a patient of Paterson's: "The difficulty that I think we have all had, certainly I would speak for myself and say I have had it every time it comes up in the press it brings this whole saga back which then accentuates the grieving process."

Patient 491

Patient 491 is deceased. Her family gave evidence on her behalf. They told us that patient 491 found some lumps in her breast. She was sent immediately to hospital, where the lumps were diagnosed as cysts and drained. A year later, she found another lump in her breast, saw the GP and was referred as an NHS patient to the breast care unit at Solihull Hospital, where she saw Paterson. He told her that he was "pretty sure it was breast cancer" but took a biopsy to investigate it. The results of that were inconclusive, and Paterson said he would remove the lump to be sure. Paterson removed the lump, said that it was cancer, and that patient 491 needed to have a mastectomy, which he carried out. One of patient 491's relatives thought the mastectomy did not look right, and asked a nurse, who replied, "That is how he does it." Paterson discussed breast reconstruction with patient 491, but she did not want it.

Later, patient 491 was recalled by the hospital. She was told she had had a cleavage sparing mastectomy and was told that she needed further surgery to complete the mastectomy, which she had.

Patient 491's family told us that she did not feel any bitterness towards Paterson. She thought that he saved her life because she believed the original cancer was aggressive, but she could not understand why he didn't do a full mastectomy. Her family trust other doctors less because of the experience with Paterson.

Patient 112

Patient 112 went to her GP as she was worried about a lump in her breast and was referred to Paterson as a private patient. Her GP told her Paterson was the "best breast man around". Paterson examined her and told her that she was on the verge of developing cancer and recommended that he remove the lump. After he had operated, Paterson told patient 112 that the lump was not cancer. Paterson operated on patient 112 twice more. The last time, he removed a large lump.

When patient 112 heard about Paterson's malpractice in the news, she contacted Spire. They told her that Paterson should have taken a biopsy before he removed the lump. Following this, she asked for her medical records to be reviewed privately and was told that removing the lump had not been necessary – she had not needed the operation. Patient 112 described the impact that living with the fear of developing cancer, as suggested by Paterson, had had on her and her family. She told us, "I kept going back because I was really worried and traumatised and my daughter who was in her teens thought I was going to die, and she kept breaking down with her friends." Patient 112 has lost trust in doctors.

Patient 100

Patient 100 had recurring breast cysts and abscesses and was treated by Paterson as a private patient. Relatives recommended Paterson to her as they believed him to be "the best breast man in the area".

Paterson suggested a mastectomy, which shocked patient 100 as she believed this to be the last resort for people with breast cancer. As she had small children and a successful business, she felt that this was her only option. Paterson arranged for patient 100 to see the plastic surgeon to discuss breast reconstruction. The plastic surgeon talked about the benefits to her figure rather than surgery being a last resort for her condition.

Patient 100 also met with Paterson's breast care nurse who explained that she would be looked after by the breast care team. Patient 100 said the nurse "almost swooned" at the mention of Paterson's name. She felt as if she was getting a "full sales job", being shown pictures of girls with flat stomachs. Patient 100 said she didn't want a mastectomy and plastic surgery to improve her appearance. She was going ahead with the surgery to stop her developing breast cancer and leaving her children without a mother.

Patient 100 is now aware that her surgery was unnecessary and that she had other options for treatment. She said at no point did Paterson, the plastic surgeon or the breast care nurse make her aware of other options.

Patient 100 feels that the whole team at Spire chose to "assist him with procedures that were totally unnecessary".

Patient 162

Patient 162 found a lump in her chest. Her GP referred her to Solihull Hospital as an NHS patient. A doctor there took a biopsy of the lump. When patient 162 returned for the results, she saw Paterson who told her that the lump looked serious.

Patient 162 researched her treatment options. At her follow-up appointment, she asked Paterson if she could have the lump and her lymph nodes removed, rather than a mastectomy. Paterson said he would see what he could do when she was in theatre and asked her to sign a consent form. Patient 162 said she was in a state of confusion at the thought she might have cancer and so signed the consent form. When she woke from surgery, patient 162 found her breast had been removed, she had "completely nothing, everything had gone". She told us she was in a terrible state and felt suicidal.

Patient 162 was sure she hadn't had cancer. When she returned to Paterson he told her she was "cured" and that "she should be happy about it". He said her lymph nodes were clear.

A few months later, patient 162 felt lumps under her arm on the side of the mastectomy. She was told by Solihull Hospital that she would need to wait for two weeks as Paterson was on holiday. When she saw Paterson on his return from holiday, she said he was “horrible”, but agreed to remove her lymph nodes.

Patient 162 asked Paterson if she could have her breast reconstructed as she felt she couldn't live without a breast. His response was that she would need to wait three years for treatment as an NHS patient or if she was willing to pay him £10,000, she could have the reconstruction as a private patient the following week. She told Paterson that he “had done her wrong” and told him, “You're nothing but a butcher and I'm going to see you in court one day.”

Two weeks later, patient 162 received an invitation from the plastic surgeon to discuss reconstruction as an NHS patient. After surgery, she had multiple operations to readjust the reconstruction. She was advised to have the other breast removed to make her breasts equal. Patient 162 is still unhappy with her reconstructed breasts and is waiting for further surgery to correct this.

Patient 162 told us all her medical records have disappeared. Patient 162 is convinced she had unnecessary surgery that she didn't agree to, and that those around Paterson were aware of his malpractice.

Patient 9

Patient 9 found a lump in her breast and was referred by her GP to see Paterson as an NHS patient at Heartlands Hospital. Paterson told her the lump was a cyst. She had several cysts after that, which the GP attempted to drain, and a small growth which was never tested for cancer.

Patient 9 saw another GP in the mid-2000s about another lump, and they referred her to Solihull Hospital for tests. Paterson saw her with the results and told her she had a lump which needed to be removed, but he reassured patient 9 and her husband that it was not cancerous. He removed the lump but then told her it was cancerous and that he had not removed all the cancer. Paterson told patient 9 that she needed to have a mastectomy. Patient 9 researched the cancer and asked Paterson whether it could be in the other breast. As a result, Paterson agreed to take samples from the other breast and found that one of those contained abnormal cells. Patient 9 had a double mastectomy, her lymph nodes remove (which she did not consent to), and breast implants, followed by radiotherapy.

Patient 9 has never been recalled by the hospital. When she contacted them, they told her “he did not do cleavage sparing on people who had immediate reconstruction”, so she did not pursue it. Patient 9 was reviewed by another consultant at a follow-up appointment but was not told that it was a review. The consultant told her that she did not have a cleavage sparing mastectomy, but she would be monitored. Patient 9 was not sure how the hospital would know whether any tissue was left behind, because she had immediate breast reconstruction so there was no visible sign. When she had a scan for her lungs, she noticed thick flaps of skin over her implants. The hospital contacted patient 9's GP who arranged for a further scan at the hospital. When she attended for that, the radiographer said that he thought the flaps were “fatty tissue” and that they could be monitored, or the implants and reconstruction could be removed. In the early 2010s, patient 9 chose to have one of them removed to give her reassurance and now has one breast which is smaller than the other.

Patient 9 cannot understand how Paterson's colleagues could not have noticed that he had left tissue behind, before the reconstruction. She described the impact of her treatment on her family as “terrible”.

Patient 447

Patient 447 noticed an indentation in her breast and thought it looked odd, especially since a relative had died of breast cancer. She was booked into the fast-track clinic at her local hospital the same day, where she had a mammogram, which showed that she did not have breast cancer.

Six months later, patient 447 noticed that her breast had become much bigger and the nipple was inverted, which she thought indicated that she had cancer. A friend arranged for her to see Paterson at Parkway Hospital. She had a mammogram and Paterson told her that she had cancer, which he confirmed later that week after a biopsy at Solihull Hospital. Patient 447 had nobody else with her when she was given the news and was shocked. She agreed to have a double mastectomy and removal of her lymph nodes, and immediate breast reconstruction.

Patient 447 had the surgery as an NHS patient at Solihull Hospital. She was very ill afterwards, and still has abdominal problems as a result of the operation. The surgery was followed by chemotherapy and radiotherapy.

Patient 447 was recalled by the hospital. She had a mammogram and was asked to return for a biopsy. Patient 447 returned to see a doctor after she was told by a nurse over the telephone that the cancer had returned. The doctor told her the most likely reason was because only half of the tissue had been removed the first time, and that they would need to remove both reconstructions, which was a shock. She thought that all the tissue would have been removed during the original mastectomy and could not understand why it would not have been. She had another double mastectomy and removal of lymph nodes but no further reconstruction at that point. Shortly afterwards, patient 447 decided that the only way she could cope with what had happened was to have a reconstruction. She was ill following her breast reconstruction, which, linked to the stress of her illness and treatment led to patient 447 leaving her job.

Patient 447 told us, "The whole thing is just terrible, it has ruined my life." She said, "I feel angry that Mr Paterson has affected so many lives as well as my own. It has hugely impacted on my life."

Patient 80

Patient 80 is deceased. Her husband gave evidence to the Inquiry on her behalf.

Paterson operated on patient 80 but left some cleavage behind after her mastectomy surgery. Patient 80 had chemotherapy and radiotherapy following her surgery.

A year later, the cancer returned in patient 80's liver and she died shortly after diagnosis.

Patient 80's husband has since questioned whether his wife would still be alive if another surgeon had operated and she hadn't had a cleavage sparing mastectomy. He told us his "mind is never at rest".

Patient 368

Patient 368 had a lump in her breast and was referred to Paterson at Solihull Hospital as an NHS patient. She had a biopsy. On giving her the results of this, Paterson told her very bluntly, "Well you know what you've got and we are going to take the breast away." Patient 368 developed an abscess before she had her surgery, which Paterson treated before referring her back to her oncologist. He did warn her "that we have got to hurry now because it might go into your chest cavity...and it might be fatal."

Patient 368 had radiotherapy before having a mastectomy. Paterson was on holiday at the time, so the operation was carried out by one of his colleagues.

Patient 368 was recalled by the hospital and it was confirmed that she had had the right treatment. Patient 368 said “her life has been saved” but told us that she “can’t understand how he got away with what he did” especially as “these other ladies were putting their life into somebody else’s hands and some of them did not even have cancer.”

Patient 230

Patient 230 saw Paterson as a private patient at Parkway Hospital. He had previously been treated in the NHS for problems with his veins. However, this hadn’t been successful and caused patient 230 a great deal of pain and discomfort when walking.

Paterson identified the problem and operated. Patient 230 said he was very pleased with the outcome.

Patient 107

In the late 1990s, Patient 107 saw a breast surgeon who carried out a partial mastectomy, privately. The surgeon died soon after the operation. She continued to be monitored by an oncologist for 10 years, privately, after the mastectomy. In the early 2000s, the oncologist found a lump in patient 107’s neck and referred her to see Paterson at Parkway Hospital as a private patient.

Paterson told patient 107 that he needed to remove her thyroid as soon as possible “to give her the best chance”. Following the operation, Paterson told her that there was some “very worrying grey jelly-like substance”, but all was okay. At a later scan, she discovered that only a small section had been removed and that this could have been done with a fine needle rather than having her thyroid removed.

Patient 107 wrote a letter of complaint to Spire but failed to receive any response. The oncologist told her that the operation was over and to “just put it behind you and get on with your life” – she didn’t follow up her complaint.

She later learnt that the grey jelly-like substance, which Paterson described as “very worrying” was, in fact, perfectly normal.

The patient said she saw Paterson when she was upset and vulnerable, due to family issues, and that Paterson saw her as a “cash cow” and “ploughed on”.

Patient 252

Patient 252 noticed that something was wrong with her nipple. She made an appointment with her GP, where the practice nurse examined her. The nurse could not find anything but referred patient 252 to Solihull Hospital as an NHS patient. She saw Paterson, who did a biopsy on her breast. When patient 252 returned for the results, Paterson told her that she had cancer. She discussed her options with a nurse and decided that she would have a mastectomy followed later by reconstruction.

Patient 252 had the mastectomy and was surprised to see that her chest was not completely flat. She queried this with a nurse who replied, “That’s the way he does it.” Patient 252 was called back to the hospital for a follow-up scan and Paterson told her he would have to remove more tissue. Paterson operated on her again, but he still left some tissue. Patient 252

subsequently had a reconstruction at Little Aston Hospital, funded by the NHS. Patient 252 mentioned the fact that her chest was not flat to the reconstruction surgeon, who replied, "That's the way he does it."

Patient 252 read the news about Paterson's malpractice and contacted Solihull Hospital who arranged an appointment to discuss her treatment. She was told that her treatment was not appropriate but was given no further details, and as a result she pursued a claim for compensation. As part of that process, a clinical expert looked at her medical notes and told her that she had a lump removed rather than a mastectomy. Patient 252 asked to be checked regularly because of the increased risk of cancer due to the remaining tissue, and the hospital agreed to an annual mammogram.

Patient 252 feels she is constantly checking herself for cancer, and the whole experience has affected her family, particularly as her children were young when it happened. She told us, "I am scared basically. Living with it daily. I am constantly checking."

Patient 67

Patient 67 was experiencing problems with her digestion. Patient 67 had private medical cover and her GP referred her to Paterson at Little Aston Hospital as a private patient. Her GP "thought he was marvellous". Paterson did a colonoscopy and prescribed antibiotics for patient 67. He did a second colonoscopy and told patient 67 he had found a polyp, which Paterson described as having "cancer at the tip". He told her that if she had not gone to see him then 'she would have been dead by September'. She had to break the news to her family that she had cancer.

Patient 67 saw Paterson regularly after that and he did a total of 14 colonoscopies on her over a nine-year period. He also operated to remove what he described as a "distressed" area of her colon.

Patient 67 was not recalled by Spire. She found out he was not working any longer when she had made an appointment to see him and was instead seen by a different consultant. This consultant told her that she did not need to have any further colonoscopies and that having them was "more dangerous than what you have got".

A medical expert who was looking into Paterson on behalf of the GMC took patient 67 through her pathology results which showed that she had never had cancer. He told her that every procedure and invasive treatment had been completely unnecessary.

Paterson's treatment of patient 67 has affected almost every aspect of her life. She and her family believed for years that she had cancer. The invasive procedures she had have left her with serious health problems. Patient 67 described her whole experience as "horrific".

Mid 2000s

Patient 2

Patient 2 was worried by the appearance of lumps on her breast when she tried to feed her baby. She saw her GP, who referred her to a local Nuffield Hospital. The consultant she saw there told her “not to be ridiculous, that breast cancer did not occur in women in their early 30s”.

The patient then rang her private medical insurance company and explained that her GP thought the lumps significant. They sent her to see Paterson as a private patient at Parkway Hospital as “lots of our patients go to him”. When she saw Paterson, he referred her for a mammogram and ultrasound. When she returned for a review, he told her he was concerned by the ultrasound; he said that she needed surgery immediately and he could see her three days later at Little Aston Hospital to remove one of the four lumps. Patient 2 was shocked at the difference in diagnosis between Spire and the Nuffield.

Patient 2 had her operation and returned two weeks later for the biopsy results. Paterson told her it was a benign tumour, and that he did not think the other lumps needed to be removed because they were significantly smaller. He advised her to check them and to return to him if they grew, or other lumps appeared.

A year later, patient 2 noticed a lump had reappeared where Paterson had removed the original lump. She saw him and he told her that one of the other lumps had moved, grown and now needed to be removed. Paterson did that, and after biopsy told her she had a condition “that had never been seen in the breast before”. She was advised to continue to be vigilant.

A few months later, patient 2 returned with a lump on her leg, and was told that Paterson had discussed her case at a multidisciplinary team meeting, whose view was that the second breast lump was pre-cancerous. After removing and testing the lump on her leg, Paterson told her that it was a malignant melanoma which required surgery. He performed this, together with an operation to remove a similar lump on her arm.

Patient 2 saw her GP, who thought it unusual that a breast surgeon was operating on a leg and arm, but on checking she found he was a general surgeon so was reassured, but referred the patient to a dermatologist, because she was worried about moles on her back. She saw a dermatologist at the Nuffield Hospital, and he wrote to Paterson to obtain the pathology of the lump removed on her leg, but this was refused, with Paterson saying “there was no need for anybody else to get involved”.

Patient 2 next saw Paterson in the early 2010s, with a breast lump in the same place as the previous ones he had removed. This time the radiographer refused to do the ultrasound. She overheard a conversation where the radiographer said, “This lady has had more than enough. There is no need to do an ultrasound. The mammogram is enough.” While she was waiting, patient 2 heard Paterson screaming down the telephone: “You do not make a decision. This is my patient. I decide what tests they need. You are only the radiographer.” After the conversation, Paterson told her that he recognised the presentation of the lump and said that “we must operate”, which he did.

A couple of years later, patient 2 opted for another operation for endometriosis. The Nuffield advised her they wished to treat it conservatively, but because Paterson had told her to have any lumps removed, she decided to have an operation instead, as there was a "hard mass" there.

After hearing in the media about patients being recalled by Spire, patient 2 contacted them. At her recall appointment, which took place in the same room she had previously seen Paterson, she was told that Paterson had misdiagnosed her condition and performed some unnecessary operations. She was also told that Paterson had given her GP different information from her and implied in some instances that patient 2 had asked for the operation.

The experience has had a major impact on patient 2. She had seven operations in five years and had to leave her job as a result. This has had a financial impact on her. Patient 2 told us she felt she could not plan beyond a year and was living in constant fear of lumps returning. She told us, "I think it cannot be underestimated, the impact that this has had on anybody. I cannot speak from anybody else's experience but the person I became during that process was a very different person to the person I was at the start of it. It is only recently that my husband says he sees signs of the person I was."

Patient 57

Patient 57 is deceased. Her husband gave evidence to the Inquiry on her behalf. Patient 57 was diagnosed with an aggressive form of breast cancer and was treated by Paterson as an NHS patient. She was told that she would need to have a mastectomy.

Patient 57's husband was at the hospital when patient 57's mastectomy took place. He was told by Paterson that the operation would take only 20 minutes, and was "shell-shocked" at this. After the operation, patient 57 said that she was pleased "because he hasn't taken all my breast away, he's left me with some cleavage so it won't be as bad as I was thinking". Patient 57 had expected to have a full mastectomy and was not given the option or informed that breast tissue would be left. She decided at this stage not to go through with a breast reconstruction.

A year after the operation, patient 57 started to experience pain and was informed that her cancer had returned. Despite further treatment she sadly died two years after her mastectomy.

Patient 57's family did not become aware of Paterson's practices until a year after her death when articles about Paterson started to appear in the local press. Her husband called and wrote to the hospital about the cleavage sparing mastectomies, but struggled to get answers as to why Paterson had been allowed to undertake these sort of operations.

Patient 57's husband remains angry that "lessons are not being learnt" and that Paterson was able to apply for legal aid. He believes that if his wife had had a full mastectomy she would still be alive today.

Patient 295

Patient 295 had problems with her breast and went to Solihull Hospital for biopsies as an NHS patient. She received a call asking her to return to the hospital.

At the hospital appointment, patient 295 said she hadn't sat down when Paterson said to her, "Well, it's cancer", and asked her "in a sarkey way" whether she checked herself. She was upset by his attitude as she had had two mammograms that year.

An X-ray identified a “big black blob” and patient 295 asked to have a full mastectomy. Paterson persuaded her to have the lump removed instead.

Two years later, patient 295 had another breast lump. She insisted on having a double mastectomy as she didn’t want to endure further procedures at a later date. She didn’t feel that anyone was listening to her request and was told by Paterson that he wouldn’t remove healthy tissue. She threatened to leave the hospital if she couldn’t get agreement to a double mastectomy.

Prior to receiving the anaesthetic, Paterson called patient 295 by a different name and he was corrected by the anaesthetist. He had picked up somebody else’s notes who was also awaiting surgery. Although patient 295 had worn a red bangle indicating an allergy Paterson had used a dressing that caused her to blister.

Patient 295 had a double mastectomy, but developed blood clots and required a further operation to remove them.

Patient 295 received a letter from Solihull Hospital which said she had been selected for “random assessment”. Since the assessment, the patient hasn’t received any communication or follow-up from the hospital.

Patient 295 appointed a solicitor but during her claim for compensation found that her notes were incomplete. She said that her solicitor was inclined to believe the medical notes rather than her. Patient 295 feels that the compensation she received did not reflect her experiences.

Patient 115

Patient 115 had a discharge from her breast, went to her GP and asked for a referral to Paterson at Parkway Hospital as a private patient. Paterson had been recommended to her by a friend. She saw Paterson and he referred her for a scan and a mammogram on the same day. He told patient 115 she had a growth in her milk ducts and it had to be removed urgently. Paterson operated a few days later and told patient 115 it was “infected tissue”. He asked her to come back for a follow-up mammogram and scan, which she did, and they showed no problems. Patient 115 asked for a sick note for a week after the operation and her GP was surprised that Paterson had operated and how quickly he had done it. Following her surgery, patient 115 was surprised to see that Paterson was charging her insurance company for chemotherapy, which she did not have. She queried this with the hospital and was told it was an error.

Much later, patient 115 had a phone call from Spire asking her to attend a recall appointment. The consultant told her she had not needed the scan or the surgery. The tissue was not infected. Patient 115 was particularly annoyed that the doctor who examined the scan must have noticed there were no problems, but the surgery still proceeded.

Patient 115 told us her experience has left her wary of having private treatment in the future. “I see their adverts about making life easier for you and everything and I do not think I would go private ever, ever, ever again.”

Patient 127

Patient 127 gave a written statement to the Inquiry. She believes that her surgery could have been avoided if a biopsy of her breast had been taken to identify what the problem was. Patient 127 believes that Paterson claimed against her private health insurance using a code that indicated that she had cancer, which was not the case.

Patient 127 feels that others who worked with Paterson should have known that her surgery was not necessary. She understands that there were already questions being asked about Paterson's practice when she had her operation. Patient 127 said, "Spire has shown that they disregarded their own duty of care to patients."

Patient 98

Patient 98 had some bleeding from her nipple and was referred to Solihull Hospital by her GP. She had a mammogram followed by an ultrasound, and was told by Paterson the same afternoon that she had cancer in both breasts and needed to have her milk ducts removed urgently. He told her that there was a three-week wait in the NHS. Patient 98 had health insurance which covered limited procedures and decided to have surgery as a private patient at Parkway Hospital.

Patient 98 saw Paterson regularly for three years after surgery, at which point he discharged her saying "he had cured her of all the cancer". Patient 98 found the period of time she was seeing Paterson very worrying and was concerned the cancer would return. She said her family was devastated, particularly her daughter who thought she would lose her Mum. Each time she saw Paterson she self-funded the consultation, ultrasound and mammogram. She recalls on one occasion being charged £10 for the remaining strip of plaster he had used on her surgery wounds.

Patient 98 was recalled by Spire. She was told that she had not had cancer and that her surgery had not been necessary.

Patient 98 said she was left feeling devastated having been told she had cancer in both breasts and finding out that this wasn't true. She told us, "It was just sheer devastation, really. I mean, it was devastating to be told you've got cancer in both breasts. And then later on to find out that you never had it. Again, that brick hitting you again. It's just devastating for the whole family." Patient 98 said she has lost trust in the medical profession.

Patient 271

Patient 271 found a lump in her breast. She went to her GP who referred her to Solihull Hospital as an NHS patient, where she had a biopsy. Patient 271 then saw Paterson who told her that the lump was pre-cancerous. He advised her she should have a mastectomy and reconstruction and told that as that would take three to four months, he could operate to remove the lump, which he did. A few weeks later, a nurse rang patient 271 and told her that her case had been reviewed and that she should have a mastectomy.

Patient 271 went back to see Paterson who suggested she should have both breasts removed as she was likely to develop cancer in her other breast. She was shocked by this but opted to have a double mastectomy and her breasts reconstructed, followed by radiotherapy.

When she became aware through the media that there were concerns about Paterson, patient 271 contacted Solihull Hospital and asked to be reviewed. She was told that it was not possible to tell if she had had a cleavage sparing mastectomy or not without removing her reconstructed breast, which she did not want to do. He suggested that the removal of one of her breasts had not been necessary. Patient 271 contacted solicitors about her treatment. Her solicitors found out that she should not have had the lump removed, she should instead have had a mastectomy straight away, and that Paterson had removed her lymph nodes when this was not necessary.

Patient 271 told us that she had felt rushed to make decisions about surgery by Paterson and that the goal posts always seemed to move. She told us: “I do not want him to define my life, but obviously it has had a massive impact. As I say, when this all started, my son was three months old. I was terrified I was not going to see his first birthday, it was awful.”

Patient 165

Patient 165 noticed some bleeding from her nipple. She saw her GP and was referred to Paterson at Parkway Hospital as a private patient.

At her first appointment, patient 165 was referred for an ultrasound, where the technician told her there were no problems. However, when she saw Paterson shortly afterwards, he told her there was a growth in the milk ducts which he would have to remove. Patient 165 had the operation and read her notes which contained a letter to her GP referring to a cancer.

Patient 165 returned for her test results and Paterson told her it was not cancer, but that he would like to monitor her. Two weeks later, she was bleeding from the nipple again, but Paterson told her “this can happen sometimes... debris from surgery”, but that it was not cancer. Since patient 165 no longer had private health insurance after changing jobs, Paterson referred her to the NHS for continuing monitoring where they found nothing of concern.

A few years later, patient 165 heard about the patient recall at Spire and contacted them to arrange an appointment. The doctor she saw told her that her pathology showed nothing was wrong that her surgery had not been necessary.

Patient 165 felt that Paterson violated her body and “messed with how I looked at things, and then to find out that it was all a lie, that is absolutely horrendous”.

Patient 145

Patient 145 saw Paterson for regular mammograms at an NHS hospital, to check on cysts in her breasts. After one mammogram showed that she had cancer, she asked Paterson how quickly he could see her if she saw him privately at Parkway Hospital, and he said, “Virtually next week.” Paterson removed a lump from patient 145’s breast and he removed lymph nodes. Patient 145 felt ill following her operation, but Paterson discharged her. She had to be readmitted after having further problems as a result of the surgery.

Patient 145 was recalled by Spire and told that her lymph nodes need not have been removed. Some of patient 145’s notes, including the results of a biopsy, are missing, and she is not sure whether she ever had cancer.

A few years later, patient 145 moved to a new house and was called to another hospital for a mammogram, which showed that she had cancer in the same area as her breast lump had been. She had a mastectomy. Patient 145 feels that, if she did not have cancer originally, an unnecessary operation may have caused the more recent cancer.

The experience has caused patient 145 to lose confidence in doctors “since all this has come to light it does frighten me to be honest, that, you know, I just feel that I’ve lost my faith in doctors now”.

Patient 24

Patient 24 was referred as an NHS patient to Solihull Hospital with a lump in her left breast, which was diagnosed as cancer. She saw Paterson, who gave her the choice of removing the lump or a mastectomy. He told her that, because of the position of the lump, her breast would be very deformed. Patient 24 decided to have a mastectomy.

When patient 24 had her stitches removed by the nurse at her GP practice, the nurse said, "Are they calling this a mastectomy?" Patient 24 asked Paterson at the post-operative check to confirm he had performed a complete mastectomy, which he confirmed.

Patient 24 was recalled by the hospital. She was told that Paterson had left about a third of her breast tissue behind after her operation. Patient 24 sought the opinion of an expert who told her that she should have received chemotherapy following the operation, and that removing the lump would not have significantly deformed her breast.

Patient 188

Following routine NHS breast screening, patient 188 was told she needed a second mammogram, which she had. She was told it was clear from the second X-ray that she had breast cancer, and she had a biopsy to confirm this. Patient 188 chose to have further treatment as a private patient at Parkway Hospital. She was treated by Paterson, who operated to remove the cancerous area from her breast.

Patient 188 saw Paterson for five years and thought she had good treatment from him and his breast care nurse. He recommended a PET-CT scan at the end of the five years, which she had.

Patient 188 was not recalled by Spire, but in the light of the publicity she heard, she asked for a review of her notes. She was told that she had the right treatment and follow-up.

Patient 251

Patient 251 discovered she had the breast cancer gene when she was sent for genetic counselling. She decided to have a risk-reducing double mastectomy and saw Paterson privately to discuss having the operation on the NHS. Patient 251 waited for the operation for three years "because Mr Paterson kept putting me back". Eventually, she received a letter offering her surgery at Little Aston Hospital as an NHS patient.

Patient 251 had a double mastectomy but, because it only lasted a few hours, she did not think she was operated on correctly. She found out later that Paterson operated on one breast, and an unqualified trainee surgeon operated on the other. She did not sign a consent form explaining the operation. Patient 251 did not see Paterson after the operation, but after contacting her MP to speed matters up, received an appointment with a plastic surgeon for a reconstruction, which she had.

Patient 251 was recalled by Solihull Hospital. At her recall appointment, patient 251 was told that there was no record of her treatment, and she was referred for a mammogram and a scan, followed by 12 biopsies. She was told that some breast tissue had been left after her mastectomy. Patient 251 decided to continue having mammograms, rather than have further surgery.

Patient 251 told us that her treatment by Paterson has affected her whole family.

Patient 305

Patient 305 had a routine mammogram which showed a lump on her breast. She went into her local hospital for a biopsy and received the results at an appointment a few weeks later with Paterson at Solihull Hospital. He told her that she had cancer, and after a series of tests, operated on patient 305 four times over the course of a year. He operated twice to remove lumps from her breasts, operated to remove her lymph nodes and finally did a mastectomy.

Patient 305 was not recalled but contacted Solihull Hospital and asked to be seen. At her appointment, she was told that her treatment was appropriate.

Although patient 305 knows her treatment was appropriate, she told us she feels sorry for other women who were not treated correctly. "Every time it comes on the television I have had that worry, and not just for me, I feel sorry for the other women that had a lot worse happen to them."

Patient 250

Patient 250 was referred by her GP as an NHS patient to Paterson at Solihull Hospital for examination of a lump in her breast. Paterson sent her for a biopsy. Paterson told patient 250 she had cysts and prescribed tamoxifen (a breast cancer drug) for her pain, although he told her she did not have cancer. After some time, her husband asked Paterson to send her for a scan, which showed that she did have cancer. Paterson removed a lump in her breast. Patient 250 was discharged shortly after the operation. Her leg swelled up and patient 250 was re-admitted to hospital, to a closed ward where dirty linen was being stored, while she waited for Paterson. He told her to have a double mastectomy but added that she did not need it. Following her surgery, she had a post-operative infection.

Patient 250 told us that her experience had affected her relationship with her husband and children and had left a lasting emotional impact on her; "Emotionally for me, because I didn't feel like a woman."

Patient 138

Patient 138 had a routine mammogram which identified cancerous cells in her breast. She was referred to Solihull Hospital as an NHS patient where Paterson removed the cells. However, two weeks later, Paterson told her he hadn't taken enough tissue and that she needed a mastectomy.

When patient 138 woke from the surgery she remembers thinking "this doesn't look too bad" as she still had a cleavage. At this point she had no knowledge of what a mastectomy should look like. After the operation, Paterson insisted she was tested for HIV. He said her blood had splashed in his eye during surgery. Patient 138 was upset by this but said she had no choice as he behaved as if he was "lord and master". She had radiotherapy following her mastectomy and was prescribed the drug tamoxifen.

Four years after her surgery, patient 138 received a letter from Solihull Hospital saying they had assessed her case and she needed to go back to the hospital. She was told at the appointment that she should have had a complete mastectomy and the breast surgeon she saw recommended that the remaining tissue was removed. Patient 138 went ahead and had a total mastectomy. She said that afterwards the staff at Solihull treated her "as if I had the plague". She requested yearly mammograms for reassurance, and was told by the breast care nurse that she would have to fund them herself.

Patient 138 took legal action about her treatment. The specialist who assessed her as part of this, told her if Paterson had carried out a full mastectomy she wouldn't have required radiotherapy or the drug tamoxifen.

Patient 138 said her experience of being treated by Paterson has had a significant impact on her and "any lumps, bumps, cold, cough I think it is the cancer coming back". She also feels her life expectancy has been shortened.

Patient 184

Patient 184 thought she had breast cancer. She saw her GP who referred her to the NHS. Patient 184 was worried at the length of time it was taking to get an appointment and, on the advice of a relative, telephoned Parkway Hospital and asked to see Paterson as a private patient. When she saw him, he arranged for her to have a mammogram and a scan on the same day. On looking at the results, Paterson told her she had breast cancer, but to confirm that he carried out a biopsy that night.

Patient 184 returned a few days later for the results. Paterson confirmed it was cancer and that he would operate, which would be followed by chemotherapy and radiotherapy at the NHS hospital. Paterson operated and, while he said it had gone well and he had removed the cancer, patient 184 suffered bleeding and had another operation for that the next day. When she saw him at an outpatient appointment, Paterson told her that she would need an annual mammogram in the NHS and would be put on an anti-cancer drug.

After five clear annual mammograms, patient 184 heard in the news that Paterson was under investigation and as a result called the recall helpline. At her recall appointment, she was told there were no records of the second operation. For the first operation, on the breast cancer, she was shown a pathologist's report at the time which showed that cancer was still present in tissue which had been left behind after the operation.

The experience has reduced patient 184's faith in other doctors. She told us, "It is a real knock when someone that you really trusted and really thought was wonderful could be found guilty of, as I say, not just doing that to me, he has operated on people who did not need the operation and you know, worse."

Patient 347

Patient 347 found a lump in her breast. She went to her GP who referred her as an NHS patient to the breast service at Solihull Hospital. At her appointment, she had a mammogram, scan and a biopsy. Patient 347 returned a few weeks later to see Paterson, who explained that she had breast cancer and that he wanted to trial injecting radioactive material into the cancer. She agreed to this.

Paterson operated and removed the lump. After patient 347 left the hospital, Paterson called her back because he was not sure he had removed enough tissue. When she returned, he operated on her and told her that he had removed enough tissue. That was confirmed when patient 347 attended her recall appointment some years later, but in the meantime, it had caused her a lot of worry.

Nearly 10 years later, patient 347 had a mastectomy, performed by another doctor, to remove her other breast. She was very happy with the treatment he provided, who was more sympathetic and reassuring than Paterson. Patient 347 told us Paterson was "arrogant".

Patient 289

Patient 289 had what she thought was her last routine mammogram, only to be called back for a further one. When she went back, the radiographer only tested one breast and was clearly looking for something but refused to say what it was. A consultant appeared and said, "I think there's something there, but I can't feel it." They took a sample from the breast under X-ray and told patient 289 that there was something there. Patient 289's husband asked if she could be seen by Paterson at Solihull Hospital. She did, and at the first appointment Paterson told her it was cancer and that he could operate in two weeks' time, and that he would also have to remove glands in her arm and check those for cancer.

Patient 289 had the operation and when she next saw Paterson he told her that there was no cancer in any of the glands. A relative with medical training checked the pathology report and told her that the treatment from Paterson was appropriate. Patient 289 experienced some problems with the radiotherapy but did not blame Paterson for that. Eventually, Paterson told her that she was "cured". Patient 289 has not been recalled by the hospital.

Patient 325

Patient 325 is deceased. Her daughter gave evidence to the Inquiry on her behalf. Patient 325 found a lump in her breast and went to see her GP who referred her to Solihull Hospital as an NHS patient. She had a mammogram and was told that she had breast cancer and that the cancer was also in her lymph nodes.

Paterson told patient 325 that he would do a mastectomy and remove the lymph nodes to stop the cancer from spreading, but that he would leave some cleavage and tissue for cosmetic reasons "so she would feel more like a woman". The operation went ahead. Patient 325 decided not to have her breast reconstructed, preferring to use a prosthetic instead.

About a year after her surgery, patient 325 started to lose weight and had back pain. An X-ray revealed that she had developed cancer in her bones. Shortly afterwards, patient 325 discovered that the cancer had spread to her liver and that there was nothing more that could be done for her. The bone and liver cancer were secondary breast cancer.

When news of Paterson's malpractice broke, patient 325's family approached solicitors to put in a complaint to the hospital and to understand what had happened to her. They were convinced that the cancer had spread as a result of Paterson's failure to remove all the breast tissue. The hospital explained that it was likely that the cancer would have returned anyway as it was an aggressive form of cancer.

Patient 325's daughter told us that her mum "had faith in him, she put her trust in him, she thought he knew what he was doing and that bit of tissue, she did not know, could have been what finished her off". As a family, "they were devastated, absolutely mortified". She told us, "We just felt disgusted and hurt and grieved all over again."

Patient 300

Patient 300 saw her GP about a breast lump and was referred as an NHS patient to Solihull Hospital, where she saw Paterson. After tests, he told her she had cancer and, unless she had a mastectomy, would only live for three months. He also told her that he "always left a little pouch", which seemed wrong to patient 300. However, after surgery, Paterson told her that he had given her a complete mastectomy, but she could tell that he had not. Patient 300 spoke to the nurses who were caring for her, who said that it was the doctor's policy to leave half of the

breast on. The surgery was followed by chemotherapy and radiotherapy. At the first check-up after this, Paterson told patient 300 that she had had a minor stroke during treatment. She was surprised that she hadn't been told this when it happened.

Patient 300 was recalled but she did not want to discuss her case at the time. She told us about how her experience had affected her family: "It had a big impact, really... Because it's affected all my kids, really." Patient 300 said she "just wouldn't like it to happen to anybody else".

Patient 227

Patient 227 found a small lump in her breast; she had previously had breast cancer. Her GP referred her to Paterson at Parkway Hospital as a private patient. Paterson sent patient 227 for a scan, which showed she had cancer, and then arranged for the lump to be removed. This was followed, at Paterson's suggestion, by a mastectomy and reconstruction. In turn, that was followed by a five-year course of an anti-cancer drug. At the end of that, Paterson wanted her to go on another drug but patient 227 refused, referring to a possible side-effect of osteoporosis. Paterson became cross and told her, "It would be very foolish of you not to go on it." Patient 227 took the drug as he recommended, and now has osteoporosis. Patient 227 continued to have follow-up appointments with Paterson. At one of these, she asked him if he had carried out a cleavage sparing mastectomy on her, and he said he had not.

Spire recalled patient 227 and on examination, found something on her breast but, after a biopsy, it was shown to be clear of cancer. The experience has made her question the medical profession. Patient 227 told us, "I just would never have questioned a medical person, and now I perhaps would a little bit more. I would be more careful about what drugs I took and looked at treatments and looked up more on the Internet than I did."

Patient 263

Patient 263 had a routine mammogram at her local hospital. Following this, she had a biopsy. She was told she had breast cancer and was sent to see Paterson as an NHS patient at Solihull Hospital the following week. As soon as patient 263 sat down, he told her that her condition was malignant and that he wanted to remove a lump. He operated and told her that she was clear of cancer.

Paterson asked to see patient 263 again and told her that he did not remove enough tissue the first time and would have to do a mastectomy, and that she could have an immediate breast reconstruction. He did not give her any other options. She saw the plastic surgeon to discuss her breast reconstruction and was told that she was "high risk", by which she meant that the cancer was invasive. Patient 263 researched her condition and thought there was a likelihood of the cancer spreading to the other breast and asked the breast care nurse for a double mastectomy. The nurse checked with the surgeons, who agreed.

Patient 263 was admitted to the Priory Hospital as an NHS patient. Paterson injected dye directly into her breast which was extremely painful, as the local anaesthetic she had been given had not worked properly. Patient 263 had the surgery and was very ill afterwards. The reconstruction surgeon was unhappy with one of the reconstructions, and the patient noticed that the breast had "dropped". The surgeon operated a few more times to improve it and continued to remind patient 263 that "you've got your life". Paterson wanted the surgery to be followed by radiotherapy, but the radiotherapist said that they did not agree to giving her

radiotherapy after reconstruction immediately after mastectomy. After a conversation with Paterson, the radiotherapy took place and it damaged her reconstructed breast. Patient 263 had further reconstructive surgery.

Patient 263 became aware of the recall helpline and contacted Solihull Hospital. She was given an appointment to see a consultant there. They could not confirm that Paterson had removed all the tissue and arranged for her to have a mammogram and biopsies, which confirmed she was clear of cancer. Patient 263 asked to be monitored at least once a year, and they agreed to do this for five years.

Patient 263 pursued compensation and saw a clinical expert who told her that she was “very, very high risk”, because insufficient tissue had been removed, and that without a further operation she may only live for 15 years. She had an operation to remove the tissue and the surgeon told her that Paterson had left “50 per cent of the original in the right and 20 per cent in the left...which was far too much”. The doctor also pointed out that the reconstruction surgeon would have seen the tissue left in her breasts when she did the reconstruction.

Patient 263 told us that Paterson “completely wrecked her life”. She spoke of the impact on her husband: “He was absolutely grief-stricken, because he couldn’t believe it. He just couldn’t believe it. Because he was thinking I was going to die.”

Patient 82

Patient 82 had a discharge from her breast and was referred by her GP as an NHS patient to Solihull Hospital. She saw a member of Paterson’s team, who arranged for X-rays. Patient 82’s employer reminded her that she had private healthcare insurance through work, so she switched to Parkway Hospital and an appointment was made for her to see Paterson as a private patient. He ordered tests and said that he thought she had a cyst in her milk duct, but that it should be investigated further because of her family history of cancer. When patient 82 was booked in for surgery, Paterson appeared with a “big smiley face” drawn on his theatre gown, which she found arrogant and disrespectful, although the theatre staff were visibly comfortable with it. She told us, “Every operation that you go under a general anaesthetic for can have its risks, and I just felt that putting my life in his hands, with someone who was very disrespectful, very arrogant and dismissive about things generally, I felt that that was wrong, quite wrong to do that and behave in that manner.” He changed his gown just before surgery and drew attention to the fact that he had “changed his outfit”. Paterson removed the cyst.

Patient 82 reflected that “private healthcare does not seem to uphold the same level of discipline that NHS hospitals do”.

Patient 109

Patient 109’s daughter gave evidence on her behalf. Patient 109 found something unusual on her breast and, because of a long NHS waiting list, paid to be seen by Paterson at Parkway Hospital as a private patient. She was only seen privately for the initial consultation, before she returned to the NHS for treatment at Solihull Hospital. There, he operated on patient 109 three times over the course of a few weeks, each time referring to it as “shaving” and “cleavage sparing”, removing more breast tissue each time.

After annual reviews, in the mid-2000s patient 109 had back pain and had a check-up at the hospital. The hospital did not connect the pain to her earlier treatment. A year later, she received a letter from the hospital which told her that she had previously had an

incomplete mastectomy, without radiotherapy, and they considered her treatment to have been inadequate. Patient 109 now has bone cancer and does not know if it is related to the original cancer.

Patient 19

Patient 19 saw her GP with a breast problem and was referred to Solihull Hospital as an NHS patient, where she saw a junior doctor. The doctor told her she did not think anything was wrong but said she would check with Paterson. After doing so, the doctor told patient 19 that she needed further tests and that her case would be discussed at a multidisciplinary team meeting. During the tests, patient 19 asked if she could be told the results there and then, and was told that she had breast cancer and would need a mastectomy.

Patient 19 returned to the hospital for her first appointment with Paterson, who started by discussing breast reconstruction and when patient 19 told him she did not wish to have that, he replied, "Of course you are...you're young." He did not discuss the reason she needed a mastectomy.

Patient 19 had the operation and checked her breast afterwards and found a lump. She asked Paterson about this and he replied that "it's fat. I like to leave my ladies with a little cleavage". That was a shock and had not been discussed in advance with patient 19. That night, a nurse came to sit next to patient 19 who told the nurse she had not expected to find a lump left after her mastectomy. The nurse replied, "Make sure you keep on at him about what's gone on. Keep asking questions of people."

Patient 19 was allergic to prosthetics and did not want one large breast and one lump, so decided to have the other breast removed for cosmetic reasons. Paterson performed the operation and left the same amount of tissue on the other side, so the breasts were matched. She spoke to the nurse at a follow-up appointment, who said that because there was no cancer present she did not need to be reviewed every year.

Patient 19 returned to the hospital in the early 2010s with her mother, who had been referred for an appointment about lumps in her breast. After she was told that her mother would need a mastectomy, patient 19 asked the nurse whether her mother would be "left flat or will she have little lumps like me?" The nurse went "absolutely beserk". When patient 19 returned with her mother the following week, the nurse asked to see patient 19 privately and said, "What you said last week, you may be more at risk." The nurse told her that someone would ring her, but nobody did.

Patient 19 received a letter three months later inviting her for a recall appointment. At her appointment, the doctor told her that her notes were in a "terrible mess". He examined patient 19 and told her that Paterson had not removed all the breast tissue and that she should have had an operation to remove the tissue. He advised her to have a further operation to remove the tissue and said that he would refer her for a mammogram; he also advised her to get a second opinion to help her make that decision. Patient 19 saw another doctor for a second opinion, who confirmed that Paterson should have removed all the breast tissue.

Patient 19 decided that she would have the operation to remove the remaining tissue and received a letter from Solihull Hospital inviting her to an appointment with Paterson. She contacted the hospital and arranged to see another doctor who arranged for her to have the operation. Patient 19 had the operation to remove a significant amount of breast tissue that had been left behind by Paterson after her mastectomies. Afterwards, patient 19 contracted

an infection and had constant swelling, which was treated at the hospital on a weekly basis and culminated in another operation. By the end of her treatment, patient 19 had effectively had six mastectomies, with more tissue being removed each time.

Patient 19 complained to the hospital about her treatment many times; she told us, “I found them to be a total waste time.”

Patient 357

Patient 357 went to see her GP with bleeding from her nipple. Her GP referred her to Solihull Hospital, where she had a mammogram and a scan two weeks later. The doctor performing the scan told her he could see a lump. A junior doctor confirmed this on examination but told her it was nothing to worry about. Paterson met patient 357 in the corridor and said that the lump would need to be removed. He told her that if she left it any later, the bleeding may stop externally, but would continue internally, which would be very bad. Patient 357 has since researched this and found nothing to support Paterson’s statement.

On finding out that patient 357 had private health insurance, Paterson said he could operate sooner if he saw her privately, and she would be “freeing up the NHS for another patient”. A few weeks later, patient 357 had surgery at Spire, and afterwards Paterson told her that “it was a good job I’d had the lump removed, because when the other doctors saw it they were all concerned it had become cancerous, as it had the tell-tale spidery legs coming away from it”. However, the biopsy showed that it was not cancerous. Paterson told her it was pre-cancerous, and he suggested she have a further operation to remove further tissue to give a “safe perimeter” and “ensure there were no rogue cells left around”. Patient 357 wondered why he had not removed the tissue initially, but did not ask and agreed to the further operation.

Patient 357 was told at her recall appointment that she did not need either operation, but noted that Paterson may not have kept sufficiently detailed notes to justify the surgery. She has carried out her own research and is satisfied that Paterson took the correct course of action by removing the lump. Patient 357 is unsure about the need for the second operation but told us it was her decision to have it.

Patient 63

Patient 63 saw her GP, who recommended she see Paterson. She had private medical cover and so saw him as a private patient at Parkway Hospital. She had surgery to remove breast tissue a few weeks later. Paterson then wrote to her GP asking to see patient 63 for regular reviews, in the NHS. She was seen by a doctor in Paterson’s team at Solihull Hospital who told her that she required a mammogram and scan in seven months’ time. These took place, and showed a small non-cancerous cyst, which was removed in an operation by Paterson. Patient 63 returned to her GP to have the stitches removed, but they were embedded so deeply that the GP had problems removing them; one is still there to this day. Patient 63 was advised by the hospital to return for a review mammogram and scan the following year.

In the early 2010s, patient 63’s GP referred her to Solihull Hospital for a mammogram, scan, and testing of cells removed from her breast with a fine needle. These tests showed that she had a non-cancerous cyst which needed no further treatment. Patient 63 has had regular mammograms since, but these have shown no problems. Patient 63 feels that if she had cells removed and tested in the mid-2000s, she would not have had any surgery or resulting scar tissue. She had support for this view when she spoke to another consultant at the Spire recall,

who also informed her that it was unusual for stitches to be inserted in that part of the breast. Patient 63 complained about her treatment at both hospitals but feels that neither responded satisfactorily.

Patient 61

Patient 61 was referred by her GP to Solihull Hospital. The results from a breast ultrasound were suspicious and Paterson told her that “either you have it out now, or you have a biopsy on it”. Patient 61 agreed to a biopsy and was distraught to learn that she had breast cancer and that she would need to have a mastectomy.

Patient 61 was keen to be treated quickly and decided to have her treatment as a private patient at Parkway Hospital. She had the mastectomy with immediate breast reconstruction, followed by chemotherapy and radiotherapy. It was only much later that she discovered radiotherapy was not required at all and that Paterson’s failure to insert a Hickman Line correctly (a central venous catheter for chemotherapy) was extremely dangerous.

When news of Paterson’s malpractice broke, patient 61 was concerned that breast tissue had been left by Paterson. She initially had differing advice on this from Spire and the NHS. Patient 61 finally discovered at her recall appointment with Spire that there was breast tissue left after her mastectomy. She was offered the option of having her reconstructed breast removed or being monitored for a number of years. Patient 61 chose to be monitored as she couldn’t face having further surgery.

Patient 61 feels anger at the failure of the private sector to acknowledge that “cleavage sparing mastectomies were a great risk to ladies”. She considers herself to be “a very assertive, strong individual but this has dented her faith in any establishment regards to health”.

Patient 508

Patient 508 is deceased. Her sister gave evidence to the Inquiry on her behalf. Patient 508 went to her GP as she had pain in her breast. Her GP referred her to Solihull Hospital as an NHS patient. She had a mammogram and then saw Paterson who told her straight away that she had breast cancer.

Patient 508 made it very clear she wanted both breasts removed. Paterson exclaimed that she was “too young” and that she would need to have psychiatric counselling to support this option. The psychiatric report was in agreement with her wishes. Paterson suggested that patient 508 meet with the plastic surgeon about reconstructive surgery. She did this and a decision was taken that reconstructive surgery was not an option.

Following patient 508’s mastectomy, her sister was shocked that so much breast tissue had been left, especially as a breast nurse had shown them medical photographs of what a mastectomy would look like. When Paterson visited patient 508 on the ward after her surgery, her sister asked why she had so much tissue left; he responded with, “I knew you’d be trouble.”

Patient 508 expressed her concerns and the fact that she would be making a complaint to her GP. This information reached Paterson before the next appointment where another doctor was waiting to meet her. She was determined to see Paterson and waited to see him. At that meeting, patient 508 told him that she did not want any breast tissue and had specifically told him so. He explained that “lots of women say that, but when it comes down to it, they want reconstruction”.

Paterson agreed to a second operation to remove the excess tissue, which took place a month after patient 508's original mastectomy. Following her surgery, patient 508 was on the ward for five days, with only the cleaner ever asking how she was. Her sister told us they felt "that everybody loved Paterson at that time and thought we were the bad children for complaining".

Patient 508 had chemotherapy and radiotherapy but started to complain of breathing problems. A scan revealed that she had secondary breast cancer in her right lung. A specialist who provided a report to support patient 508's claim for clinical negligence told her sister that if she "hadn't been touched at all, she would have had a longer lifespan than if, after all this messing around and everything she went through, she would have actually lived longer if he...if nobody had touched her at all".

Patient 5

Patient 5 had a problem with her breast and was referred to Parkway Hospital as a private patient. Her GP described Paterson as "the GP's surgeon of choice".

Patient 5 had an initial consultation, mammogram and ultrasound. Paterson removed some cells from her breast with a fine needle and told her to be prepared for a cancer diagnosis. A few days later Paterson confirmed the results and three weeks later, operated. Patient 5 had chemotherapy and radiotherapy following her surgery. She remained under the care of Paterson for five years.

Patient 5 said everything Paterson did in the five years he was treating her was "as expected and wanted". She told us, "I have now and had then no problem at all, or no concerns about the care that I received from Ian Paterson." Patient 5 said Paterson was aware she was a self-funding patient and did offer to refer her back into the NHS.

Patient 331

Patient 331 saw Paterson as an NHS patient following a routine mammogram. Patient 331 had a further mammogram, scan and biopsy, after which Paterson told her she had breast cancer and that he would perform a wide local incision. Patient 331's sister had had a breast lump removed by Paterson privately at Spire and therefore she felt she "was in the greatest hands".

Patient 331 had two lumps removed from her breast. At her follow-up appointment, Paterson told her that the cancer had spread to her lymph nodes and she would need a further operation, chemotherapy and radiotherapy.

Following the second procedure, patient 331 had an appointment with an oncologist who asked why she hadn't had a mastectomy and stated, "If you were my wife you would have had it done by now." Patient 331 asked Paterson why he hadn't recommended a mastectomy and was told that her treatment was discussed at a multidisciplinary team meeting and a mastectomy wasn't considered necessary, but that he would perform a total mastectomy if that is what she wanted. After much consideration, patient 331 had a total mastectomy and breast reconstruction.

Patient 331 was recalled by Solihull Hospital. The consultant she saw confirmed she had had cancer but could not tell her if she had had a cleavage sparing mastectomy or a total mastectomy, as Paterson had kept very few notes.

Patient 331 feels the oncologist she saw saved her life by encouraging her to have a mastectomy but said she would have felt happier if she had been advised to have a mastectomy from the outset of her treatment. She said she has had a “three-year fight” with Solihull Hospital to gain agreement to annual mammograms until she reaches 70.

Patient 331 feels the impact of her experience has been significant for her children. They lost their father shortly before she was told she had breast cancer and assumed they were going to lose their mother too. They have also found reports of the Paterson case in the media difficult.

Patient 144

Patient 144 was referred to Solihull Hospital by her GP when she discovered a lump in her breast. She underwent a day of tests but as they were inconclusive she had a further 20 biopsies taken. Paterson said she had “ductal carcinoma in situ”, and needed the lump removing. Patient 144 said she was shocked as she anticipated a mastectomy (having seen white patches on an X-ray during tests). She queried this with Paterson who said, “I have not actually read your report.” He was referring to previous test results rather than the most recent tests when making a diagnosis. A few days later, patient 144 was called by a nurse who said she needed a mastectomy.

Paterson said patient 144 needed immediate surgery, followed by reconstruction, as her cancer was aggressive. He told her that the NHS waiting list was long, but he would “see what he could do”. She was referred to The Priory as an NHS patient. Patient 144 said she felt guilty to “leapfrog over 80 patients”.

Patient 144 was discharged from The Priory after four days and without aftercare. Both Solihull Hospital and The Priory considered the other to be providing aftercare and changing her dressings. Patient 144 went to see her GP as she had an infection, he called both hospitals to clarify who was taking care of his patient. Patient 144 said she called Solihull several times chasing aftercare, but nobody responded.

Paterson had referred patient 144 for chemotherapy. The oncologist was surprised she had had a mastectomy and reconstruction. He said she only had a five per cent chance of requiring further treatment and therefore she didn’t require chemotherapy. Patient 144 said she left feeling confused that she had received contradictory advice from Paterson and the oncologist.

Patient 144 was referred to Paterson in the NHS with a further lump. He felt the lump was scar tissue but asked why she had refused chemotherapy. He said everyone at the MDT had agreed she should receive chemotherapy, except for the oncologist, and emphasised her risk factors. Paterson offered to refer her for a second opinion as he had a friend working at Queen Elizabeth hospital. As the second oncologist agreed with Paterson, patient 144 went ahead and had chemotherapy over a two-year period.

When the news about Paterson’s malpractice broke, patient 144 phoned Solihull Hospital and the Priory. Both felt the responsibility for her recall appointment was with the other. The reconstructive surgeon’s PA told patient 144 that she couldn’t have had a cleavage sparing mastectomy as she had an immediate reconstruction. Patient 144 didn’t find this reassuring and was concerned that the oncologist at Solihull was correct in saying she hadn’t needed chemotherapy. Her spine is eroding as a result of the chemotherapy.

It took over six months for patient 144 to receive her medical records and she was shocked that there was very little information in them. Her records consisted of blank pages detailing only the dates she saw Paterson. She also thought that the handwritten notes that did exist were not authentic.

When patient 144 was recalled, she was told that she should have had the lump removed from her breast rather than have a mastectomy. She was also told that the chemotherapy had not been necessary. Patient 144 has since discovered that she had in fact had a cleavage sparing mastectomy, and that one third of her breast had not been removed.

The impact on patient 144's life has been considerable. She feels she has been left with a "ticking time bomb". Patient 144's experience has affected her confidence, contributed to the breakdown of her marriage, affected her children, her relationship with her father, and she has also lost many friends who found her diagnosis and treatment very difficult to deal with. She still has regular tests and is constantly reminded of her experience of being treated by Paterson.

Patient 273

Patient 273 found a lump and her GP referred her to Solihull Hospital for an urgent appointment. She had a mammogram and the registrar told her the results were normal and she could go home. Patient 273 questioned why she hadn't had a biopsy or ultrasound scan. The registrar carried out a biopsy and the results identified abnormal cells.

Patient 273 was given an appointment with Paterson at Parkway Hospital as an NHS patient.

Patient 273 described the appointment with Paterson and his breast care nurse as "it was all quite dramatic" – how he delivered the news she had cancer and he stated he could "cure" her. She remembers thinking, "well, that's quite a sweeping statement". Paterson said he needed to operate and asked if she could pay for her treatment as the waiting list in the NHS was six to eight weeks. Patient 273 said she didn't check waiting times but agreed to pay for treatment as she had very young children.

Due to her family history, patient 273 asked about cancer gene testing. It was identified from the test that she was carrying the breast cancer gene. She was offered surveillance or mastectomy. She decided to have a mastectomy, which Paterson did. Patient 273 had breast reconstruction at the same time.

Although patient 273 was told she had had a full mastectomy, she was recalled by Spire and, following further biopsies, learnt that she had remaining breast tissue. She was shocked by this news and said it took her a year to decide to have corrective surgery.

Patient 273 said she had no reason to doubt Paterson at the time and saw him as "old school arrogant" rather than "somebody doing things incorrectly". She is upset that she recommended Paterson to two family members, one of whom has since discovered that Paterson operated on her unnecessarily.

Patient 281

Patient 281 discovered a lump in her breast and chose to see Paterson. She had an ultrasound scan and Paterson told her she had cancer, which he later confirmed by phone. He said she had two choices of treatment, to have an area of breast tissue removed or a mastectomy.

Patient 281 had a mastectomy and immediate breast reconstruction at Parkway Hospital as an NHS patient. She had chemotherapy following her surgery.

Patient 281 had heard concerns about Paterson carrying out cleavage sparing mastectomies. She saw Paterson again after finding a further lump in her breast. Patient 281 asked him if she had had a cleavage sparing mastectomy. She said he was “bullish” and wanted to know how she knew about leaving breast tissue. She said he became “quite irate”.

Paterson told her she needed a further biopsy and following this, phoned her to say the lump was benign. Patient 281 was not happy with this advice; she told us: “I knew I had a problem.” She raised her concerns with a healthcare professional and medical director in the NHS but said she felt “fobbed off”, and that “they were brushing everything under the carpet”.

Patient 281 chose to see a different breast surgeon who removed and re-built her reconstructed breast. She had complications from this surgery but said she feels it was the right thing to do, as she had had tissue remaining after her first mastectomy and therefore had an increased risk of the cancer returning.

Patient 281 describes herself as being really strong but has been affected by her experiences of being treated by Paterson. She worries about her body image as she has numerous scars.

Patient 251

Two of patient 251’s relatives had had breast cancer and she went for genetic counselling which confirmed she had the breast cancer gene. Patient 251 decided to have a double mastectomy to prevent her developing breast cancer. She said this was a decision she didn’t take lightly but wanted to be around for as long as possible for her children.

Paterson saw her at Solihull Hospital. She saw him every 18 months for over three years. At each appointment he delayed her surgery, saying, “You won’t get that for another 18 months.” Patient 251 said the wait affected her mental health as she was convinced she would develop breast cancer. She now feels that Paterson was deliberately delaying her surgery in order that she would opt to be treated privately.

After three years, patient 251 received a letter offering surgery at Little Aston Hospital as an NHS patient. She was then contacted by the plastic surgeon who said that the surgeon due to carry out the reconstruction wouldn’t undertake a double mastectomy, and she would need to return for her second breast reconstructing. She said that this news “horrified” her and she has since discovered that this was in fact a lie.

Patient 251 said that when she was admitted to Little Aston Hospital she was hysterical, as the staff didn’t appear to know what procedure she was having. She was asked if she was having a breast lump removed. Patient 251 had an eight-hour operation. She has since found out that Paterson operated on one breast and a trainee surgeon on the other. She was not aware this would be the case in advance of her surgery.

Patient 251 had a difficult time after her operation. She was really anxious about her procedure, had swelling and was taking a considerable amount of medication. She said she was complaining about feeling fluid dripping down her back, but this was being dismissed by the staff until a spine surgeon was called and confirmed that the fluid was either epidural or spinal fluid leaking from her spine. Patient 251 also mentioned that a doctor dropped a needle on the floor but went ahead and used it on her.

Patient 251 said she wasn’t expecting to be recalled by the hospital following news about Paterson’s malpractice, as her procedure was totally different from those who had a diagnosis of breast cancer. She initially saw someone from the patient advice and liaison service at the

hospital, which was followed by an appointment with a consultant. He said there were no notes so he couldn't see what surgery had taken place. He recommended a mammogram and biopsies. She had seven biopsies on one breast and five on the other.

On returning for the results, patient 251 was told that she had remaining breast tissue and did not have as much of her breast removed as was necessary. The consultant said he couldn't say how much she was still at risk. Patient 251 has annual mammograms but said she has to "chase up" as she isn't automatically invited.

Patient 251 said for a long time she couldn't look at herself in the mirror as it was a constant reminder of her experience. She feels there has been a series of errors and that, as a result, patient 251 has suffered with anxiety and depression.

Patient 314

Patient 314 found a lump in her breast after a routine mammogram. Her GP referred her to Paterson at Solihull Hospital as an NHS patient. He told her she couldn't have another mammogram and contacted the hospital that had arranged the routine mammogram for the results.

Paterson told patient 314 she needed a mastectomy, which she had. At her follow-up appointment, Paterson told her the cancer had been taken away and it had not spread into her lymph nodes. He told her to "go home and get on with your life". Patient 314 had chemotherapy after her mastectomy. She told us she "hated the treatment, the hospital and everyone there", but she needed to believe that Paterson did the best for her.

Four years after her surgery patient 314 was recalled by the hospital and told that Paterson had not removed all her breast tissue when he operated on her. She talked through her options with her GP and decided not to have further surgery to remove the remaining breast tissue but opted to have mammograms each year.

Late 2000s

Patient 372

Patient 372 found a lump in her breast. She had private medical insurance and her GP referred her to a specific radiologist at Parkway Hospital.

Patient 372 had a mammogram and ultrasound. The radiologist said that all looked okay and that he suspected that she had a benign lump. He said she would need to see Paterson later that day but said, "If you were my wife I wouldn't have anything done."

Paterson didn't agree with the radiologist. He took some cells for testing and she returned for the results a couple of days later. Paterson had a breast cancer nurse with him at the appointment and patient 372 automatically thought the worst. She told us she took a dislike to the nurse, said they were a double act and felt uncomfortable with their behaviour.

Paterson said the results were inconclusive and that he must act immediately. He wanted to operate the following day but didn't explain what operation he would do. Patient 372 was clear she didn't want an operation and asked about alternatives. Paterson and the breast care nurse put her under immense pressure and insisted he operated. Paterson said, "This isn't debatable, we have to get this out."

Following her operation, the breast care nurse told patient 372 that she had had a cancerous tumour. Patient 372 asked Paterson whether it would kill her, and his response was that "it isn't breast cancer that kills you, it's where else it goes that kills you". This triggered patient 372 to have extreme anxiety, which lasted for 10 years.

Patient 372's GP contacted her to say that Paterson had written to her and that she had never heard of the type of tumour Paterson said she had. Her GP also told her that Paterson had stated in his letter to her that he didn't agree with the pathology report, which said the tumour was benign.

Patient 372 returned to Paterson a few times with a lump on her arm which concerned her, again believing that she would get secondary cancer. Each time Paterson sent her away and said it was a cyst. He wrote to her GP and said, "I told her if she wants to be sure I'll do an endoscopy and that seemed to scare her off."

Following local publicity about Paterson, patient 372 contacted Spire and asked to be seen. She saw an NHS consultant who confirmed that she had indeed had a benign lump and that the operation had not been necessary.

The effect on patient 372 and her family has been considerable. Due to the time off work and her anxiety she lost her senior level position at work, her medical notes incorrectly record that she had cancer. Patient 372 is now mistrustful of the medical profession.

Patient 309

Patient 309 was diagnosed with breast cancer following a mammogram, ultrasound scan and biopsy. She was referred to Paterson at Solihull Hospital as an NHS patient. He told her that she had a small cancerous lump which needed to be removed, after which she would be "cured...and everything is rosy". Paterson operated to remove the lump and reassured patient 309 that "from what I can see, that is it". When she returned for a check-up six weeks later, Paterson told her that the pathology reports on the lump had indicated that there was cancer

elsewhere in the breast and that she needed to have a mastectomy, which was a massive shock to her. Patient 309 asked if she could have her breast reconstructed but Paterson told her she could not, because of the treatment she would need, including chemotherapy.

Patient 309 returned for the mastectomy and again was reassured by Paterson that “everything is going to be fine” but that he was going to carry out 12 biopsies on her other breast to check whether cancer was present there. Following her surgery, patient 309 was left with a flat chest but noticed a small bulge at the side. When she questioned Paterson about it, he said it was “probably just fluid” and that “it is nothing...it will make it look like you have got a cleavage”. The biopsies on her other breast showed that there was no cancer there.

Patient 309 saw Paterson again at the end of the 2000s and was then referred for breast reconstruction. By this point, a lot of patients were discussing cleavage sparing mastectomies, which led to patient 309 to question what happened to her. When she was recalled by the hospital, she asked the consultant, but he was able to reassure her. However, in the late 2010s, when patient 309 was considering claiming compensation, she saw a consultant at the hospital who gave her a list of operations she had undergone. One of the notes in the records was that for the original mastectomy: “mastectomy may not be complete”, which the consultant told her could mean there might still be breast tissue present.

Patient 309 describes her illness and treatment by Paterson as being a stressful time for her and her family. She told us that she found sharing her feelings about it difficult and that this contributed to the breakdown of her relationship with her husband.

Patient 350

Patient 350 had a pulling sensation in his chest. He was referred by his GP to Paterson at Parkway Hospital as private patient. Patient 350 had a scan at the hospital and remembers the radiologist he saw saying that there did not appear to be any problem. Paterson looked at the scan results and told him, “There is something, I think we need to get it.” Paterson operated, however, patient 350 continued to feel the discomfort in his chest. Paterson told him this was “remembered discomfort”. Two or three years later the problem disappeared.

When patient 350 was recalled by Spire, he was told that “there was absolutely no need for you to undergo the surgery you did. We would have recommended a non-invasive course of treatment”.

Patient 351

Patient 351’s daughter gave evidence on her behalf. Patient 351 found a lump in her breast. Her GP referred her to Paterson at Solihull Hospital as an NHS patient. Paterson examined her and referred her for a mammogram but did not do a biopsy of the lump. He diagnosed patient 351 as having breast cancer. Paterson explained that she needed to have a mastectomy, which would be followed by radiotherapy, and booked her in for the operation. Both patient 351 and her daughter felt reassured by the treatment from Paterson.

As part of the recall process, the hospital wrote to patient 351 asking her to come in, if she had concerns. One of the letters from the hospital pointed out that she had some remaining breast tissue. Patient 351 was not previously aware of this or told it was a possibility, since she thought she had a full mastectomy. She saw the breast care nurse who arranged for a further mammogram and reported no concerns.

Patient 351’s daughter told us that she felt the hospital could have been more open and transparent about what had happened.

Patient 297

Patient 297 had a routine NHS mammogram at Solihull Hospital and following this, received a letter asking her to go to her local hospital. She had a further mammogram and biopsy, and a doctor told her, "We cannot say whether it is cancer or not, but if it is, it could go into the bones, and this is what we are concerned about." Patient 297 had a further appointment at Solihull Hospital, where she was told by a doctor that she would need an operation to remove some lymph nodes. Paterson operated on her and told her that everything was clear and that she could go back to having routine mammograms. The letter patient 297 was given by the hospital was for a different patient. She alerted the hospital to this and arranged to return the letter. When she next saw Paterson, he asked if she had complained about him. Patient 297 replied that she hadn't but that she had had to tell the hospital she had been given the wrong letter. She told us his demeanour towards her changed: "He was always very friendly and sociable and I found him a bit 'offish'."

In the early 2010s, patient 297 was asked by the hospital to come in for another mammogram, but that was clear too. Patient 297 has not been recalled by the hospital. While patient 297 feels that Paterson gave her the correct treatment, her experience of being his patient has lessened her trust in doctors.

Patient 317

Patient 317 found a large lump in her breast. She saw her GP, who referred her to Solihull Hospital as an NHS patient. Six days later, she saw a nurse who sent her for a mammogram and ultrasound scan, and then biopsies. A week later, patient 317 saw Paterson, who diagnosed her as having cancer and said the treatment would be to remove the lump in her breast. She had the operation and returned two weeks later to be told that she had cancer in one of her lymph nodes. She had a further operation to clear her lymph nodes.

Patient 317 returned for a check-up six months later. Paterson saw her for two minutes, so there was no opportunity for her to ask any questions. She was upset and worried that she had not been able to ask him questions about her treatment and contacted the nurse afterwards and arranged to see her. At this appointment, the nurse reassured patient 317 that there was almost no chance of the cancer returning in her breast, but that it might return elsewhere. This information and the cold way it was said to her by the nurse shocked patient 317. She saw Paterson for two or three further six-monthly check-ups.

In the late 2010s, patient 317 found another lump, in the same place as the original lump. She was referred to Solihull Hospital and had biopsies on the lump. She was told that Paterson had not removed all her lymph nodes. The consultant she saw told her that she was unlucky to have the cancer return in the same area. He advised her that she needed a mastectomy, which she had, and which showed the same type of tumour as before. Patient 317 is trying to find out from a specialist whether the cancer is a new cancer or a recurrence of her first cancer.

Patient 317 spoke to us about her anger at Paterson; "I look at my mum and I could kill him with my bare hands from what he's put my mum through. Because my mum is totally convinced, and has been for quite a few years now, that it's his fault that things happened the way they did. Or that he never treated me right."

Patient 262

Patient 262 is deceased. Her son and his wife told us about her treatment. They continue to be distressed as they feel that patient 262's final months were spent in pain and ill health due to Paterson's mis-handling of her treatment. They later accessed her medical records

and have said these are incorrect. They are distressed that despite her son being her next of kin no attempt has been made by Solihull Hospital to recall them in relation to Patient 262's treatment under Paterson.

Patient 262 was referred as an NHS patient to Solihull Hospital by her GP as she had problems with her breast. Following tests, Paterson told her, "It looks like cancer, we need to take it off." He said there was no rush and he would operate in three or four months' time, reassuring her that "everything would be fine" following surgery. Patient 262's family were concerned by the delay in treatment as she was in her 80s and had lost a significant amount of weight over a very short period of time. When her daughter-in-law mentioned the weight loss Paterson quickly changed his mind and said he would operate sooner.

Patient 262 had a mastectomy and asked to return home the following day as she was uncomfortable in hospital. Her family said that other than a visit from a district nurse they received no follow-up or aftercare from the hospital. She did not see Paterson again.

Shortly after her mastectomy, patient 262 had significant back pain. She had an X-ray and was told she had cancer. Patient 262 was shocked at this news as Paterson had told her that she would be fine following surgery. Her family said they believe she "gave up" at that point and "took to her bed". Patient 262 died shortly afterwards.

Her family feel very strongly that if patient 262 had been given the facts by Paterson in relation to the extent of her breast cancer she would have not gone ahead with surgery. They said she was a very strong woman and would have lived the rest of her life to the full.

They are upset that patient 262's medical notes state that her condition and treatment were fully discussed with her. This was not the case. They are very clear that she would not have proceeded with surgery in her 80s if Paterson hadn't said she would be cured after the operation.

Patient 262's treatment has had a devastating impact upon the family. Her son and daughter-in-law say she is purely a statistic and has been ignored by the hospital.

Patient 153

Patient 153 found a lump in her breast. She did not want to wait two weeks to be seen as an NHS patient and so her GP referred her to Little Aston Hospital as a private patient. She saw Paterson the following day. Following a mammogram, Paterson said he was 90 per cent certain that patient 153 had cancer. He took a biopsy without a local anaesthetic. Patient 153 said she had never felt pain like it and "cried out". She now feels she should have seen this as a warning sign.

Patient 153 had to have a further biopsy as Paterson hadn't taken enough cells in the original biopsy. Within two weeks she had a mastectomy and lymph node clearance. Patient 153 is aware that the surgery only took 40 minutes which she believes is very quick for such a procedure. Paterson told her that she was "cured of cancer". She had chemotherapy and radiotherapy and 18 months later had a breast reconstruction.

Patient 153 mentioned she became involved with a local support group where the members believed Paterson to be "wonderful". On one occasion, Paterson was due to talk at a support group event and the venue had to be changed to accommodate a larger audience. Patient 153 said she was convinced he was a "highly skilful, highly qualified surgeon who was the best of the best".

Once news about Paterson's malpractice broke, patient 153 contacted Spire and asked for a recall appointment. It took several calls to get an appointment which made her feel that Spire were "generally chaotic". Patient 153 learnt that she had had an incomplete mastectomy. Spire did not offer any support, but her insurance company agreed to pay for mammograms every six months.

Seven years after the initial diagnosis, patient 153 has been diagnosed with secondary breast cancer. Her consultant said it was not related to her treatment by Paterson but she feels the fact she did not have a total mastectomy could have been a factor.

Patient 153's insurance company wouldn't continue to pay for her treatment. She said being treated by the NHS, she can now see how things should operate. For example, her oncologist sends a letter regarding her treatment to her GP and she receives a copy. She said this wasn't the case when she was being treated by Paterson.

Patient 153 said the emotional impact of her experiences has been huge. She told us, "So emotionally, it had a big impact and it was, you know, a big shock, and, you know, you just feel ... I was not naive but you are a lay person and I had never been in hospital, I had never had an operation, I had never had cancer. And, you know, you put so much faith and trust in these people, and then they basically let you down."

Patient 110

Patient 110 found a lump in her breast. She had private health insurance and her GP referred her to Parkway Hospital as a private patient. She saw Paterson, who found nothing wrong with that lump, but found a lump in her other breast. He referred patient 110 for a scan, which showed a "solid mass" and therefore referred her for a biopsy, which she had within days. When she returned for the results, Paterson told her she had a tumour which could become cancerous. Because her family had a history of cancer, he advised her to have the lump removed. When Paterson wrote to her GP, he said that patient 110 was "keen to have it removed", which was not true.

Patient 110 had the lump removed. She had no concerns with her treatment at this point. Two years later, she had groin pain and her GP referred her to Parkway Hospital where she saw Paterson. He diagnosed a hernia and booked her in for surgery with him, telling her that he was a vascular surgeon as well as a breast surgeon. While she was under anaesthetic he also operated on her foot. Patient 110 found out later from another surgeon that she did not need the hernia operation because she had never had a hernia. Spire did not recall patient 110 and so she rang and asked for a recall appointment. When she attended the recall appointment, she was told that she did not need any of the surgery, including the breast surgery.

Patient 110 has ongoing problems with her leg and stomach as a result of the operations Paterson did. She told us about the impact of being treated by Paterson: "I've always thought I was a good judge of character, and you feel as though you've been made a complete and utter fool of. You feel violated, because somebody's put you to sleep, got into your body and done things that you didn't consent to, and you trusted, wholeheartedly, and they're a monster."

Patient 29

Patient 29 had a routine mammogram which picked up something was not right. She was called into her local hospital for a series of tests. The hospital told her she had cancer and that the only treatment was a mastectomy. Patient 29 agreed to a mastectomy and breast reconstruction but wished to pay for a private room. The hospital could not offer her a private

room and she did not like the surgeon who would be doing her operation, so she called her medical insurer to ask them to recommend a hospital. They told her that their “best breast care centre is Solihull”.

Patient 29 saw Paterson as a private patient at Parkway Hospital. He arranged for a scan and said that he wished to remove her lymph nodes first “because it is much better done before the operation”, which she has since found was unnecessary. Patient 29 contracted MRSA before her mastectomy. A nurse from Parkway Hospital rang her to say that they would have to cancel her surgery until patient 29 was clear of MRSA. However, Paterson then rang patient 29 to say that he could operate on her. Patient 29 had the mastectomy and breast reconstruction at the same time. She told us that the care after her surgery was poor and that she was left on her own for four or five hours in the cold. The MRSA infected patient 29’s back where some of the tissue for reconstruction had been removed. She told us that despite her being gravely ill, the team responsible for her care at Parkway continued to care for her there, rather than arrange for her to be transferred to an NHS hospital with more appropriate facilities for someone so ill.

Patient 29 was discharged after 10 days. She saw Paterson six weeks later, who said that the operation was a “wonderful job” but that her back was “not my problem” and that she needed to see the plastic surgeon. The infection in patient 29’s back got worse over the next few weeks and Spire agreed to her being readmitted. Patient 29 had developed sepsis. She was the only patient in the hospital throughout her two stays. Patient 29 had reconstruction on her back at another hospital later to rectify the damage caused to it.

Patient 29 was recalled and was seen at her local Spire hospital. They could not tell her whether she had a cleavage sparing mastectomy. She still does not know, and therefore has a mammogram every year. Patient 29 no longer trusts healthcare professionals. She told us, “I was angry with myself for being so duped, and I think that affected me.”

Patient 89

Patient 89 went to see her GP about a lump in her armpit and, because she was insured, asked to be treated privately. Her GP referred her to Paterson at Parkway Hospital. She saw him, and he arranged for a scan and did a biopsy. Patient 89 returned for her results and, because Paterson was on holiday, saw a nurse. The nurse told her that her breast implants, which she had inserted following an earlier mastectomy had ruptured, and they needed to be removed urgently otherwise the silicone would spread into her lungs. Her insurer refused to cover the cost, saying that it was cosmetic surgery, so patient 89 had to fund it herself. Paterson took the implants out the next week. He told patient 89 she would have to see a cosmetic surgeon to have them put back in.

Six months later, patient 89 saw a reconstruction surgeon who asked why Paterson had removed the implants. She showed patient 89 the scan taken prior to her operation, which showed no evidence of implant rupture. Paterson had removed the implants for no reason.

Patient 89 asked for her medical records from Spire and found that Paterson had also informed her GP that the implants were ruptured. She contacted Spire to ask for a meeting and was told that her complaint would be taken further.

Spire recalled patient 89 and confirmed that her implants had not ruptured. They also told her that the lump she originally found was an infected area in the armpit, which could have been treated by antibiotics. Patient 89 claimed compensation and used the money to pay for breast reconstruction.

Patient 89 lost her job because of the stress of the experience; it took over her life and she has not been employed again. She no longer trusts doctors.

Patient 69

Patient 69 went to her GP as she suspected she had a lump in her breast. She had private health insurance through her employer and chose to be treated at Parkway Hospital. Following an ultrasound scan, Paterson told her he needed to aspirate where the lump was. He didn't mark where the lump was but "jabbed" the needle into her breast. Patient 69 said it was incredibly painful, like "a red-hot poker". She told Paterson she had lost her parents to cancer and she believes he saw her as vulnerable.

When patient 69 returned for the results, Paterson told her she had cancer which was curable but that she needed a mastectomy. He said, "Don't worry you will go in with two boobs and come out with two boobs and a nice flat stomach."

Paterson's breast care nurse explained the surgery and that the immediate reconstruction involved taking muscle from her stomach, cutting from hip to hip and routing the blood supply under her chest wall. Paterson said he would also remove her lymph nodes.

Patient 69 said that prior to her operation, the reconstruction surgeon treated her like a "piece of meat" and made her stand against the wall and drew on her. She said she looked like a "patchwork quilt". The anaesthetist had to cut her wedding ring off which she found upsetting.

Patient 69 told us she didn't give informed consent. She wasn't made aware that she could have opted for the mastectomy with no reconstruction, the only option offered to her was mastectomy and immediate reconstruction. Following surgery, patient 69 woke in the high dependency unit and was aware her oxygen levels were dropping. At the time she didn't suspect things weren't right as all the staff were telling her how lucky she was to have Paterson.

As she wasn't feeling well after surgery, Paterson said patient 69 could have another few days in bed. Ten days after the surgery, she couldn't stand up straight and was prescribed antibiotics as her wound wasn't healing. A stitch had been broken when being moved in bed and the hole wouldn't heal.

Patient 69 said the most debilitating thing about the surgery was the removal of her stomach muscle. She was previously very strong and physically fit but now has very limited strength and movement. The surgery left her with two hernias due to a very weak stomach wall.

Patient 69 feels that her having premium medical insurance cover was "a license to print money". She saw Paterson two or three times a year and had five or six scans she now knows she didn't need. Patient 69 had chemotherapy which she has since discovered was unnecessary and which has damaged her veins.

Paterson carried out additional surgery on patient 69. He diagnosed gallstones after referring her for an X-ray with pains in her side. Paterson operated and showed her some gallstones in a jar, claiming they were hers which he had removed. She later discovered from pathology reports that she hadn't had gallstone trouble.

Patient 69 was recalled twice by Spire. She was given conflicting information at the recall appointments. At the first recall appointment, she was told all treatment was necessary and only "fatty tissue" remained. She then received a letter recalling her again. Only volumes 1 and 4 of patient 69's notes were available, but the consultant had enough information to say

that she hadn't had cancer. She has since discovered that the surgery was not necessary as the tumour was very small and has not spread into her lymph nodes. Patient 69 feels that Paterson deliberately spoiled the pathology notes to "cover his tracks".

Patient 69 feels the recall hasn't been handled in a systematic and organised way. She believes it wasn't robust, was a cover up and felt that the consultant she saw when she was recalled had been told to get rid of her.

Patient 69 said, "He put me through all that for nothing."

Patient 125

Patient 125 considers herself to be "one of the lucky ones". She was referred to Solihull Hospital after discovering a white mark on her nipple. She saw Paterson in one of the clinics who told her that the mark "had to come off". He also asked whether she had private medical insurance and advised her, that if so, then he would be able to see her at Parkway Hospital within 10 days.

Patient 125 started to complete the forms to go to see Paterson as a private patient and it was during this time that she was advised by a friend not to "go near Paterson". She wasn't provided with any information as to why but a consultation with another doctor was arranged for her.

The doctor told patient 125 that she appeared to have a sebaceous cyst and advised her on what she needed to do to treat it herself at home, avoiding any invasive treatment. This was in contrast to Paterson, who had been prepared to operate and remove the patient's nipple.

Patient 125 told us, "I am one of the lucky ones; I was lucky that someone I knew and I spoke to warned me."

Patient 86

Patient 86 was referred by her GP for tests in the NHS. These confirmed that she had breast cancer. Following a friend's recommendation and an internet search she chose to see Paterson as a private patient at Parkway Hospital.

Paterson removed a lump in her breast and some lymph nodes to check the cancer had not spread. Patient 86 said she was surprised to learn that her lymph nodes were affected. She had further surgery to remove the lymph nodes and Paterson recommended she have chemotherapy, followed by radiotherapy.

Following her radiotherapy, patient 86 found a further lump. Paterson advised her it did not need to be removed and that she should have regular check-ups. However, patient 86 felt that if the lump was removed she wouldn't have the on-going worry. Paterson agreed to operate and told her that she had made the right decision. This concerned patient 86 as Paterson had previously advised her to not have the lump removed. She continued to have three-monthly check-ups with Paterson.

Patient 86 had some MRI scans. Following these, Paterson advised her to have her ovaries removed, he described them as "positively glowing". A different consultant carried out the operation and found a non-cancerous tumour on her ovaries. Patient 86 thought Paterson had "saved her life".

Patient 86 and her husband trusted Paterson implicitly and now feel that their trust was misplaced. Patient 86's GP confirmed she had had breast cancer but also told her that due to the number of scans and X-rays she had, she has an increased risk of illness. Patient 86 was critical about the lack of communication and support she received from Spire.

When the Paterson case went to court, patient 86 said it was "a real dawning for me that this is completely factual", as she had previously felt press reporting about him was sensationalised. She has had recurrent nightmares of having surgery by Paterson and feels strongly that if she had been aware of the concerns about his practice she wouldn't have seen him. Patient 86 said she was previously a naturally positive person and now feels "he has stolen that positivity".

Patient 336

Patient 336 discovered a lump in her breast. Her GP referred her to Solihull Hospital as an NHS patient. She saw Paterson who she found "a little blunt". Following a mammogram, scan and needle biopsy, Paterson told her she had breast cancer and this was confirmed by the test results two weeks later.

Paterson operated to remove the lump from patient 336's breast. He told her, "The good news is we've got all the cancer in the breast, the bad news is it's gone to the lymph nodes." Patient 336 said she thought this "was a bit odd". Patient 336 had her lymph nodes removed, followed by further surgery because of internal bleeding. She had chemotherapy followed by radiotherapy and saw Paterson regularly for a period of approximately five years.

Patient 336 wasn't recalled by the hospital but contacted them for reassurance that she received the correct treatment following publicity surrounding Paterson. Although she was told her treatment was appropriate she is concerned that things could have been "hushed up". She feels the experience has caused her a lot of stress and continues to have concern about the treatment undertaken by Paterson. Patient 336 has been left with a distrust of the medical profession.

Patient 359

Patient 359 saw her GP about lumps in her breasts and was referred as a private patient to Paterson at Parkway Hospital. At the first appointment, she had a scan and mammogram and Paterson told her, "There is something there", and operated to remove a lump. He saw her several times over the decade and each time he operated and removed the lumps.

Patient 359 was recalled by Spire and told that all the surgery was unnecessary. Paterson should have carried out a biopsy first, and then operated, if necessary, in the light of the results. Patient 359 felt that as if she had been assaulted by Paterson. She told us, "I was absolutely flabbergasted with what came out."

Patient 321

Patient 321 went to see her GP as she had a discharge from her nipple. Her GP prescribed antibiotics but as they made her ill she was referred to Paterson at Solihull Hospital as an NHS patient. He said that antibiotics wouldn't cure her problem and that she may need a mastectomy. She then had a mammogram and biopsy.

Paterson confirmed she needed a mastectomy. Patient 321 asked if she could have a reconstruction and said Paterson replied, "'No', very sharp". She said she was very upset – not about the mastectomy but who would look after her ill husband while she was in hospital.

Following the mastectomy, patient 321 had a “watery discharge” from her nipple, which was making her sore. She returned to Solihull Hospital and had needles inserted into her nipple with a local anaesthetic. She asked for a general anaesthetic, but Paterson refused. She said she felt immense pain and “was fighting them to get them off”.

Patient 321 found the whole experience very traumatic and contacted a solicitor to make a complaint to the hospital. The letter she received back from Paterson said that the anaesthetic did not suit her and in future a different one should be used.

Patient 321 said that she feels the medical profession did not listen to her.

Patient 32

Patient 32 found a lump in her breast. She contacted her medical insurer, who gave her the names of three consultants, one of whom was Paterson. She contacted Paterson and saw him as a private patient two days later at Parkway Hospital. He referred patient 32 for a mammogram and ultrasound scan. Once he had the results, he told her that the mammogram showed nothing, but that he could feel a lump and that it needed to be removed. When she asked what the lump was Paterson said it was “partly fibrous tissue and partly fatty tissue”. Patient 32 had the surgery and Paterson told her there was nothing to worry about, but that he wished to see her every six months for X-rays and ultrasound scans. She stopped attending the six-monthly check-ups and decided to switch to the NHS screening programme.

Patient 32 was recalled Spire and was told that normally patients in her position would have had a biopsy. The doctor at the recall appointment showed her a letter Paterson had sent to her GP which said that the patient had been very concerned about the lump, and wanted it removed, which was not the case. Patient 32 was told at the recall appointment that the lump would have dispersed if it had been left alone and that the operation and the six-monthly checks were not in line with good practice.

The experience has had a significant impact on patient 32’s life. She had decided to leave a well-paid job she enjoyed, on the basis of her discussions with Paterson, and now questions whether this was the right thing to do. She spoke of always being a Paterson patient: “It is, you know, one of those things that is going to be there for the rest of my life.”

Patient 68

Patient 68 was originally referred by her GP for treatment at the BMI Priory Hospital for breast cancer, but left part way through her treatment, at the suggestion of a breast care nurse, to see Paterson as a private patient at Little Aston Hospital. She was not comfortable when she met him, but he encouraged her to see a reconstruction surgeon. Patient 68 subsequently found out that the surgeon had been de-listed by her medical insurer. She told Paterson, who said, “We can get round this. I will write to your insurance company. I will say that I will do some work on your chest. We will get [the reconstruction surgeon] in. She can do the reconstruction surgery. We will say we kept you in hospital for a few extra days, so that will bolster [the reconstruction surgeon’s] fee and I will pay her my fee for some work that I didn’t do.” The patient did not take up Paterson’s offer but later discussed it with her insurance company.

Patient 68 was due to have her portocath (a device inserted under the skin to administer chemotherapy) removed. She asked if this could be done under sedation as she had previously had problems with general anaesthetic. Patient 68 told us that this was ignored and that she was “knocked out” against her wishes and without her consent.

Patient 68 complained about many aspects of her treatment, including Paterson's treatment of her, and the anaesthetist going against her wishes. She told us that she did not get a satisfactory response, even when she raised her concerns with third parties. Patient 68 told us, "I think my view is that it really did feel like bashing your head against a brick wall. They would do the formality of looking at the issues that you raised, but I think solving the underlying root causes is too hard for any of the bodies that you are talking to."

Patient 363

Patient 363 found a lump in her breast. She had private medical insurance and her GP referred her to Parkway Hospital as a private patient.

Following an ultrasound and mammogram, Paterson recommended patient 363 have a biopsy as he suspected cancer which was spreading into her lymph nodes. Following this, Paterson operated quickly as he was due to go on holiday. He removed a lump from her right breast and cleared her lymph nodes.

Patient 363 got an infection after her surgery. She was prescribed antibiotics and had fluid regularly drained from her wound by the breast care nurse. Paterson suggested a further operation to remove the infection, followed by chemotherapy. He removed what he described as "friable yucky dead tissue", which he said had been caused by draining.

Patient 363 attended hospital daily for the wound to be unpacked and repacked – she described this as "horrendously painful". Paterson stitched the wound so that she could begin to have chemotherapy. Patient 363 recalls the reaction and "horror" on the oncologist's face when he saw her wound. She had seven months of chemotherapy treatment. This was followed by radiotherapy and a number of mammograms and ultrasound scans. She was told that this was because she was an "anxious lady", rather than necessary. Paterson had used this terminology when recommending previous treatment to her.

Paterson later referred to patient 363's scar as his "bad handiwork" and wanted to repair it. A consultant separately described the scar as though Paterson had "tucked in a bit of skin", which he said was easy to remedy. Patient 363's husband questioned whether Paterson had intentionally carried out a bad repair in order that he could operate again.

Patient 363 found another lump. Paterson told her that the biopsy on the lump was unclear and said she could go ahead with an operation or leave the decision for a further four weeks. As a radiographer failed to find the lump the patient decided not to go ahead with an operation at that point. At a follow-up appointment, Paterson said that there was nothing there and "sometimes lumps can just disappear".

Patient 363 has not been recalled by Spire. She has not spoken to anyone, nor sought legal advice following her experience, but does wonder whether her treatment was necessary and feels that she was not making informed choices.

Patient 270

Patient 270 found a lump in her breast and was referred to Paterson at Solihull Hospital. When he saw her, he thought the lump felt suspicious and said he could remove it. She asked how quickly she could be seen if she saw him privately and he saw her at Parkway Hospital a few days later. After surgery, Paterson told patient 270 that it had looked like a tumour but was a non-cancerous lump.

Two years later, she had another lump and saw Paterson again in the NHS. He took a biopsy and this time it came back as a cancerous tumour for which he said the only treatment was a mastectomy. Patient 270 was worried about having a mastectomy, but Paterson reassured her, saying, “A pretty young thing like you, I can make you look fine”, which she thought was inappropriate but was scared to challenge as she wanted to get the operation over with. Paterson told her it was a dangerous tumour, which would spread to her lungs and heart and did not respond to chemotherapy. He said that it would be six weeks before he could operate if she was treated in the NHS and so she asked to be seen as a private patient again.

Paterson carried out a cleavage sparing mastectomy at Parkway Hospital and removed all patient 270’s lymph nodes at the same time, which she had not been told about in advance. Eighteen months later, she had a breast reconstruction. When she was examined prior to her reconstruction, the surgeon told her she had a “good mound of breast tissue there for me to work on”. Patient 270 said it was “just fat” and the surgeon did not say anything.

In the early 2010s, patient 270 contacted Solihull Hospital to check what she had been told about the tumour. She was told by the consultant that Paterson had cut into the tumour while it was in the breast, but they did not know why. The consultant told her that she only needed the lump to be removed, rather than a mastectomy and that the lymph nodes should not have been removed at all. He thought it was “nothing short of assault”.

Patient 270 was recalled by Spire and was scanned, where they found cysts in her remaining tissue. She was told that it was not breast tissue, because the reconstruction surgeon would have removed it all. Patient 270 had sufficient knowledge to know that this was not true and realised that other patients were being told the same thing.

Patient 270 told us about the impact her experience had had on her: “He frightened me so much with what he said, and I trusted him, and I thought it was a dangerous tumour, and I was frightened to look at it on the internet because I did not want to be bombarded with things that would stick in my head about it, so I kind of, buried my head.”

Patient 329

Patient 329 was getting lots of cysts in her breast. Her GP referred her to see Paterson at Solihull Hospital as an NHS patient. Her GP described Paterson as “the top man”. Paterson removed a lump from patient 329’s breast. He told her that he had not been able to remove all the “pre-cancer cells” and that she needed to have a mastectomy. Patient 329 had some “flesh” left behind following her mastectomy. She had chemotherapy and radiotherapy after her operation.

Patient 329 was recalled by the hospital before news of Paterson’s malpractice broke in the media and found having to go back as part of a recall process “quite disturbing”. She did not feel reassured by her recall appointment.

The experience has had a massive effect on patient 329 and she thinks it contributed to her husband’s ill health. Patient 329 has been left feeling suspicious of the medical profession and said, “I just do not trust any of them now and it has all come from him.”

Patient 60

Patient 60 found a lump in her breast. Her GP referred her to the NHS breast care team at Solihull Hospital as an NHS patient, where she saw Paterson. He examined her and told her that he would remove the lump but did not say if it was potentially cancerous. Patient 60 can

still feel the lump. She feels that her operation was unnecessary and has left her with scarring. She has had mammograms which have not shown any problems. Patient 60 has not been recalled by the hospital.

Patient 60 told us, "I think I feel for people that have gone through, you know, far worse than me, but I suppose my story, even though how small it might be, is just one of many and that needs to be shared."

Patient 319

Patient 319 is deceased. Her parents gave evidence to the Inquiry on her behalf. Patient 319 saw her GP as she was having problems with her breast. Her GP referred her to Paterson at Parkway Hospital as a private patient. Paterson took a biopsy, told patient 319 she had breast cancer and referred her to a cancer specialist for chemotherapy. After chemotherapy, Paterson carried out a mastectomy and told patient 319 in advance of her operation that he would leave some tissue at the top of her breast if it was safe to do so. Following her mastectomy, patient 319 had more chemotherapy and a breast reconstruction. After a year, she became ill again. The cancer had spread to patient 319's bones.

Patient 319 was recalled by Spire who offered to remove the excess breast tissue, but she decided not to have any more surgery. Spire made no suggestion that the treatment had not been appropriate.

When Paterson was in the news, although patient 319 had always been pleased with the treatment she had from Paterson, her relatives wondered whether her remaining breast tissue should have been removed. They told us, "All the time she was with Mr Paterson, I cannot honestly say that I was worried about her. Not with him, but when all this came out then I started thinking about it and maybe she should have had the breast tissue removed."

Patient 140

Patient 140 found a small indent in her breast and saw her GP who referred her to Paterson at Solihull Hospital. She had a mammogram and a scan. When patient 140 returned to the consulting room, Paterson told her she had cancer, before he had taken a biopsy, and that he could operate on her in two to three months at Solihull Hospital, or two weeks if she saw him privately. Patient 140 wanted to be seen quickly, so opted to be seen at Parkway Hospital as a private patient.

Paterson took the biopsies away with him, intending to take them to Parkway Hospital. He saw patient 140 there three days later, where he told her she had cancer and that he could operate quickly and would remove a tumour and some lymph nodes. At her follow-up appointment, Paterson told her that the cancer had not spread to her lymph nodes. Following her surgery, Paterson arranged for her to see a colleague for chemotherapy and radiotherapy. She had very bad side effects from the chemotherapy and had to go to A&E in great pain.

Paterson arranged for patient 140 to have a PET scan and other tests while she was having radiotherapy, including an endoscopy to check for stomach cancer, and a CT scan. Patient 140 had six or seven PET scans over three years at Paterson's request. When she pursued compensation, a clinical expert who patient 140 saw said that the number of PET scans she had was excessive and could have killed her. He also told her that she had too much radiotherapy, and that she should not have had an endoscopy.

A week after patient 140's first PET scan, Paterson again told her that the cancer was back. She said that it could not have come back so quickly, and he said, "Your cancer's really bad. Cancer can come back while you're sleeping. It's like ants that come out looking for sugar." So, patient 140 returned for further surgery, but in a different part of her breast. When she returned for the follow-up appointment, she saw the breast care nurse, who told her that the cancer had not returned. She could not offer a satisfactory explanation about why Paterson had told patient 140 that she had cancer before she was operated on. Meanwhile, patient 140's wound after surgery did not heal for six months, and the nurse told her that was because she had radiotherapy just before the operation.

Patient 140 heard about the Spire recall on the radio and called the helpline. At her appointment, her notes were incomplete. However, she was told that Paterson had noted in them that she had asked him to carry out the second surgery, which was not true. She was also told that Paterson should have done a biopsy before deciding to undertake the second surgery.

Patient 140 has been left in ill health as a result of her treatment by Paterson. She suffers from anxiety attacks and told us the experience had destroyed her and her husband. Patient 140 told us, "We've just been through hell together, the two of us."

Patient 15

Patient 15 found a lump in her breast. She went to see her GP who told her that she needed to have a mammogram. There was a three-week waiting list for a mammogram on the NHS, so patient 15 asked to be seen as a private patient at Parkway Hospital, where she saw Paterson. Following a mammogram and a scan, Paterson told her, "It's breast cancer. It's sinister. It needs to come out urgently." The breast care nurse told her, "You haven't got time to waste, unless you want your son to lose his mum."

Ten days later, Paterson operated on patient 15. She had expected to have some breast tissue removed, however, when she came round from the anaesthetic, patient 15 was shocked and upset to discover Paterson had removed three quarters of her breast, and a lymph node from under her arm. The nurse explained that Paterson had to remove more because the cancer was much worse than it appeared to be on the scan.

Three days later, patient 15 developed an infection in her wound. This was made worse by having four CT scans at Paterson's request, to check whether the cancer had spread.

Patient 15 was recalled by Spire. At her recall appointment she was told that she had never had breast cancer. Patient 15 has serious physical and mental health problems following her treatment by Paterson, including the side effects of having too many scans affecting her bones. She has needed additional surgery as a result of her treatment, including a breast reconstruction and operations to repair her bones.

Patient 15 told us, "I was fit and healthy before I went to see Ian Paterson. I worked six days a week. I went to the gym every day, and I had a brilliant social life. And then going from that to being a patient of Dr Paterson, I don't think even my life will ever be the same. No amount of compensation will give you your health or your mental health back."

Patient 183

Patient 183 discovered a lump in her breast and went to see her GP. She was referred to Solihull Hospital for a mammogram, scan and a biopsy. She had the mammogram and scan and the nurse told her she had cancer, which was a shock. Patient 183 asked the nurse how

she could be sure it was cancer without the biopsy and she said, "Well, the doctors who do these scans and mammograms are pretty good", but she arranged for a biopsy. The nurse fetched Paterson, who told patient 183 the biopsy would take weeks if she was seen in the NHS, but if she was seen privately, he could take it immediately and give her the results the following week. She agreed and transferred her care to Parkway Hospital as a private patient.

Patient 183 saw Paterson the following week for her results. He confirmed it was cancer and said that he would remove the lump. Patient 183 told Paterson that she wanted a mastectomy if there was any chance, and that removing the lump would not be enough to remove the cancer. She asked her GP whether she should seek a second opinion and her GP told her that Paterson was a renowned surgeon and that if she had breast cancer she would want him to operate on her.

Paterson removed the lump and subsequently told patient 183 that "the lab was not happy with the margins around the lump". He assured her that all the cancer had been removed but that he would remove the "margin" (the tissue which had surrounded the lump). Paterson performed further operations on patient 183 over two years, including removing her lymph nodes. He also removed damaged tissue from her leg, which he described in a way that suggested it was cancerous.

In the mid-2010s, patient 183 started to hear of concerns about Paterson and discussed this with the consultant who took over her care. He checked her medical notes and told her that, given the size and the position of the lump, she should have had a mastectomy, and that Paterson had not operated correctly.

Patient 183 was never recalled by Spire. Her treatment has been reviewed by a cancer specialist as part of a compensation claim. She was told that she had four unnecessary procedures, and that Paterson continually opened the same scar, which has left her with a lot of pain.

Patient 183 told us that she is less confident since being treated by Paterson and feels the need to keep being checked all the time. She said, "Sometimes it just keeps going over and over in your head. All the time. I think in a funny way, I think of him every day because I have got discomfort every day with the scar tissue."

Patient 272

Patient 272 found a lump in her breast and saw her GP who recommended that she see Paterson privately, due to local NHS waiting times. She saw Paterson at Parkway Hospital and he arranged a mammogram, scan and biopsies. She returned to see him a few days later for the results and he explained that the biopsies were inconclusive, so he referred her for further biopsies to be taken by a radiologist. Patient 272 returned for the results two weeks later and Paterson told her she had breast cancer and needed a mastectomy, and a potential reconstruction. He also carried out a further biopsy which confirmed that the cancer had spread to her lymph nodes, and therefore they would need removing.

Two weeks later, patient 272 had the surgery. She signed a consent form for the reconstruction surgeon where she agreed to a skin sparing mastectomy, but it was not clearly explained to her what that was. After the surgery, patient 272 was in a great deal of pain and had difficulties breathing. Another doctor arranged for patient 272 to have a scan, which showed that she had pneumonia and clots in her lungs. She was kept in Parkway Hospital for over two weeks while she recovered from the operation. Patient 272 had chemotherapy after her surgery and at the end of that contracted a serious infection, which was followed by radiotherapy.

In the early 2010s, patient 272 had a follow-up appointment booked with Paterson, which was cancelled without explanation. Patient 272 booked an appointment with another doctor at Parkway Hospital. Three years later, the same doctor arranged for a mammogram and took a blood test, which showed a slightly increased chance that she had cancer and advised her to repeat the test through her GP.

Patient 272 was recalled by Spire in the mid-2010s. Following this, she had an operation to remove tissue that had been left behind after her mastectomy.

Patient 160

In the late-2000s, patient 160 saw her GP as she had a lump in her breast. He said he wasn't concerned but would refer her to a specialist, but this could take several months. Patient 160 was covered by her family's private health insurance, so she contacted Spire and saw Paterson the following day.

Paterson examined her and she had an ultrasound scan. He recommended that the lump be removed, although patient 160 told us he said the surgery was optional. Two days later, she had the lump removed. Patient 160 went on to have three further lumps removed by Paterson over the next three years.

Patient 160 was recalled by Spire but said the experience was not a good one. The consultant said, "I suppose you have already been through this with a solicitor." She had not and said this put her in a bad mood. She thought Spire were being defensive rather than reassuring her.

Patient 160 discovered at the recall meeting that Paterson had coded her lumps as cancerous so that he could charge her insurance company more for her treatment. Paterson had never told her the lumps were cancerous and the pathology results did not indicate she had cancer.

The impact of being treated by Paterson has been significant on patient 160 and her family. Her parents feel a sense of responsibility for encouraging her to be treated at Spire.

Patient 434

Patient 434 discovered lumps in her breast. Her GP referred her to Solihull Hospital where she had a scan and biopsy, as the mammogram machine wasn't working.

A nurse rather than a consultant told patient 434 that she had breast cancer. Patient 434's husband wanted her to receive treatment as soon as possible. They asked for advice regarding the best surgeon and were told it was Paterson; they arranged to see him privately at Spire.

They saw Paterson at Spire who requested further biopsies. The nurse undertaking biopsies was working at Solihull Hospital that afternoon and patient 434 managed to get an appointment in the NHS. As a result, she didn't have to pay for the procedure.

While waiting for an appointment with Paterson at Spire, she received an appointment with him at Solihull Hospital. Patient 434 said Paterson was "furious" she was seeing him at Solihull Hospital and that the biopsy had been carried out in the NHS. He said, "Because you are now involved with the NHS I'm going to have to bring your notes up at a multidisciplinary meeting and see what they decide to do." He said if she needed a mastectomy he could operate at Spire the following week, but she would need to wait six weeks if treated in the NHS.

The breast care nurse at Spire told patient 434 that the NHS thought she should have a full mastectomy and her lymph nodes removed but that Paterson recommended she just have the lump removed. Patient 434 decided to go ahead and have the lump removed, despite her husband's concerns.

Following surgery, Paterson told patient 434 it had gone well, but as the multidisciplinary team had recommended removal of lymph nodes he had removed them at the same time. Patient 434 returned to see Paterson two weeks later, when he said that he shouldn't have removed her lymph nodes as they were clear, but he was concerned he hadn't removed enough clear margins. He recommended further surgery. Paterson confirmed she would have to pay for the operation as he had to open the theatre.

At the next follow-up meeting, Paterson said he didn't feel she needed chemotherapy but would refer her to the expert – the oncologist. The oncologist said it would be too expensive to have chemotherapy at Spire and suggested he treat her in the NHS. Patient 434 decided not to go ahead with chemotherapy as she learnt that it would only make a marginal difference to her. She had radiotherapy, as the oncologist recommended this “just to make sure”.

When the news broke about Paterson's malpractice, patient 434 made an appointment to see the breast care nurse at Spire who reassured her she had had the correct procedure. The breast care nurse arranged for an ultrasound scan. Patient 434 was surprised to receive an invoice for £500 for the consultation and ultrasound as it was only required due to the bad press about Paterson. Patient 434 was not recalled by Spire.

Patient 434 has continued to have regular checks in the NHS but was diagnosed as having cancer in her kidney five years after her original surgery. She has received reassurance that it is not related to her breast surgery.

Patient 434 is still unsure whether Paterson carried out the correct treatment; “I just, you know, every now and again it comes into my head, do you know, every time it comes up I think, ‘I saw him and I trusted him,’ and whether he did the right thing for me.”

Patient 349

Patient 349 visited her GP as she had a lump in her breast. She was referred to Paterson at Solihull Hospital as an NHS patient. She had a mammogram, ultrasound scan and biopsy at the hospital, and met Paterson the following week for her results. Patient 349 said she hadn't even sat down when Paterson said, “It's breast cancer and you are going to have to have a mastectomy.” It was the first thing he said to her, which shocked her. Patient 349 asked if she could have the lump removed rather than a mastectomy. Paterson told her the cancer was “too severe” and the only option was a mastectomy.

Patient 349 said she was content with the surgery but had to return one month later for a further operation to remove more tissue. She had radiotherapy and chemotherapy following her surgery, followed by an operation four years later to reconstruct her breast.

Patient 349 was recalled by Solihull Hospital. She was asked if she had any concerns about her treatment with Paterson and said she thought he was “abrupt and quite arrogant”. Patient 349 wasn't told at the recall appointment whether her treatment was appropriate. She told us that since the press activity about Paterson's malpractice, she has wondered if she had a cleavage saving mastectomy and says she will never know if her cancer was as “severe” as Paterson had said, and whether a mastectomy was necessary.

Early 2010s

Patient 256

Patient 256 was diagnosed with early stage breast cancer at Solihull Hospital by a colleague of Paterson's. She was offered a full mastectomy or removal of the nipple. The patient had private insurance so opted to see Paterson at Parkway Hospital. Paterson suggested he remove her nipple and tumour, and that she have reconstruction by another surgeon. The patient had the tumour removed, but Paterson told her that because it was not where he thought it was, he did not have to remove the nipple. At the follow-up appointment, she was told that it was a small very early tumour. This was followed by a course of radiotherapy.

Patient 256 continued to see Paterson for three-monthly reviews, and at one of them told him she had a cyst in her breast, which he drained during the consultation. At another consultation, Paterson noticed that the patient had backache, and referred her for an MRI scan, "bearing in mind what has happened", but it showed wear and tear compatible with her age. After Paterson was suspended, she was passed to another consultant, who told her he was happy with the treatment she had received.

Although patient 256's treatment was appropriate, she told us, "I think like, anybody who has been a patient of Mr Paterson, it is very, very scary... Because you question everything."

Patient 352

Solihull Hospital wrote to patient 352 to invite her for a breast test with Paterson as an NHS patient. He examined her and told her that he could feel a lump, that she had cancer and would need a mastectomy. She was given no other option or information. Patient 352 disagreed, as she regularly examined herself and could feel no lumps and asked for a second opinion, which Paterson told her she did not need. He relented and agreed to a second opinion, which turned out to be with him. Paterson accepted that, as he was the surgeon, he would be right and that she did have cancer and she went ahead with the mastectomy. Patient 352 has been to see her GP recently who referred her to the hospital with pain in her breast. The hospital believe that breast tissue has been left behind after her mastectomy.

Patient 352 spoke of her anger towards Paterson: "I wish that man could go to hell... because it's not me alone he did this to. I think he did this to a lot of people."

Patient 371

Patient 371 went to see Paterson at Parkway Hospital as a private patient. Paterson was recommended to her by friends.

A mammogram identified that patient 371 had "calcifications". Paterson said she needed further investigation and referred her to the NHS. No explanation was given regarding the calcifications, nor why she was being referred to the NHS, particularly as she was happy to pay privately for the additional tests.

When patient 371 went to the NHS she saw a nurse who reassured her that tests for calcification were usually negative. The nurse repeated a couple of times, "You will come back to the NHS won't you?". Patient 371 said she felt "something was going on" at the time.

Patient 371 said she was not sure if she liked Paterson at the consultation. She found him arrogant and was uncomfortable when he rubbed his hands and smiled before the breast examination. Patient 371 described him as "smarmy".

Patient 354

In the early 2010s, patient 354 found a lump in her breast and was referred to Parkway Hospital as a private patient, where she was seen by one of Paterson's colleagues. Following tests, he told her that it was cancer and that surgery would take place the next week. Patient 354 asked him for a CT scan to check it had not spread, but the doctor said it was high risk and "people can die from that". On the day of the surgery, patient 354 was told that the doctor was no longer going to operate. She was worried by this as she understood the decision to operate had been made following discussion with the doctor's colleagues. The nurse she shared her concerns with made an appointment for patient 354 to see her GP.

Patient 354's GP referred her to Paterson for a second opinion. He examined her and her scans and told her, "You clearly have a big mass on your right breast that's actually on the chest wall and may well be going into your lung." He also told her that he was concerned there was something on her left breast, and proposed a CT scan. While patient 354 was horrified, she was reassured that Paterson was arranging the scan she had previously asked for. She had the scan, which confirmed cancer in the right breast, for which she would need a mastectomy and reconstruction, followed by chemotherapy and radiotherapy. Patient 354 told us she had a cleavage sparing mastectomy.

A few weeks later, patient 354's wound burst open. Because the reconstruction surgeon was unavailable, she saw Paterson who advised removal of the "spacer" that had been inserted to help keep the shape of her breast prior to reconstruction. Paterson carried out the surgery, and patient 354 had no further problems. She returned for reconstruction with the original reconstruction surgeon a few months later, which she had as an NHS patient. Patient 354 was recalled by Spire and is happy with her treatment by Paterson. She told us, "Both of them, the plastic surgeon and Mr Paterson were absolutely marvellous. They were very kind. They explained everything fully. They explained what they were going to do. They gave me a full list of the risks, both of them."

Patient 55

Patient 55 saw her GP with bleeding from her breast. Patient 55 had private medical insurance and her GP referred her to Paterson at Parkway Hospital, on the basis that he had a good reputation. After tests, Paterson told her that there was a possibility that the bleeding "could be something a little bit more sinister, and that the best option was to have surgery and to have the nodules in my right breast removed". Patient 55 had the surgery and at the follow-up appointment a few weeks later Paterson told her there was nothing wrong. Paterson recalled her for a mammogram, but patient 55 called to say she thought there was no point, so did not proceed with it.

Spire recalled patient 55. Spire told her that Paterson gave her incorrect information at her consultation, and "skewed my decision making in having the surgery". He presented the facts as if there was no choice other than to have surgery, whereas she was not given all the facts and may not have needed the surgery. Patient 55 felt let down by Paterson, and it has affected her trust in the medical profession. She told us, "I felt really, really, really let down by him."

Patient 244

Patient 244 is deceased. Her daughter gave evidence to the Inquiry on her behalf. Patient 244 found a lump in her breast and was referred by her GP to Solihull Hospital as an NHS patient. She was seen by Paterson who, after tests, told her she had cancer in both breasts. He recommended a double mastectomy, which she had a few months later. After the operation,

patient 244 was left with large lumps under each arm, which Paterson explained away as “just fatty tissue”. Patient 244 “felt butchered” and was “always really concerned” that it was breast tissue and asked about the lumps every time she had a check-up.

After about a year, the hospital called patient 244 and told her that because she had a double mastectomy, “the chances of her having any breast tissue left were quite slim”. They advised her that she did not need to be seen at recall. Patient 244 died a few years later of lung cancer. She thought her lung cancer was because breast tissue had been left behind, but this was never confirmed.

Patient 362

Patient 362 was referred as an NHS patient to Solihull Hospital by her GP. She had had a tumour removed from her breast 20 years previously.

Paterson referred patient 362 for an ultrasound scan as neither he, nor his “assistant”, could locate the lump with a needle. The scan and subsequent biopsy identified that she had cancer. Patient 362 said that Paterson talked mainly to her friend who had accompanied her to her appointment and she assumed he thought her friend was her carer. Paterson confirmed that she needed a mastectomy.

Paterson encouraged patient 362 to go on a holiday she had already booked and operated on her return. Following surgery, Paterson told her that everything was fine, but he had left some breast tissue as “women like a bit of a cleavage” and said many women “don’t feel like a woman following breast removal”.

Soon after her operation, patient 362 was recalled by the hospital, but at the time assumed it was a routine follow-up appointment. She was told at the appointment that there were concerns about the breast tissue that had been left after her operation and was advised to have it removed, which she did. Patient 362 had an appointment to review her case and was shocked to read in the notes that she had a life expectancy of five years.

Patient 362 feels that Paterson saved her life and stated that he was a “brilliant surgeon”. She said he was not on his own when he operated and that others must have been aware about cleavage sparing mastectomies but did nothing.

Patient 345

Patient 345 told us that her daughter was diagnosed with breast cancer and was treated as an NHS patient at Solihull Hospital. She was told by a colleague of Paterson’s that her cancer was inoperable, and her only treatment option was palliative care. Later, Paterson took over her care and arranged for her to have a mastectomy, which gave her parents hope. Sadly, the cancer spread to her brain and she died not long after the operation.

Patient 345 had herself been treated for breast cancer by Paterson as an NHS patient at Solihull Hospital in the early 2000s. She had a lump in her breast which Paterson removed. This was followed by a biopsy, which showed patient 345 had an aggressive form of cancer. Paterson advised her to have a mastectomy, which she did. Patient 345 was recalled by the hospital. She was told that she had had a cleavage sparing mastectomy and was given the choice of further surgery to remove the remaining breast tissue or regular monitoring. Patient 345 opted to have regular monitoring.

Patient 345 spoke of her shock at what Paterson had done. She told us, "Oh, I was shocked, I was shocked. I always thought, you know, he gave you the impression he knew what he was doing, and well, you know. But he was a bit, he gave me the impression that he was big-headed as well, really, he was bit, you know, 'I'm it', sort of thing."

Patient 500

Patient 500 found a lump in her breast and saw Paterson at Parkway Hospital as a private patient. He took some cells from her breast with a needle and arranged for her to have an ultrasound scan. The radiologist who did the scan couldn't find a lump but identified a "collection of breast tissues that were denser". They told patient 500 they suspected this was hormonal. Patient 500 returned for her results two days later and Paterson told her she had pre-cancerous cells. He said he could remove the lump, or she could wait and be monitored.

Two weeks later, Paterson was suspended from practising. Patient 500 was concerned about the lump in her breast and followed this up with Spire. She was told that there was nothing in her medical notes about pre-cancerous cells.

Patient 500 has found it hard to believe that Paterson could lie to her. She thought he was going to look after her and it was a massive shock to find out he had told her something that was not true. Patient 500 told us, "You go to a doctor and you believe them if they say that this is what you have got, because that is what their job is, that is what they do. So for somebody to do that, it makes you question everything really."

Patient 360

Patient 360 saw her GP with breast pain. Her GP referred her to Solihull Hospital where she saw Paterson as an NHS patient. Paterson took biopsies of her breasts. He told her the pain was caused by cysts. Paterson operated twice on patient 360.

Patient 360 told us she thought Paterson was "kind, polite and interested in me as a person, or seemed to be. I could not fault him". However, in contrast to her experience of Paterson, she had concerns about one of the other doctors. While the other doctor was taking a biopsy, the needle slipped repeatedly and caused bruising to her breast.

Patient 313

Patient 313 was referred to Paterson at Solihull Hospital as an NHS patient by her GP after experiencing problems with her breast. Paterson arranged for her to have a mammogram and a biopsy of her breast. He told her she had cancer and offered her the option of doing nothing, having a partial mastectomy or having her entire breast removed. Patient 313 wanted her entire breast removing but Paterson persuaded her to have a partial mastectomy.

Two weeks after her surgery, Paterson told patient 313 that the cancer had spread and that she needed to have her entire breast removed. She was cross that her initial wish for full mastectomy was ignored and that she had to have a second operation. Patient 313 had chemotherapy and radiotherapy following her surgery.

Prior to her surgery, patient 313 had heard "whisperings" about Paterson's practices, and visited her GP looking for assurance about her forthcoming treatment. Her GP spoke highly of Paterson and suggested that everybody would soon be doing cleavage sparing mastectomies.

Patient 313 was recalled by the hospital. She found out that some breast tissue was left behind after her mastectomy. She had decided against having further surgery to remove this.

Patient 313 feels that the whole experience has had an impact on both her and her family. She told us, “Well, you know, mentally it scars you a bit. It really doesn’t do you a lot of good.”

Patient 333

Patient 333 found a lump in her breast and saw her GP, who referred her to the breast clinic at Solihull Hospital as an NHS patient. She saw a nurse at the clinic, who arranged a series of tests. Patient 333 returned for her results two weeks later, and was seen by Paterson who told her she had cancer and that she would need a full mastectomy, rather than the cleavage sparing one.

Patient 333 spent the next fortnight having checks before her surgery, including a scan, which showed that she had clear lymph nodes. When she was admitted to hospital for surgery, Paterson explained that, despite the scan showing the lymph nodes were clear, he proposed to also remove and check some nodes for cancer. He did this, and found that all of them were affected, so removed the lymph nodes. Patient 333 told us that this stopped the cancer from spreading and feels that it saved her life. Her surgery was followed by chemotherapy and radiotherapy.

Paterson asked whether patient 333 wanted a breast reconstruction and she decided that she did not. Patient 333 asked whether she could have a mastectomy on the other breast and Paterson told her there was no clinical reason and he could not be seen to remove healthy tissue. She has since found out that this could have been possible.

Patient 333 was recalled by the hospital shortly after her treatment. At her recall appointment, patient 333 was told that her treatment had been correct and that she had had a complete mastectomy. She told us, “I was extremely fortunate. I had a good experience, and hopefully, as far as anybody can tell, a cure.”

Patient 150

Patient 150 had a routine mammogram. This picked up a problem with her breast and patient 150 had a biopsy at an NHS hospital. She was told she had breast cancer and that she would need surgery. Patient 150 had private health insurance and chose to see Paterson privately at Little Aston Hospital, as he had been recommended by friends. Paterson operated to remove a small tumour from patient 150’s breast and he also removed some lymph nodes. At her follow-up appointment, Paterson told patient 150 that she needed to have a further operation to remove more breast tissue. Following this operation, Paterson told patient 150 she was clear of cancer. At her next follow-up appointment, she was told that Paterson no longer worked at the hospital, so she saw a different consultant. She had regular mammograms which showed there were no problems.

Spire recalled patient 150, but as she was seen by a consultant who had seen her as a patient, she did not consider him to be independent. Patient 150 does not feel she has had an adequate explanation from Spire about whether her treatment was appropriate, and whether she needed the second operation. She told us, “I hope it will never happen again but if it does they need to stand up and tell the patients what is going on because they did not tell me anything.”

The experiences of patients summarised in this chapter have been presented here without comment or interpretation. The evidence they shared with us has been analysed and informed the findings and recommendations presented in this report. Alongside this, it has been important to acknowledge and hear what has happened to patients and the impact that this has had on them and their families.

CHAPTER FOUR – Safety and quality of care

Patients expect healthcare professionals to provide care which is safe and of a good quality. They also expect hospitals to have systems in place to support patient safety. The Inquiry heard that this was not the case with Paterson – in the independent sector or in the NHS. In chapter three, we recorded patients' experience of the care they received in their own words. This has shown in graphic detail that most of them did not receive safe or good quality care.

In this chapter, we examine these failings and consider whether improvements have been made since Paterson was suspended by HEFT in 2011. We do this under three headings:

- Care that people received. This sets out the clinical care provided by Paterson, including procedures which were not safe or necessary. It also considers his inappropriate behaviour towards patients and their relatives, and the care given by other professionals.
- Paterson breaking the rules of wider patient care. This section shows how Paterson ignored or broke rules in the hospitals which were in place at the time. This includes the way he undermined effective multidisciplinary team meetings and failed to gain patient consent.
- Checks and balances at the hospitals. This covers the checks which were in place in hospitals in the NHS and independent sector which, if they had been applied correctly, should have stopped Paterson from providing the poor clinical care. It does not consider checks within the wider health system; these are covered in chapter six – working with others to keep patients safe.

Care that people received

Two hundred and eleven former patients of Paterson, or their relatives, shared their experiences with the Inquiry. Significant as these numbers are, they are a small proportion of the patients Paterson treated. We have been told that Paterson saw 6,617 patients between 1997 and 2011 at Spire hospitals, of whom 4,077 underwent a surgical procedure – 2,399 of these were breast surgery. The total number of patients treated by Paterson for breast symptoms during his tenure at HEFT between 1998 and 2011 was 4,424. During the same period at HEFT, Paterson performed mastectomies on 1,207 patients.

More than 130 patients, or relatives of patients, gave evidence that included specific references to poor quality of care from Paterson, both at HEFT and Spire hospitals. We refer in this report to evidence of patients, even if it was given by relatives.

Spire supplied us with a report prepared in 2016 from the findings of a programme of medical records reviews and recall consultations of Paterson's patients, undertaken to support the GMC's investigation into his practice. Spire reviewed the medical records of 337 patients. It contains shocking examples of Paterson's treatment, including procedures on minors where other tests revealed no abnormalities. The report also refers to other healthcare professionals, who did not question Paterson's clinical practice.

Around a third of patients spoke to us about incomplete breast surgery, and another third spoke to us about unnecessary treatment, including surgery and scans. We also heard evidence that Paterson’s behaviour was, at times, inappropriate and unprofessional.

Other healthcare professionals were also responsible for experiences of poor care, and we set out what we were told by patients about them.

Patients reporting appropriate treatment

Although the majority of patients who gave evidence told us about poor quality and unsafe care by Paterson, some did tell us about positive experiences they had, and appropriate care they believed they had received. A consultant breast surgeon, who provided expert opinion for compensation claims and reviewed around 150 patient records, estimated that around one per cent of the cases he reviewed indicated their care was appropriate:

“ I mean, I think there were some patients that came with cancers that he sent for chemotherapy first, that probably was the right decision. So yes, there were some. And there were patients who there was no case, you know, you have to say there was no case, he did everything right. But they were very few and far between. But it might be less than 1%. It might be that kind of order of the notes I saw. ”

[N379, consultant who reviewed some patients who pursued legal claims]

In chapter five, we set out the experiences of those patients who had their cases reviewed through patient recall. We heard from around 10 per cent of patients that they were informed during recall that they had received appropriate care, including full mastectomies where they were required:

“ When your treatment was reviewed the panel noted that you had a standard complete left mastectomy in 2000 and as a result your operation conformed to the correct procedure that all the breast surgeons would have performed. ”

[Extract from letter from consultant to patient 368, treated at HEFT]

Even for patients who had received appropriate care, many described the emotional impact that this experience has had on their lives, with several describing themselves as having had a “lucky escape” and losing trust in the health system. Patient 263 told us that although she was told that her treatment had been correct, she requested further monitoring for her own assurance:

“ [I said] ‘I’m really scared, you know?’ ‘I would rather be monitored for a while, you know?’ And he said, ‘Okay.’ And I said, ‘How do you know Mr Paterson would have taken everything away?’ And he said, ‘Well, he would have. Well, he would have, or should have.’ And I said, ‘Yeah, but you don’t know. You can’t give me a guarantee, can you?’ I said, ‘Absolutely you can’t. No, I want to be monitored, please.’ So he agreed to monitor for a further five years. ”

[Patient 263 treated at HEFT]

Other patients we heard from have chosen not to have a review of their care and remain confident and trusting that the treatment they received was right:

“ I mean, the fact that I have only got one breast now, you know, is not very nice, but as far as I was concerned, my life was saved. ”

[Patient 368 treated at HEFT]

We also heard from some healthcare professionals who worked with Paterson that his practice was not always unsafe or poor quality:

“ He has got really great bedside manners, from what I heard, and he is a very good surgeon... And I thought Ian is actually a very good Vascular Surgeon, and most of his vascular colleagues will tell you he is really very good. He does things other people take so long to do. He will simply ... he is technically quite a gifted surgeon. ”

[N430, Clinical Manager at HEFT]

“ I mean I saw some of his patients, I think he cared about cosmesis, he did not like to have horrible scars and things. ”

[N463, healthcare professional who worked with Paterson at HEFT and at Spire hospitals]

It is important to acknowledge that the treatment provided by Paterson was variable, and some patients had positive experiences. It is possible that, had Paterson's practice been consistently unsafe and inappropriate, he would not have been able to harm other patients for such an extended period. However, these examples of appropriate treatment do nothing to reduce or remove the traumatic impact for those who experienced poor and unsafe care. Nor do these examples of good care convince the Inquiry that failures to stop Paterson's unsafe practice can be regarded as in any way acceptable.

Poor care given by Paterson

In some cases, the treatment Paterson provided was not accepted practice, including the so-called cleavage sparing mastectomy (CSM). Patients had incomplete mastectomies without realising it. Paterson also failed on some occasions to complete full diagnostic tests. In other cases, surgical treatments and diagnostic tests were entirely unnecessary, and performed without any clinical justification. We also heard accounts of patients having repeated surgeries and tests. In other cases, Paterson performed surgical procedures for which he was not qualified and was sometimes explicitly restricted from undertaking.

We heard from around one third of patients (primarily treated at HEFT and some at Spire hospitals) that Paterson performed CSMs on them. The Association of Breast Surgery told us this was not a recognised operation, and this was confirmed by the Inquiry's clinical panel:

“ I have never, we are not quite sure where the term ‘cleavage-sparing mastectomy’ came from. It evolved during the late noughties... It is not a technique any of us would recognise. And I think you could argue that a lot of things were not done very well back in the 50s maybe, but a mastectomy is a mastectomy and you are never going to take every cell away with a mastectomy... But we do not deliberately leave big wads of tissue and a mastectomy operation is different in ladies and men with different body shapes, so if you have got a lot of subcutaneous fat, the amount of tissue that is left behind would be more than if you are a thin lady, so obviously because otherwise you end up with a cavity there, so you will have a different thickness of the flap, depending on the body habitus of the individual. But you should not be leaving lumps of tissue. And I have had it described to me by colleagues, I have never been involved with cases, but you know the amount of tissue that people are describing are completely off the scale. ”

[N390, Mark Sibbering, Association of Breast Surgery]

We heard different accounts from patients about why Paterson performed CSMs:

“ So when I had my surgery Thursday morning, and when I woke up later on, he came to see me, and I said to him, ‘I’ve got tissue left.’ And he said, ‘Yes, that’s the way I do it.’ ”

[Patient 6 treated at HEFT]

“ Well, we did ask the question, because he said it was a cleavage-sparing, and we asked somebody, I can’t remember who we asked, I think it was one of the nurses, why that was. She said, ‘Oh, it’s so they can look normal when they’ve got their underwear on. It looks like a normal breast because you’ve got a cleavage.’ ”

[Relative of patient 109 treated at Spire hospitals]

Paterson told us that:

“ I always regarded the CSM adaptation as a more cosmetic alternative than a ‘standard’ flat chest wall procedure but still a complete removal of all glandular breast tissue. ”

[Paterson]

One of the healthcare professionals who had worked closely with Paterson, told us that he was very open about his preference for leaving tissue in place:

“ He would occasionally say to ladies things like, I will probably be able to leave you with a bit of cleavage and often in the MDM [multidisciplinary meeting] if the oncologist said you know have they had, you know if we were discussing surgical margins and they said you know have they had, is there any scope for further surgery? He would say I have removed all the breast tissue, what is left behind is fatty tissue and he would say that quite [often], and that was his mantra and that is what I believed. ”

[N400, healthcare professional who worked with Paterson at HEFT].

Around a dozen patients told us that Paterson had informed them that he would leave some tissue prior to the procedure:

“ He then told me that it was a very small tumour, but it was a grade four tumour and that I needed to have a mastectomy. Again, it was within a few weeks, I went straight back and I was given a mastectomy. He did explain, he came and explained exactly what he was going to do. He did tell me he was going to leave cleavage. ”

[Patient 316 treated at HEFT]

Around half of the patients who had CSMs did not find out that they had had this procedure until they were recalled by the hospital where they were treated. Some of these patients had undergone immediate breast reconstruction and were unaware that they had any remaining breast tissue. Others had noticed the remaining tissue at the time of treatment but had been reassured that this was “normal”, or had accepted that this was not a concern and did not challenge it:

“ He told me that he was going to take every single cell he could, but obviously you cannot get 100 per cent, but he would get as close to it as he could, and that is what I thought I had had. And then when I was called back...and there was doubt cast upon Mr Paterson’s practices and the cleavage sparing mastectomies, I was quite confident I had had a full mastectomy at that point, because that is what he had told me he was going to do... [And what was your conclusion (following recall...?)] It was incomplete. It was mostly complete on the right side, but on the left side, which was where I had the primary cancer, there was a good proportion of breast tissue remaining, which was obviously the more high risk area. ”

[Patient 273 treated at Spire hospitals]

We also heard from patients that they returned for further surgery after “insufficient margins” were achieved after the initial operation – that is, not enough of the tissue surrounding the cancer had been removed.

We heard from Kennedy, who reviewed the response to Paterson’s malpractice at HEFT. Kennedy said, “I think he carried out 42 more CSMs after being told not to do it.” Other witnesses discussed their concerns about the poor quality of this surgery and the risk to patients:

“ I think the evidence would point categorically to bad surgery...It wasn’t just a little bit of tissue, maybe, like a dog ear or something, there was actually large amounts of breast tissue left behind. To the extent that patients were having further surgery and essentially another mastectomy or they were having follow-up mammograms of what should have been no breast tissue. ”

[N431, healthcare professional who worked at HEFT]

Furthermore, a consultant breast surgeon who provided expert opinion about the treatment of some of Paterson’s patients who pursued legal action, described how Paterson frequently sent patients for multiple procedures instead of dealing with multiple issues in a single operation:

“ In the case of Paterson both in the NHS and privately, he would regularly take out impalpable screening lesions, such as micro calcification, using localisation techniques but never ensured radiological assessment (by specimen radiology) that the lesion was removed and often ignored calcification elsewhere on the mammograms and thus procedures were done by multiple repeated operations. ”

[N379, consultant who reviewed some patients who pursued legal claims]

Around a dozen patients gave evidence of incomplete testing. Most of them told us that they did not have a biopsy – a requirement of the triple assessment before surgery. Linked to this, some patients told us that Paterson’s preference was “to be safe” and to go ahead with surgery, despite inadequate evidence that it was required:

“ I had a mammogram and I had an ultrasound. And as a result of that it was recommended that I have the lump removed. I don’t know whether it’s relevant, but I will say it, I have subsequently been told I should [have] had a biopsy at that point, but I didn’t. And in fact, I can quote Mr Paterson at this point. His actual words to me when I explained to him about my concern about the lump was, “No woman should live with a breast lump. We will remove it. ”

[Patient 154 treated at Spire hospitals]

A consultant breast surgeon who reviewed former patients of Paterson when they were recalled to Spire, also confirmed that Paterson was not following guidelines on triple assessments:

“ [Did you come across any other practice he was doing where he was doing something that was out of standard practice in terms of what insurers could have or should have seen or picked up?] Yes, not doing a triple assessment firstly. I think the number of scans and images people were having, his follow-up rates, they are seeing back and so on, frequently, even the benign conditions. So there was a lot of things that should have been picked up. ”

[N478, healthcare professional who reviewed Paterson's patient at Spire hospitals]

In some cases, Paterson was undertaking surgery which was completely unnecessary. We heard evidence from over a fifth of patients treated in Spire hospitals about this, and approximately a dozen more treated at HEFT.

Some patients gave evidence that Paterson operated on them when they were known to be at risk of infection:

“ and then they found the MRSA, and so they said, “Oh, well we cannot do your operation,” and he said, “Oh, nonsense, nonsense, we can do that.” [So Spire had told you they could not?] Yeah, the Spire nurses said, “He cannot do it.”... And then he rang me... and said they were going ahead, that it was fine. ”

[Patient 29 treated at Spire hospitals]

In another case, when patient 67's GP learned of her private medical insurance, she was referred to Paterson as a private patient because of continence problems. Paterson decided to carry out a colonoscopy, and followed it by colonoscopies every three months for a year. After the last operation, the patient was seen by her GP, who referred her back to Spire:

“ I had gone to my GP and told him I wanted to see Paterson. He wrote and I got an appointment at the Spire Little Aston. When we entered the consulting room a consultant introduced himself... He told me I did not need any investigations or colonoscopy and that a colonoscopy was more dangerous than any problem with my bowel. He was quite short with me and discharged me back into the care of my GP. I felt I had been dismissed. ”

[Patient 67 treated at Spire hospitals]

Many of the patients treated at Spire hospitals were given a cancer diagnosis and Paterson performed mastectomies, frequently cleavage-sparing. They were later informed, often when they were recalled by Spire, that their surgery had been unnecessary:

“ I went home, called up Spire Parkway, and they booked me an appointment. When I got there I was introduced to Mr Paterson. I had a mammogram and a scan, came back to the room, waited outside. [A nurse] came and took the results from me. She went inside. About 20 minutes later called me back in, and I could tell that there was something wrong from when I'd seen him before I went for the test. And he just said that, “It's breast cancer. It's sinister. It needs to come out urgently... ”

[Patient 15 treated at Spire hospitals]

The patient was later recalled by Spire:

“ And then I just got a letter saying that Mr Paterson's patients were being reviewed, and there would be an appointment to follow. ... and he [consultant breast surgeon] just said that, “We've reviewed your notes, and we're very sorry that you didn't have breast cancer. ”

[Patient 15 treated at Spire hospitals]

In another case:

“ I was called back by Spire. And then Spire told me in the interview that my operation was totally and utterly unnecessary, there was nothing wrong with me. I did not need it, there was no biopsy, he had just done the operation regardless. ”

[Patient 43 treated at Spire hospitals]

Around a dozen patients treated at HEFT told us that they had surgery at too early a stage to know whether it was required, including after insufficient testing:

“ [Can I just check... that you had had surgery that you needn't have had?] Yes, unnecessary surgery. I wasn't offered the wait and see option. ”

[Patient 294 treated at HEFT]

Around a dozen patients gave evidence relating to unnecessary scans, which would have increased their risk of exposure to radiation:

“ He said having six-monthly x-rays and ultrasounds, there was absolutely no need for those, whatsoever. And the results of the x-rays and ultrasounds, I have got the information there, and it very clearly says, you know, there is nothing found, you know, it is very clear. ”

[Patient 32 treated at Spire hospitals]

A consultant breast surgeon who was involved with reviewing patients recalled by Spire, described evidence of Paterson performing unnecessary positron emission tomography (PET) scans, which exposed patients to radiation and also gave Paterson opportunity to undertake other unnecessary procedures, such as the removal of lymph nodes:

“ [Can I just check I have got this right? So he set up PET CT scans as a regular screening technique for around 135 patients which was outwith usual practice at the time.] Completely, yeah. [As a result of that he then extended his scope of practice to do other things?] I think he would have said that he could do thyroid surgery but the numbers that he was doing. ... So if you have a sore throat you would get a lymph node, this would be picked up on a PET scan, so he started taking out lymph nodes on groins. He would then re-image them and see them. He took out several areas of breast tissue that were inflammatory or, reaction to previous surgery. [And were those procedures necessary in your experience of ones you reviewed?] In quite a number of them, no. ”

[N478, healthcare professional who reviewed Paterson's patient at Spire hospitals]

Some of the patients who had unnecessary scans commented about the alleged financial incentives which they believed caused Paterson to say they were required:

“ So MRI scans, PET, you name it, I have had every scan under the sun multiple times, because at the end of the day he was raking in, Spire were raking in that money. ”

[Patient 69 treated at Spire hospitals]

Patients also told us of the impact on their health of the PET scans:

“ I had a PET scan while I had an open wound, and the drugs that I was on. I should have been given a drug to protect my bones, which I was never given. So for 18 months when I'm shuffling around saying my bones are hurting, he's saying, "You need another scan because it might have gone to your bones." Where really and truly it could have been simple with medication. ”

[Patient 15 treated at Spire hospitals]

Around a sixth of patients and relatives gave evidence that Paterson performed procedures other than breast surgery, mainly at Spire hospitals. These procedures included thyroidectomies, hernia repairs and anal stretches:

“ And another thing is that when I had my haemorrhoids taken – anyway, it was in that area – when he saw me afterwards he said that “Your anal opening was very small so I’ve stretched it”. Now, he did not say before or whatever – not that I have ever noticed that he did stretch it – but that is what he said and that was on my things for the insurance people. ”

[Patient 34 treated at Spire hospitals]

One healthcare professional we heard from also referred to Paterson performing procedures other than breast surgery, both at HEFT and at Spire hospitals.

“ I had an incident brought to my attention where he was operating on a patient; he was doing a thyroid operation. Which he shouldn’t have been doing anyway ‘cause it wasn’t something he was trained to do or did in the NHS. So he was doing a thyroid operation, on a lady. When she came to hospital she’d fallen on the way down to the hospital and hurt her arm. Now there’s all kinds of issues, but anyway, he decides he still has to do the operation, he can take her to theatre. But she’s x-rayed on the way to theatre and in fact she’d got a broken arm. So, he goes ahead with the thyroid operation whilst she’s under anaesthetic he asked one of the orthopaedic surgeons if they’d have a look at her. And, not surprisingly, none of them would get involved because of consent, so this woman is actually anaesthetised. So, he ended up I think putting what’s called a back-slab plaster on it to stabilise it and then got somebody to subsequently treat it the next day. Theatre staff felt this was really out of order and reported it to the managing director I think they’re called. And, interestingly, she then asked Ian to come explain himself to her. This is where he comes in. He came in like a bull and really aggressive, threatening to sue her, “Don’t you dare,” absolutely intimidating her. She was relatively new in the job and I think at the end it was enough to make her back off. ”

[N431, healthcare professional who worked at HEFT]

In some cases, patients were later informed, as part of clinical recall, that their non-breast-related procedures were unnecessary:

“ I had not got a hernia. I had a large lymph node. And then the ligation, the tying off of that vein, I should never have done because if you have got lymphatic problem, lymphedema, you should not have any veins treated because it is contra-indicated. And what that has done is compromised my whole lymphatic system on the top of my leg... He [consultant who reviewed Paterson’s patients in independent sector] said that I was seeing him...and then he explained why and he said, ‘Mr Paterson had been suspended.’ And that he had actually gone through my notes and in his opinion, I need not have had any of the surgery I have had. There is nothing wrong with me on either occasion. [So both the breast surgery.] And my leg surgery. I did not need them. ”

[Patient 110 treated at Spire hospitals]

Inappropriate behaviour by Paterson

Many patients told us about Paterson’s inappropriate and unprofessional behaviour.

While many of the patients we heard from described how they had found Paterson to be “reassuring” and “charming”, we heard that his behaviour would at times be unprofessional, manipulative and indecent:

“ I mean he was very charming, Mr Paterson, but the only thing that I did not like and I did mention to [husband] when I came out, we had just been on holiday and I was quite tanned and he said to me, “Well, who has worn an itsy bitsy bikini then? ”

[Patient 228 treated at Spire hospitals]

“ I remember going back to my GP and saying, ‘He told me I’ve got teenage breasts,’ and she said, ‘He should be careful what he says.’ I do not think we pursued that discussion. ”

[Patient 27 treated at Spire hospitals]

We also heard accounts of Paterson’s behaviour appearing uncaring, insensitive and aggressive:

“ Me mum was lying on the bed. Ian came in with a nurse and he put his hand on her chest, grabbed the stitch and yanked it out. She had no pain relief, nothing and her whole body literally nearly fell off the bed in shock and the nurse went... and walked out and he literally, when he grabbed her, held his hand there, grabbed the stitch. Honest to God me mum lifted off the bed practically and went with him as he yanked it out. ”

[Family member of patient 237 treated in the NHS]

“ He would have known that it was a lie to tell me the lump could burst and I could die. He says that is an absolute down and out lie. There is no way I would have died.” But maybe that is what Ian believed. I do not know. And how does he know? Unless somebody can 120% prove that nobody will ever die from one of these little lumps rupturing. So, yes, very charming, very nice, but how do I know he is really telling me the truth? I do not know. ”

[Patient 334 treated at Spire hospitals]

“ So I am already dressed ready for surgery and Mr Paterson comes along and sees you before you go down to surgery. And he comes into the room and he is standing there in his scrubs, and on the front of the scrubs is a big smiley face. So I was sitting there. I was thinking, “Well, this for me is no laughing matter.”... It was also disrespectful to me, but also is that the standard that is expected of a senior consultant?... And then suddenly Mr Paterson bursts through the doors, stands in front of me and he is waving his hands up and down to say, “Look, I’ve changed my outfit,” and I just thought that was a really bizarre thing to do. So obviously something triggered a panic in him in some way that what he had done previously was totally inappropriate. ”

[Patient 82 treated at Spire hospitals]

Paterson denied that he behaved inappropriately or insensitively to patients, saying that no patients had ever raised this with him or as far as he was aware, lodged a complaint of this nature.

Some patients gave evidence that Paterson had been absent from providing treatment, or was speeding through procedures because he was going away on holiday; which may indicate that there were issues around continuity of care:

“ So, straight to the hospital I went, Solihull. I seen some doctor, abrupt as well he was, I don’t know who he was. He said, “Well, I’m sorry you’ll have to come back in two weeks because he’s in Greece at the moment on holiday” that’s the words he said. So, I had to wait till after Christmas. ”

[Patient 162 treated at HEFT].

We heard from both patients and healthcare professionals who worked with Paterson that he often treated colleagues with disdain and disrespect:

“ So we did day case lists of general surgery together. And essentially he would do things like, he would sometimes be late, because he was often doing private practice first thing in the morning. And then he would berate me for not having started the list by myself. Really inappropriate for [a junior doctor]. And there was one particular time, this happened every single time, and there was one particular one, where he said something had happened to one of the machines at the private hospital, he needed to go back, and therefore I just needed to do the list by myself. Which clearly is really inappropriate, nobody in the same building, let alone in the theatre, and I just said, “I really cannot do that.” But he forced me to do at least one operation on that morning. And I did tell the other consultant about that, and as far as I know he did not raise it any further. ”

[N488 healthcare professional who worked with Paterson at HEFT]

“ He lacked empathy or emotion, I believe he looked at any sign of illness or emotion as a weakness. So, my uncle died and I went to the funeral and it just happened to be on the Thursday which is breast clinic, you do not take time off on a Thursday unless you are on holiday. So, the next time we went to MDT he said in front of the whole team, ‘No close family members died today then?’ ”

[N403 healthcare professional who worked with Paterson at HEFT]

Paterson denied that he treated colleagues with disdain and disrespect and said that no one ever raised such matters with him personally.

Later in this chapter we look at how Paterson’s behaviour impacted on the effectiveness of MDT meetings, and ultimately on patient care. We also discuss these issues in more detail in chapter seven, and consider how Paterson’s behaviour affected, and was affected by, the culture in the hospitals where he worked.

Care given by other healthcare professionals

Paterson did not work in isolation. He was part of a team of healthcare professionals from different disciplines. Patients expect all healthcare professionals to work together, and to provide safe, consistent and joined-up care. In chapter seven, we look at how other healthcare professionals responded to the poor care provided by Paterson. In this section, we examine what we heard about some of the clinical care provided by others.

Around a tenth of patients spoke positively about nursing staff or doctors involved in their care. Many of these comments described the personality or character of the medical professionals, rather than specific comments about the quality of treatment provided:

“ And [a consultant who worked with Paterson] was a lovely man. ”

[Patient 292 treated at HEFT]

“ [So, was she always happy with the treatment she had had with [a consultant who worked with Paterson]] Oh, yes. He was like a second father to her... he was amazing... If he went away on holiday he would come back 8.00pm perhaps and phone her up to see if there had been any problems while he had been away... He was a marvellous man. ”

[Relative of patient 246 treated at Spire hospitals]

Around 15 per cent of patients raised concerns about care and treatment they received from other healthcare professionals. Some patients talked about a lack of sympathy and inadequate consideration of their needs. They commented on poor communication and behaviour, and some also reported inappropriate comments made by staff:

“ She [doctor who worked with Paterson] didn’t want anything to do with me whatsoever. I rung her, on the number I was given, she screamed at me, ‘Where have you got my number from?’ I said, ‘Well, the nurse gave it me.’ ‘No one should give you my number.’ She went absolutely ballistic at me, and she said, ‘I can’t see you now.’ She said, ‘I’m busy.’ ”

[Patient 250 treated at HEFT]

“ He [doctor who worked with Paterson] was quite abrupt actually. There was no sympathy. He was just, ‘This is what’s going to happen. You’re going to lose your hair. You’re going to get ulcers in your mouth. If you get pregnant, you’ll have to have an abortion.’ To someone that couldn’t have kids, you know? And that was it. ”

[Patient 140 treated at Spire hospitals]

A small number of patients described situations where healthcare professionals had failed to provide appropriate treatments or had carried out unnecessary procedures.

We heard from a small number of patients and some other witnesses that other surgeons working locally were leaving breast tissue following mastectomies.

“ but then obviously we had this lady.....who was worried that she had got this residual tissue on the chest wall... When she came in, she saw the independent reviewer... who determined in his clinical letter, and backed it up with radiology, that she had had a cleavage sparing mastectomy.”... “We had another patient actually... She offered to us over the telephone that she had had the cleavage procedure done by another surgeon by the name of [doctor who worked in the NHS], who had worked similarly. ”

[N5, non-clinical staff working with Paterson at Spire hospitals]

One witness who provided expert opinion in patient litigation, told us that similar practices were taking place in Manchester at the time Paterson trained.

“ And he was the person who said, ‘Oh, if you leave a bit of breast on, the woman likes it better.’ So that’s where Paterson got it from and there is a track record that that was a common thing around Manchester, it was commoner than you might imagine. ”

[N379, consultant who reviewed some patients who pursued legal claims]

We heard numerous concerns, from both patients and other witnesses, about the care provided by the breast care nurse with whom Paterson worked in the private sector and the plastic surgeon with whom he worked very regularly in both the NHS and Spire.

“ [Nurse who worked with Paterson] was going around putting adverts in schools saying, ‘Come to this clinic.’ That was outrageous. They’re meant to argue with the surgeon if he’s doing the wrong thing and they’re meant to know the guidelines just as well as the surgeon so they can do. Whereas [Nurse who worked with Paterson] would frequently describe marching the patient down to see [doctor who worked with Paterson] to ensure she gets chemotherapy, and some of these patients didn’t need chemotherapy”...“And then for the sake of getting money in, she [doctor who worked with Paterson] would often have the patient irradiated because they’d had DIEP and she’d have a radiation because the patient who needed radiation arguably didn’t need immediate reconstruction and should have been told, ‘No, you need proper treatment first.’ And then she’d put a nipple reconstruction on. Now you can’t reconstruct. You have no bloody supply after radiation, you don’t have a great one for a long time you’d need to leave it six months. She’d be doing it a few weeks after the radiation. So she [doctor who worked with Paterson] really cut corners as well and that became more apparent towards the end. ”

[N379, consultant who reviewed some patients who pursued legal claims]

Emergency care

Some patients told us that they experienced problems when they required emergency care and had to be transferred from an independent hospital that did not have this facility to the NHS.

“ Something went really, really wrong. She [plastic surgeon] took a flap of skin, apparently, with a vein that runs through it, or an artery, and during the process of preparing my wife for this reconstruction it died. And my wife ended up having to be taken by ambulance, in an emergency ambulance, from Little Aston to New Cross Hospital in Wolverhampton... ”

[Relative of patient 37 treated at Spire hospitals]

“ They had got an ambulance on standby to take me to the QE to go on life support because they did not think I would be recovering because of lying ... I was in theatre for 13 plus hours and because I had been lying on my back, I think it was, for so long, all my organs would have started to have, not fail, but not work properly. ”

[Patient 174 treated at Spire hospitals]

Spire, BMI Healthcare LTD (BMI), Nuffield Health (Nuffield), HCA Healthcare UK (HCA) and Ramsay Health Care UK (Ramsay) told us that they have arrangements in place with the NHS in relation to the emergency transfer of patients. They assured us that the decision to transfer would be made on a clinical, and not financial, basis. We did, however, hear from BMI and Nuffield that some NHS trusts were reluctant to sign formal agreements for the emergency transfer of patients to them. Private providers told us that they monitor such transfers closely:

“ So, all of the hospitals have one responsible person in terms of activity in terms of outcomes, in terms of complications, in terms of transfers out into the NHS and each of those incidents will be looked at locally. And if there are any concerns, will get escalated upwards. ”

[N417 Nuffield]

Paterson breaking the rules of wider patient care

There are many features of patient care which extend beyond clinical treatment. These include effective MDT team meetings, where patients are discussed by a range of healthcare professionals; patient consent, which allows patients to be informed and involved in choices about their care; and good record keeping, to ensure continuity of care for patients. These features of wider patient care are all vital to ensure that patients are kept safe and that care is of a good quality.

In this section, we explore how Paterson was dishonest and broke the rules of wider patient care at HEFT and at Spire, and in doing so, betrayed his patients' trust and harmed them. If the safety nets in the system had worked, this would have been more difficult. We also consider how the hospitals failed to make the rules clear, or did not effectively enforce the rules of wider patient care.

Paterson did not always explain to his patients that he would leave breast tissue behind during a mastectomy, or when he did so he failed to make the risks inherent in his practice clear. If he did discuss a CSM with them, he told patients any tissue left behind would be fatty tissue. Patients were unable to give true consent in these circumstances.

We heard accounts of Paterson lying in medical records, thus potentially misleading other healthcare professionals. Paterson did not follow guidance on MDT team working and was therefore not open to challenge about patient care. If his patients had received the correct

information about waiting times in the NHS, they may not have been so quick to agree to be treated by him in the independent sector. These are all failings which we explore in this section. We also describe how the hospitals where he practised contributed to these failings.

We heard evidence that Paterson was not alone in breaking the rules. Others – for example, the hospitals and the regulators – were aware of his malpractice and allowed it to continue, as well as breaking the rules themselves. This is discussed further in this chapter and in chapter six.

Information to patients including consent

Department of Health guidance (Guidance to Consent for Examination or Treatment, 2009), which applies to both the NHS and independent sector, advises that “clinical procedures are explained to patients so that they understand the implications of the treatment and any options available to them, allowing them to give valid consent or refusal (including discharging themselves against medical advice), which is documented in the patient’s health record.”

Patients expect their healthcare professionals to be truthful when they set out their options for treatment and associated risks. They put their trust in them and Paterson betrayed that trust. He lied to his patients about their options and therefore removed the first opportunity for the patients to question what he was doing, and for this to be recorded in their notes.

Some patients reported that they felt the initial consultation with Paterson was so rushed there was no opportunity to ask questions.

In some cases, patients reported that they were told they had cancer immediately as they came into the consulting room:

“ So, I went and I spoke to Mr Paterson, and the conversation went ... I hadn’t put my bum on the seat, and the conversation went, ‘Well, it is cancer, you know?’, and I sat down. ”

[Patient 295].

“ And then I had to see Mr Paterson the following week. And as soon as I went in to see him, I had only just sat down and straight away he says, ‘Well, it’s malignant.’ ”

[Patient 263]

One patient reported that she was given inaccurate information about the drug tamoxifen, which had influenced her decision to consent to the treatment proposed:

“ [They’d scanned me previously and they were saying that they were just cysts. But I just kept getting the pain with it. But, as I say, Mr Paterson then put me on the Tamoxifen. But it was through that what my husband said that they took me for that scan. Reluctantly but he did that. We went for the scan and it came back that I had got cancer in the left breast, grade II cancer in the left breast. So, he did a lumpectomy on the 14th of March, something like that, wasn’t it, in 2006? ”

[Patient 250]

Around a third of patients treated in the NHS told us that they did not provide consent to their treatment. We heard that in some cases, consent was obtained only shortly before the procedure and sometimes by someone other than Paterson, most commonly a junior doctor. We heard from more than 10 patients that they consented to a full mastectomy rather than to the cleavage sparing one they were given:

“ [Did he mention whether there was any choice in the mastectomy? Whether it was a full mastectomy or whether it was the cleavage-sparing?] No, he didn’t. He just said mastectomy, and I just have to just give you a little input. I’d already gone through a mastectomy myself and reconstruction with another surgeon, so I was already familiar with a lot of what was going on with my mum. So no, he didn’t offer any choices. He just said this is what we’re going to do, and obviously my mum being of the age that she is, and the trauma of it all, just accepted what he said. ”

[Relative of patient 351 treated at HEFT]

In more than five cases, patients explicitly asked for a full mastectomy rather than a CSM, but Paterson refused and carried out the procedure he intended to:

“ Well, I saw Dr Paterson. He came to talk to me while I was in the hospital and went through what we was going to go through. And I even asked him there and then. And I said, “If like to have them ... If I can’t have them both off, I want at least all of this one off.” And he said, “No,” he still can’t do it. “You’ve got to have that ...” Because his policy is that he leaves that on. And I said to him, “Well, I always thought that they take it off. All of it.” And he says, “No, not necessarily.” And I said to him there and then, “Well, I would prefer to have it off.” And he said, “No.” And then when I came, of course, it was ... after he had seen me after the surgery and that, he said I had it all off ... No, I didn’t have it all off. I only had half of it off. He just left me like that. And I was really upset. And I said, “Well I really wanted it all off. ”

[Patient 300 treated at HEFT]

One healthcare professional told us that patients did receive an explanation of CSM before some of them had it, and around 10 patients confirmed that they felt they had consented to the procedure they received. However, even when patients were given an explanation of CSM, the risks, benefits and differences were not fully explained to them. Paterson failed also to make it clear that it was not a recognised procedure.

We heard evidence from around 30 patients treated at Spire hospitals related to unnecessary surgery. Many of those patients were given a cancer diagnosis and had some form of mastectomy. They were later informed, as part of the recall process, that their surgery had been unnecessary:

“ I got the letter from Spire inviting me to an appointment to see a consultant who worked for Spire but was independent of the original procedures, it was only that when we went to see him, and he sat me down and said to me that my first operation was completely unnecessary, it was only at that point that I felt like somebody had hit me over the head with a brick. ”

[Patient 159 treated at Spire hospitals]

We heard about the importance of consent and the part it plays in patient care and safety, from many witnesses. The Independent Healthcare Providers Network (IHPN), the representative body for almost all independent sector healthcare providers, said that it was fundamental to the delivery of safe patient care. The Professional Records Standards Body (PRSB), which defines the standards needed for good care records, told us that a standard on consent and shared decision making was needed.

Around a quarter of witnesses told us that Paterson did not properly obtain consent from patients in the independent sector. A consultant breast surgeon who reviewed patients as part of the Spire recall, told us that in some cases an anaesthetist got consent for procedures from Paterson's patients and the risks involved were not explained to them:

“ When you looked at his consent, it was so inappropriate. There were issues where people were being consented by the anaesthetist. So no risks or anything put on there, totally against standard policy, standard practice. There was also his operative note which was fairly brief. ”

[N478, healthcare professional who reviewed Paterson's patient at Spire hospitals]

Medical records and notes

It is important that a patient's medical record contains an accurate and full description of their treatment and options. As part of the annual check of performance, hospitals must declare their level of compliance with a number of standards. It would have been the responsibility of the registered manager to implement this check and it would have been inspected by the Care Quality Commission (CQC) or its predecessor.

We have already heard that in most cases the medical record did not contain an accurate confirmation that the patient had consented to the treatment they received. The records were also lacking in other ways.

While we heard that the quality and completeness of patient notes was better in the NHS than in the independent sector, Paterson's notes were generally of poor quality and contained insufficient detail to allow the reader to determine what procedure had been undertaken, particularly if it had been a CSM:

“ And then all the medical records came through and I was really shocked because there were not any medical records. There were just blank pages. There were just dates of when he had seen me. [So the medical records did not reflect the consultations you had had?] There was no information on there at all. There was just dates. He had not made any notes. They were blank pages. ”

[Patient 144 treated at Spire hospitals as an NHS patient]

Some patients gave evidence that Paterson had lied in the letters he sent to GPs about them:

“ And then he showed me this letter that had been sent to the doctor which was, basically, a lie, because it said that I had been very concerned about this lump and that I wanted it out, and it was like it read as though it was my decision, I had forced him to take ... I said, “That is a complete and utter lie. ”

[Patient 32 treated at Spire hospitals]

We also heard from other witnesses that Paterson lied in patient letters and notes:

“ I think the one thing we haven't really talked about is the fact that Paterson blatantly lied and misrepresented the results of radiology and pathology. And in fact, you only needed to read one of Paterson's notes to tell he was lying about the results. ”

[N380, consultant who reviewed some patients who pursued legal claims]

We heard too that Paterson's notes were only available to his breast care nurse:

“ He would have a set of notes, where he would see the patient, he would write down what he has seen, he would write down his operative notes if he did an operation, he would file my radiology report in, he would file the pathology report in. I would have no idea what the notes said. And the only person who would have had access to the notes, would be his breast care nurse, who was in the room with him. ”

[N463, healthcare professional who worked with Paterson at HEFT and at Spire hospitals]

However, one patient told us that Paterson shared scan results with her. This is the only example we received of such transparency and was not reflected in the experiences of other patients in their evidence:

“ Mr Paterson always gave me this vast brown paper envelope with my scans inside. And I used to say why am I getting this? And he said well it is your property, you know if you want to take it anywhere, if you want a second opinion you have to have them. Which seems quite transparent to me. [Yes. So he was effectively sharing your diagnostic imaging with you.] Yeah. And his phrase was you know if you want to go somewhere for a second opinion, then you take those with you and you do not have to have the procedures re done as it were. ”

[Patient 218 treated at Spire hospitals]

Around a dozen patients told us that some or all their notes were missing. A witness who worked with Paterson at Spire informed us she had been instructed to destroy a substantial number of patient notes:

“ [Nurse who worked with Paterson] came into the office in a right tizzy first thing one morning, and unlocked a cabinet and asked me [if] I would destroy every set of notes that was in there, take all the insides out and put them in a clinical waste, confidential waste bag, but keep the folders that they were in, and the folders were just like a cardboard folder, but it did have the patient’s name on and a number. But she asked me to take everything out of the insides, tear it up and put it in this sack, which I am ashamed to say I did, but now I just think, you know, somebody of my experience should never have probably done that, even though she was my first line manager up there, if you like. I just did it. [Can I just ask? How many folders do you feel that, you know, that were destroyed?] That I probably got rid of? [Approximately?] It could have been between 20 and 50. There were quite a lot. I know it took me quite a long time. ”

[N492, former hospital staff working with Paterson at Spire hospitals]

This instruction by an employee of Spire to a temporary member of staff was contrary to all guidance and regulation in place at the time.

HEFT, Spire, HCA, Nuffield, Ramsey and BMI told us they were moving towards an electronic patient record. Spire, HCA, Ramsay and BMI told us that the position had improved since Paterson practised, with consultants’ notes now recorded as part of the inpatient record. Nuffield told us that they were moving to a system where consultant notes would be part of the inpatient record and were appointing a Medical Notes Guardian to lead this. The independent sector providers told us that checks are now undertaken which examine the quality and accuracy of the medical record. We were told also that a consultant would be stopped from practising if there was sustained poor record keeping.

Referrals to the independent sector and waiting times

The speed of being seen in the independent sector was a key factor for patients in deciding where they should be treated, especially given their perception of long waiting times in the NHS and if they had private medical insurance to cover the cost of treatment.

NHS cancer waiting times figures, setting out the percentage of patients seen within the targets, are available on the NHS England website and are approximately two months in arrears. The figures do not inform an individual patient how long they may wait.

Paterson had a financial incentive to treat patients in the private sector rather than the NHS. In many cases, Paterson exaggerated the length of waiting times in the NHS, playing on people's fears when they were particularly vulnerable since they had just received their diagnosis. There was a lack of independent information available to patients to allow them to make an informed decision:

“ And I went into his office with him and I says to him, I was on my own, “I need a reconstruction” I said, “I need it now, as quick as possible, because I cannot live like this” and he looked at me and he said, “Well, you’re going to have to go on a three year waiting list. If you go and get me £10,000 I will do you next week”. ”

[Patient 162 treated at HEFT].

“ And then he ummed and ahned, and said, ‘Well it is going to probably be about six to eight weeks on the NHS, is there any way that you could fund private?’ And I just thought ‘Yes’ you know, I wanted to know if the lymph nodes were involved... So I paid to come in the following week, and I did not check whether it would be six or eight weeks on the NHS. I still do not know today whether it would have been. ”

[Patient 273 treated at Spire hospitals]

Paterson denied that he exaggerated the length of NHS waiting times to patients.

In some cases, Paterson is alleged to have referred NHS patients to see him in the private sector. We heard that Paterson was also proactive in asking patients if they had private medical insurance, indicating that they could have quicker treatment as a private patient. This was contrary to Department of Health guidance at the time:

“ I mean, one of the first things he said to me was did I have private medical cover. And my husband said, “Oh, no.” And he said, “Oh, that is a shame, you know, because of the waiting times. ”

[Patient 9 treated HEFT]

“ He asked if I had private insurance. I said ‘yes’. He said, ‘I can see you in 10 days at Spire Parkway’. ”

[Patient 125 treated at Spire hospitals]

However, one patient told us they were informed that it did not matter if they had private medical insurance, because they would see the same person either in the NHS or privately:

“ I saw Ian Paterson probably about a week later. When I explained that I did have private health insurance, they said, “Well, it doesn’t really matter if you go NHS or private because you will see the same person. You will see Ian Paterson, and he is one of the best surgeons in the country to deal with breast cancer. ”

[Patient 188 treated at Spire hospitals]

Many patients were referred to Paterson specifically by their GP, both in the NHS and independent sector. Their GP’s personal recommendation built their trust in Paterson in advance of meeting him. We heard that Paterson built a strong local reputation which appeared to influence referral behaviour. We also heard that he would provide local GPs with hospitality, such as tickets for rugby matches.

The Competition and Markets Authority looked at this issue in 2014, and its resulting Investigation Order states that the following low-value services provided to a referring healthcare professional by a private hospital operator are permitted: “general corporate hospitality, to the extent that it is proportionate and reasonable and is not provided by a private hospital operator with the intention of inducing, or may reasonably be regarded as inducing, a referring clinician to make referrals, or of rewarding them for having made referrals.”

The recent report by the Centre for Health and the Public Interest (CHPI) – Pounds for Patients (June 2019) notes that “it appears that Spire’s corporate hospitality for referring clinicians is much more lavish than other private hospital companies...For example, it provided 10 of its referring consultants with tickets to the England v France Rugby match in February 2017 at a cost of £1226 per person”. It appears that Paterson may have copied this behaviour locally, since many patients were referred to Paterson by their GP as the “go to” person for breast surgery – both in the NHS and private sector. Some of these patients told us that as a result they no longer have the same trust in their GP.

“ I discovered a problem, went to my GP. She said that I needed to be seen, and I elected at that point to be seen privately. She described Ian Paterson as the GP’s surgeon of choice. ”

[Patient 5 treated at Spire hospitals]

“ [The patient’s GP] spoke very highly of Ian Paterson, extremely highly, ie you know, ‘There is only one guy to go to, he has won awards’, or language around that to do with the work that he has done around breast cancer care and surgery. ”

[Patient 50 treated at Spire hospitals]

Several patients also spoke of Paterson being recommended by others, including family and friends:

“ [And did that locum GP recommend you go to Spire? To see Paterson?] Yes. Due to waiting times in the NHS locally. ”

[Patient 272 treated at Spire hospitals]

Checks and balances in the hospitals

The final area we examine in this chapter is the action taken by the hospitals where Paterson practised. We heard claims that it is difficult to prevent someone who is determined to break the rules. However, hospitals should ensure that it is very difficult for them to do so. Patients have a right to expect that hospitals will do everything to keep them safe. This was not the case with Paterson in either the NHS or the independent sector, since the hospitals broke the trust the patients had placed in them. There was manipulation of the system and this facilitated Paterson’s malpractice.

In this section, we describe how the hospitals did not look closely at the procedures Paterson was performing to make sure that he was fit to practise them. We also look at how the appraisal system failed to pick up concerns about him, and how the monitoring then in place did not pick up any problems. In addition to the failure of the individual hospitals, there was a failure of both the independent sector and the NHS to communicate fully with each other.

Other organisations in the healthcare system have their own parts to play in keeping patients safe, and we return to this in chapter six. The actions of other individuals – including health professionals who worked alongside Paterson – is covered in chapter seven.

Appraisal

Another opportunity to pick up, discuss and address issues of consultant performance, arises when they have their annual appraisal. Appraisal is unlikely to identify poor practice on its own and is not intended to do so. Although we heard from health professionals that appraisal has not had a major impact on changing behaviour, it increases the chances of doing so when it is used alongside other measures; for example, monitoring a consultant’s scope of practice and award of practising privileges, discussed in a later section.

We heard of evidence of poor practice of appraisal in both sectors and in the sharing of any NHS appraisal with the independent sector. Again, if concerns about Paterson had been raised and recorded during his appraisal, there would have been a possibility that these may have been investigated further and addressed. The appraisal processes for Paterson did not pick up his poor practice. It should have been part of a package of measures.

There were policies and guidance in place, but these were not implemented. Advance Letter (MD) 5/01, issued by the Department of Health on 5 April 2001, stated, “The appraisal process will not of itself result in the generation of significant amounts of new evidence or information, rather it will capture the information that already exists. What goes into the folder will, for the most part, be available from clinical governance activity, the job planning process and other existing sources. One result of the appraisal process will be to identify areas where there are gaps to be filled, or where perhaps data needs to be better collated or presented. This is likely to be more apparent in the early years after appraisal is launched.”

Witnesses from both the NHS and independent sector expressed a view that appraisal was not a tool that should be used to identify or address issues that should be acted on immediately.

A Spire hospital manager told us:

“ I did not depend on just an appraisal once a year to be told of any issues – I would have expected any trust that I dealt with, and for some reason it did not happen with HEFT but did for all the other trusts, to get in contact if there were issues to be raised, contemporaneously, as opposed to at the end of the year. So, I would not expect to just find an appraisal with any issues on. I would have expected to be told about it before. ”

[N448, hospital manager at Spire]

Two legal firms who represented patients, Irwin Mitchell and Access Legal, told us they had seen evidence of poor practice relating to Paterson’s appraisal. This view was also expressed by a consultant breast surgeon who reviewed Paterson’s practice as part of action for compensation, who said that there was “false assurance that there was appraisal going on”, and a Spire hospital manager (N448) said:

“ Can I show you the one-liners that I used to get from the Clinical Director at HEFT? So, I had letters every year to say that he [Paterson] had had a satisfactory appraisal. ”

[N448, hospital manager at Spire]

Four representatives from the independent sector claimed they would suspend practising privileges (described in a later section) in the absence of an up-to-date appraisal.

We heard from around a dozen witnesses that generally the appraisal process had improved in recent years and was more robust than when Paterson was practising. Spire and UHB both state that they now have robust appraisal systems in place, with Spire appearing to have invested much in this area. However, some healthcare professionals who currently practise at Spire hospitals mentioned that poor practice in relation to appraisal continued, with two referring to it as a “tick box exercise”.

There is still doubt about whether “good”, properly implemented appraisal would have been enough to stop Paterson on its own. In addition, we heard criticism from some witnesses of a consultant’s ability, even now, to pick his or her appraiser. There may be a perverse incentive in being appraised by a colleague where there is financial interest. Spire told us that they no longer allow this to happen.

We heard from witnesses that the area where there was the greatest need for further improvement was in sharing information between and across the NHS and independent sector to support appraisal. The GMC said:

“ Most doctors who practice in the independent sector practice also in the NHS. And when they are being appraised, when they are being revalidated, those conversations, that feedback, should be informed by the totality of their practice. Both in the NHS and the independent sector. I think when doctors are working in different settings, there is a mixed picture in terms of the degree to which all of that information is brought into place as part of that appraisal process. Now it is for the designated bodies to share that information and then for the Responsible Officers to make judgments about revalidation on the back of that information. But, we think Responsible Officers do not have enough of that information sometimes to make that judgment, which is one of the reasons why we have called for a statutory power, statutory duty, for that information shared so that Responsible Officers can make that judgment. In terms of practising privileges, clearly one of the issues in terms of Ian Paterson, was the fact that he was performing colonoscopies in the independent sector and that was outside his scope of practice in the NHS. We think there is a question for particularly independent providers, in terms of ensuring that they understand the degree to which a doctor’s practice in the independent sector may be differing from the NHS, and we are not convinced that that is as consistently applied as it should be. ”

[N338 Charlie Massey, Chief Executive, GMC]

The issue of sharing information and concerns is explored in further detail in chapter six.

Revalidation

Revalidation places legal duties on healthcare organisations and individual professionals to provide additional assurance that doctors are fit to practise. Every five years, the responsible officer for a doctor makes a recommendation about their revalidation to the GMC. The role and responsibilities of responsible officers is considered in more detail in chapter six.

Most patients were not aware of or did not mention revalidation, possibly because it was not in place when Paterson was practising. Consequently, we heard limited evidence from patients on this subject.

The view of the Inquiry’s clinical panel was that revalidation does not add anything to appraisal. Often, it is a “paper exercise” where the responsible officer offers limited challenge. In the Panel’s view, poor quality of care would not easily be identified through revalidation.

However, we heard from several witnesses that appraisals were taken more seriously as a result of revalidation. NHS England felt that revalidation had led to improved information sharing between organisations:

“ I think in the five or six years since revalidation has got underway, my observation would be the links between the private sector and the NHS sector have got closer because the responsible officers who are responsible for those both areas come together. They discuss cases together, so it would not be unusual in responsible office networks – a typical case that would be discussed would be one which involved private sector and NHS. So working out the interface of that I think has been a real developmental opportunity over the last five years that people have focussed on and I suspect you might have the evidence for this, that as a consequence of that and the revalidation there is more information exchanged between the private sector and the NHS, because there is a better way of doing it and there is a structure on which to do it. ”

[N423 NHS England]

Monitoring by the hospitals

There may be many checks and balances in place, but if they are not monitored, their effectiveness is greatly reduced. We consider how monitoring took place across the system between organisations including hospitals, in chapter six. In this section, we look at the monitoring which took place within hospitals – both in the NHS and the independent sector.

Numerous regulations, national and local initiatives, policies and best practice guidelines have been introduced in recent years. However, these are not all mandated across private healthcare. We heard from the IHPN that Getting it Right First Time (GIRFT) – an initiative in the NHS which aims to reduce unwarranted variations between hospitals – is now expanding into the independent sector. We also heard that the World Health Organization surgical safety checklist, intended to decrease errors and adverse events, and increase teamwork and communication in surgery, had been adopted by some private hospitals.

Patients told us that they thought consultants were being monitored by both the NHS and independent sector providers. We heard that this did not take place in any meaningful way in either sector, but that this was particularly the case in the independent sector where Paterson continued to do operations the hospital director had told him to stop, carried out operations he did not perform in the NHS, and did unnecessary procedures. We heard that the hospital monitoring data in the independent sector did not show Paterson as being out of the ordinary. A Spire hospital manager told us:

“ I would note that – prior to the recall Spire conducted due to concerns about the general appropriateness of the cleavage sparing mastectomy treatment – Mr Paterson’s patients did not appear to be outside of any clinical indicators which were or are collected contemporaneously (such as infection rates, returns to theatre, number of complaints etc). Although appraisals are clearly more robust, and software systems such as Datix have been introduced (in 2012), which make recording and tracking indicators easier, nobody raised any issues about Mr Paterson until January 2008, and no indicators that were available at the time suggested a problem. ”

[N448, hospital manager at Spire]

From what we know about Paterson’s practice, it is unlikely that his patients would be outside clinical indicators, given that many were not ill.

Whilst monitoring will play a role in identifying when things are going wrong within an organisation or with an individual consultant, it may not give the full picture; staff raising concerns and their concerns being dealt with also plays a part. This is explored in chapter five.

CQC told us that, although not perfect, monitoring in the NHS is generally more robust than in the independent sector. They highlighted measuring patient outcomes as a cause for concern due to uncertainty over who is responsible for doing so – the hospital or the consultants:

“ the other real concern we have about independent providers is measuring outcomes, which again we found a lot of uncertainty about whose responsibility it was to measure outcomes. And we take a view, across NHS and independent healthcare, that every service should be measuring its outcomes, but I think some independent healthcare providers told us, ‘Well, that’s the doctor’s job, not ours. So if you want to know the outcomes, ask the doctors.’ Of course, you know, we hold the providers to account, and so we have not been willing to accept that. And I think there is a real necessity for independent healthcare to get its act in order around measuring and reporting on outcomes for its procedures. The NHS is ahead of the game. NHS is not perfect in that regard, but it is ahead of the game on this, and I think there’s real worry that the independent healthcare, if you like, are lagging behind. ”

[N342 Ted Baker, Chief Inspector of Hospitals, CQC]

This was reinforced by the Royal College of Surgeons who told us that they are concerned by the lack of robust clinical governance procedures in some independent hospitals.

Spire, BMI, HCA, Nuffield and Ramsay told us that monitoring has significantly improved since Paterson practised. They described systems now in place to ensure that issues are identified and addressed, through the use of local clinical audit and by recognising the importance of “soft intelligence”. A hospital manager at Spire told us:

“ So, it changed, as I explained, over time, so the kind of clinical indicators that have been collected for many years will include things such as return to theatres, transfers out (if a patient needed to be transferred out because they had a complication that the hospital could not deal with), surgical site infections, complaints. So, those were the main indicators that would have been collected over many years. They are collected through Datix now, which is obviously much better. Collected at an individual consultant level by the matron through things that were reported, and the collection of data has definitely improved. And the ability of people to track trends has improved significantly over the years. ”

[N448, hospital manager at Spire]

Several witnesses told us about the Medical Practitioners Assurance Framework which was being developed by IHPN and others, and which aims to introduce consistent standards for clinical governance. The IHPN has shared a draft of the framework with us, and our view is that, while it is welcome, much of it appears to be voluntary and is currently untested.

Approximately a quarter of the witnesses mentioned coding as an issue. Paterson frequently coded a procedure as cancer when it was not:

“ What Paterson used to do is he would tell, this is where he falsified information, because I had problems with my shoulder that were unrelated to breast cancer. He said, ‘Oh, we’ll put it down as potentially related to your breast cancer, no questions asked then.’ So he would put a different code down then, so it was breast cancer code, anything related to breast cancer code it used to get fast-tracked through BUPA and there was no questions, everything was paid for. ”

[Patient 69 treated in Spire hospitals]

Paterson denied that he miscoded procedures in this way.

We heard that miscoding procedures generally could not and did not happen now, due to changes in how codes are checked. Insurers and private providers have told us that there is an increased appetite to challenge consultants if they spot or are told about concerns by others. This is covered in further detail in chapter five.

Multidisciplinary teams

The multidisciplinary team (MDT) is a group of professionals from one or more clinical disciplines who make decisions together regarding recommended treatment for individual patients. MDTs may specialise in certain conditions, such as cancer.

The MDT should have provided another opportunity for Paterson to be challenged about his malpractice and for it to be stopped. Indeed, it would have been the individual professional’s duty to do this under their code of conduct. However, this did not happen, for different reasons, in both HEFT and Spire Parkway.

The Inquiry’s clinical panel told us that MDTs become increasingly unwieldy when all patients are discussed in detail and are a “burden” on resources. We understand NHS England is currently considering policy and guidance on MDTs.

Independent sector

When Paterson was practising, guidance was in place which said that the treatment of breast cancer patients in the independent sector should be considered at an MDT meeting. Just under half of the witnesses who mentioned MDTs told us that no meaningful MDTs took place at Spire Parkway at the time Paterson practised there. We heard that generally Paterson was the sole decision maker about patients’ care and when MDT meetings did take place, they were usually only attended by him and his breast care nurse, and that very often a pathologist or radiologist was not present. Paterson denied this and told us that MDT meetings were held each week, with input from oncologists, radiologists and pathologists.

Around a tenth of patients were aware of MDTs but did not know if they had taken place and, in some cases, presumed or were told they had:

“ My main point is that this ought to be made impossible. I know it still goes on, and it ought not to. It’s completely wrong, and private hospitals perhaps ought to be required by law to follow the NHS. You know when they have a group meeting for every patient to decide on the best treatment for them? [Yeah, MDT teams...] [So in your case, in terms of MDT team, you had seen [doctor who had worked with Mr Paterson], and he had referred you on to Mr Paterson, and Mr Paterson told you, you had this test that day, but from your point of view how many people were involved in that decision, what you should have?] Him. Just him. Just Paterson. ”

[Patient 107 treated in the Spire hospitals]

Just under half the witnesses who mentioned MDTs referred to private patients being discussed at NHS MDTs, often where the independent providers had an insufficient number of patients to form their own MDTs. In some instances, NHS hospitals were paid for this service. We heard some evidence that where private patients were discussed at an MDT, this was done at the end of the meeting and there was limited discussion. Four healthcare professionals thought there was no discussion of private patients at all in the NHS.

We heard that, at the time Paterson was practising, there was no requirement for the results of NHS MDTs to be communicated to the independent sector hospital. We also heard there was then no system to prevent a patient being sent for surgery in the independent sector without agreement of the proposed procedure at an MDT. Some of the independent sector providers told us that this has now changed, and there is a requirement for written authorisation before treatment. A consultant breast surgeon who provided expert opinion for many of the patient litigation cases, said:

“ The issue of MDTs in the private sector has been addressed, either by a SLA with the standard hospital MDT where they’re sent back or not very many hospitals have a private MDT, they always go back. So there is a disconnect because the private hospital’s in one place and you go into an MDT somewhere else. How much that gets sent backwards and forwards varies. Whether, in fact, the private sector checked the patient’s been through an MDT is also another matter. And remember they should go to an MDT now before they have any surgery because a pre-op diagnosis should go to an MDT to see whether they think they do need surgery. ..the problem is there isn’t a join up between the private and the NHS. ”

[N379, consultant who reviewed some patients who pursued legal claims]

We also heard differing views about the issue of whether patients had consented to, or had been told that, their case would be discussed at an MDT, particularly when this was in the NHS. Spire told us:

“ [And do you get the patient’s consent for discussion at the NHS MDT?] So, I think that we have based it on the fact that on the booking form we say that we may use that information with clinical governance activities, and I have considered that the MDT discussion is part of the clinical governance activity in their best interests. I hand on heart cannot tell you whether they are identified, you know, at the MDT or whether they are presented as, ‘case A.’ ”

[N438 JJ de Gorter, Chief Medical Officer Spire]

We also heard different views about whether insurers paid for healthcare professionals in the independent sector to attend MDTs.

The five independent sector providers who gave evidence to the Inquiry told us they had improved their MDT processes. Spire, BMI and Nuffield told us that evidence that a patient had been discussed at an MDT meeting was required for them to have surgery. Spire told us any concerns about the functioning of an MDT at their hospitals would be subject to investigation, and if the concerns related to a healthcare professional, that might result in an investigation of their performance, or the triggering of the whistleblowing policy. Spire has introduced a “virtual MDT” meeting across its hospitals, to help make sure that the right specialties are involved in discussion of a patient’s treatment.

NHS

Around a third of patients treated at HEFT gave us their views on MDTs. Around 20 patients reported that they knew that there was an MDT discussion about them. A few patients thought, or were told, that any decision about their treatment was solely the decision of Paterson; however, a similar number were told that it was a team decision. Some of those patients asked, if this was the case, why concerns had not been raised about Paterson’s practice by other members of the team:

“ [As a patient... did you get the feeling that there was a team involved in your care? And that that team were making the decisions?] Well, there was supposed to be a team. [Was that your experience?] Well, everything that you had was supposed to go back to a team discussion. That’s why you sort of think, ‘Well, how ... you know?’ Unless other people were involved, how can it have been ... How could things have happened anyway?’ But I have no idea. But, you know, which is different, I suppose, to the private people. Obviously things were missed on that, which I don’t understand why a lot of things happened on the NHS, if it was supposed to be all with a team. ”

[Patient 336 treated at HEFT]

We heard from witnesses that breast MDTs were introduced in the mid-1990s, and should include two consultants, a pathologist, oncologist, radiologist and the breast care nurses. About a third of the healthcare professionals who mentioned the MDT at HEFT described it as not functioning well. We were told that Paterson would dominate the discussion and sometimes “bully” staff when his patients were being discussed, or not engage at all if the discussion was about other healthcare professionals’ patients. There were difficulties between

Paterson and the oncologists over discussions about how much breast tissue had been left behind. Paterson's domineering behaviour in MDT meetings meant that his clinical decisions were not appropriately challenged:

“ And then I often noticed in the MDT that Paterson and the oncologists, it was, like, very acrimonious debates. The oncologists would say that they want this and then Paterson would say, 'No, it is not necessary.' Basically, it will be something to do with the margins. They will say the margin is inadequate and then the oncologists will say you have to go back and remove. And Paterson will say, 'I've removed, it's a mastectomy, I removed everything, I can't remove anything more.' At that point the oncologist, I haven't seen what the oncologists have seen. They had seen a big bulge of tissue because they had direct access and they were thinking that there is scope for more removal. ”

[N399, a healthcare professional who worked with Paterson at HEFT]

“ Between about 2002 and 2003 there were issues at the MDT, he was quite abrasive, quite demanding. We would say one thing and he would say, 'No, I disagree with that.' There were issues with regard to his selection of patients for immediate reconstruction. ”

[N442, a healthcare professional who worked with Paterson at HEFT]

In 2007, some of the healthcare professionals who were part of the MDT at HEFT wrote to Mark Goldman, the Chief Executive at the time, to raise concerns about Paterson's practice. HEFT responded by commissioning Dr Polson, a clinical director at the Trust, to look at, among other things, the interaction between Paterson and his colleagues, particularly on the MDT. Once Polson had delivered his report to HEFT, he was surprised not to hear of the outcome:

“ So I was disappointed not to hear more and I would have thought it would have been nice to have had some feedback but it would almost have been a nicety to tell me what happened and a politeness rather than an expectation that I would be told. [And to your knowledge beyond that group of people, your report, was the board ever involved?] I did not know. I never knew and never heard. I mean, obviously, from Sir Ian [Kennedy], like you will hear later on, that it did not get to board level quite as well as it should have done. And again, whether it should or should not have gone to board, I would have felt that the people I was giving the report to were senior managers on the board and I suppose I naively would have thought that if it needed to go to the board they would have taken it to the board, but I probably did not understand quite how the board is meant to function at that time. ”

[N449, Dr Rex Polson, Clinical Director at HEFT]

Following this, in January 2008, Ian Cunliffe, the Medical Director of HEFT from 2007 (acting Medical Director from 2006), took over the chairing of the MDT for six months. We heard that the operation of the MDT improved; afterwards, Cunliffe handed the chair to an external healthcare professional.

UHB told us that there is a greater use of technology now to track patients who have been discussed at an MDT, but we heard no evidence that outcomes following MDT decisions are monitored or discussed at the board level to provide assurance that the MDT decisions are appropriately delivered.

Practising privileges

Patients expect the doctor who treats them to be competent within the speciality applicable to their care. In addition to the checks made by the GMC, when patients are treated by a doctor in the independent sector, the consultant is awarded “practising privileges” to allow them to do this.

The operation and awarding of practising privileges is defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consultants are not usually employed by independent hospitals. Consequently, the circumstances in which an independent hospital may be vicariously liable for the actions of its consultants are complex and currently uncertain.

Practising privileges are based on the “scope of practice” – that is, the procedures a consultant is competent to perform in the independent sector are based on what they undertake in the NHS. There are some exceptions to this, for example, cosmetic surgery which is not usually available in the NHS, and there are separate requirements covering a consultant’s competence in these areas.

In Paterson’s case, as we have seen in an earlier section, he did not limit himself to operations he was competent to perform in the independent sector. He was undertaking operations and procedures he did not do in the NHS. Measures to monitor and limit this at Spire were inadequate.

We heard that, while it was primarily the responsibility of the consultant to present accurately their scope of practice to independent hospitals, there should be a check made by such hospitals with the relevant NHS trust employing the consultant to ensure it was right.

We heard that the introduction of the role of “responsible officers” has improved information sharing about consultants’ scope of practice between the independent sector and the NHS. This is discussed further in chapter six.

While the position had improved, some witnesses thought that there remained too little challenge, and that practising privileges are still awarded as a matter of course. The GMC described oversight of clinical governance by the board in both sectors as a “very mixed picture”:

“ Responsible Officer framework has been a game changer, Responsible Officers need to have the totality of information that enables them to make judgments about a doctor’s practice, which we do not believe is adequate at the moment. And, of course, the last piece in terms of the leadership and management is the question about the Board’s role in overseeing those clinical governance arrangements locally. And, again, I think there is a very mixed picture. Both in the independent sector and in the NHS about the degree to which Board has appropriate oversight, which is why we have said we think that very positive recommendation that might come out of this inquiry would be to create a much clearer responsibility at Board level for oversight of clinical governance. ”

[N338 Charlie Massey, Chief Executive, GMC]

If the consultant wishes to carry out a procedure in the private sector which is not provided in the NHS, we were told that in some cases they are asked to provide evidence of their ability to practise it, sometimes in the form of a log book. However, this does not appear to be applied universally:

“ So the log book, so we are meant and I do not think, well I know for a fact not everyone does, to just keep a list of all the operations we do. ”

[N405, healthcare professional working in the NHS]

More encouragingly, we heard that Aviva and Spire conducted their own assessment of the evidence base of new procedures before a consultant could carry them out on insured patients.

We heard evidence that monitoring of practising privileges after they had been awarded was patchy. Spire told us they were reviewing the coding of consultants’ procedures to ensure they did not exceed their scope.

One potential aid to monitoring, which was mentioned by several witnesses, was a single repository of information relating to each consultant, to include their scope of practice, location of practising privileges, designated body and other critical consultant performance data. Such a repository does not currently exist. We note that currently the GMC only collect information about consultants’ qualifications and training. The IHPN told us:

“ A significant challenge to the effective operation of the whole practice appraisal process and monitoring scope of practice is that no single dataset or repository of a consultant’s whole clinical practice exists, i.e. across the NHS and independent sector. Having such a dataset or repository would enable any healthcare provider, across the independent sector or the NHS (granted access by the consultant), to view that an appraisal has been completed and to see the supporting information on their practice that is required for effective governance oversight. The system could potentially also be developed so that an annual appraisal or revalidation cannot be signed off until each of the independent hospitals where a consultant works has inputted into it. For such a system to succeed, NHS and independent sector ROs [responsible officers] would need to make full use it and be held to account for doing so. ”

[David Hare, Chief Executive, IHPN]

Senior staff from the independent sector told us of occasions where practising privileges had been suspended in the absence of consultants supplying an up-to-date appraisal or details of indemnity. They also told us that they would “mirror” suspension of consultants in the NHS, if information was shared with them, but pointed out that this did not always happen. However, CQC said that suspension was applied inconsistently across the independent sector.

IHPN gave the following example of good practice at HCA:

“ There was a decision-making group to discuss any areas of concerning consultant’s practice and decisions around suspending or removing practising privileges. We saw that this information from this was fed back at a weekly incident discussion meeting. We saw that managers from the medicine services had used this in the past to voice concerns over a consultant’s poor practice and took this to the MAC which then used the decision-making group to suspend practising privileges. ”

[David Hare, Chief Executive, IHPN]

Cigna, a company providing private medical insurance, thought that independent sector providers should inform them if consultants’ practising privileges were suspended, so that they could act to cease pre-authorising treatment.

Concern was also expressed about how well some of the agencies that supply resident medical officers, who provide the medical cover in independent sector hospitals when consultants are away from the hospital or practising in the NHS, oversee their practice and share information between the NHS and independent sector.

One witness did not consider that the model of engagement of consultants was accurately represented on the private providers’ websites. We checked this throughout the Inquiry and found that in some cases hospitals are still referring to “our consultants”, giving an inaccurate impression that consultants are employed by the independent sector hospitals.

What we have learned

The care patients received from Paterson was not always safe or appropriate. The CSMs he performed were not acceptable clinical practice.

In many cases, patients had treatment that was not complete, or necessary, or which was harmful, and this led to long-term avoidable health issues and may have contributed to some deaths.

We also heard accounts of cases where Paterson performed surgeries and procedures which he was not qualified to do or was restricted from doing.

Paterson manipulated and lied to people. He broke the rules to facilitate his malpractice.

Paterson often failed to obtain consent from his patients, and then did not properly discuss their treatment with other healthcare professionals.

Checks and balances designed to ensure safety of care at the hospitals where Paterson practised were inadequate or were not followed, and this allowed him to continue with unsafe and unnecessary treatment which harmed patients.

Checks and balances which have been put in place since Paterson practised, and which may have detected his malpractice, are not universal or uniform across the NHS and independent sectors. It is our opinion that it remains possible for poor or unsafe practice to be undetected today.

CHAPTER FIVE – Responding when things go wrong

While errors of the magnitude of Paterson's malpractice and his offending should never happen, things do go wrong in clinical services. When this happens, the response should be swift, adequate and ensure that patients are safe. Patients should be at the heart of any response. The Inquiry heard that this was not the case in response to Paterson's malpractice.

In this chapter, we examine the response to Paterson's malpractice and consider whether things have improved in recent years. We look at five areas:

- Colleagues raising concerns. This sets out instances where healthcare professionals who worked with Paterson, raised concerns about him. We consider how these were handled by the hospitals where he worked and by others.
- Recall of patients. This section looks at what HEFT and Spire did to recall patients who had been treated by Paterson, to let them know if their treatment had been incorrect and unsafe, and to offer them further treatment, if necessary.
- Patient complaints. This examines what happened when patients and their relatives became aware of Paterson's malpractice and complained about the treatment they received from him.
- Compensation. This examines patients' experiences of making claims for compensation arising from Paterson's malpractice and the response of the hospitals involved, legal representatives and medical defence organisations.
- Private medical insurance. This sets out how companies who provide private medical insurance responded to patients when they became aware of Paterson's malpractice.

We look at the response of the wider healthcare system to Paterson in chapter six – working with others to keep patients safe.

Colleagues raising concerns

All healthcare professionals in the UK, including doctors and nurses, have a professional duty, as part of their codes of conduct, to raise concerns where they believe that patient safety or care is at risk.

Professionals raising concerns about a healthcare professional offer the opportunity to hospitals and others to examine the treatment and care patients receive, and to stop any which is poor or inadequate. We heard that this did not happen in a way that was thorough or adequate in the case of Paterson. There were differences in how concerns were raised by professionals in the NHS and the independent sector. However, the response when professionals did raise concerns was inadequate in both sectors.

Healthcare professionals in the NHS

Opportunities to stop Paterson practising as a result of concerns raised by healthcare professionals in the NHS were missed on a number of occasions. We heard that concerns about Paterson's practice led to his suspension by his previous employer, Good Hope Hospital, in the late 1990s prior to his appointment by HEFT in 1998.

The first concerns about Paterson were raised with HEFT in 2003 by an oncologist who worked alongside him. This oncologist was concerned that women were at increased risk of cancer recurring as a result of Paterson leaving tissue behind after surgery. HEFT responded by asking Mark Wake, a senior clinician at the Trust, to investigate. HEFT's response to his investigation report in 2004 was inadequate and they did not act on all the information in the report (source: Kennedy Review, 2013). Paterson continued to operate on patients at HEFT for a further seven years.

In spring 2007, concerns about Paterson's conduct and clinical practice were raised by a newly-appointed breast surgeon at HEFT and two oncologists who worked alongside him. In response, Cunliffe, the Medical Director, and Goldman, the Chief Executive, set up an investigation under disciplinary procedures. Rex Polson, a senior clinician at HEFT was asked to examine Paterson's conduct. Colm Hennessy, a breast surgeon from another trust, was asked to review Paterson's clinical performance, with a focus on incomplete mastectomies and referral for breast reconstruction.

In December 2007, six healthcare professionals who worked alongside Paterson were so worried about his clinical practice and patient safety, that they wrote to the Chief Executive of HEFT to raise their concerns.

In response to the concerns that were raised by healthcare professionals in 2007, and following the investigations by Wake and Hennessy, HEFT asked Paterson to stop doing CSMs and shaves after mastectomies (removing tissue left behind following a mastectomy). The Medical Director took over the chairmanship of the MDT team meetings for six months and one of the healthcare professionals who had raised a concern about Paterson was moved to a different part of the Trust (source: Kennedy Review 2013, and evidence from healthcare professionals and managers from HEFT).

Many who gave evidence to the Inquiry commented that HEFT investigated Paterson using HR processes, and this meant that he was guaranteed a duty of confidentiality which stood in the way of patient safety, so patients being treated by Paterson were unaware that there were concerns about the safety of his operations. We believe this approach to have been a mistake, given that patient safety should have been the paramount consideration. We understand that, where concerns about a doctor's practice arise, they can be managed by placing restrictions on what that doctor can or cannot do, or excluding them from practising altogether, pending the outcome of any investigation or HR process. In that way, "transparency" with patients would not be an issue since the option of treatment – or a particular treatment – by the doctor in question would not arise.

Some witnesses we spoke to who worked alongside Paterson shared this belief that he could and should have been suspended by HEFT earlier than he was.

“ I also remember having a conversation with Mark Goldman [Chief Executive of the Trust] on the phone. . . I was saying, you know, ‘Why don’t you see the argument for suspending him?’ What he said to me was they’d met with the Trust’s lawyers and they felt that to suspend him without evidence, this was the problem, this lack of evidence of actual harm might blow up in the Trust’s face and he might turn around and sue them if they didn’t find this evidence at a later date. And I kept saying, ‘No, no, you can suspend him.’ Clearly I thought you could suspend him without prejudice because issues of patient safety have been raised and your paramount duty is to protect patients, not him. I remember him saying particularly he was worried if he was suspended from the NHS the private sector would also suspend his practicing rights. He was making huge amounts of money in the private sector. He could then turn around and sue them for loss of earnings if he was subsequently found to be innocent or without blame. ”

[N431 healthcare professional who worked at HEFT]

“ I said, ‘Mark, you know one of the things you had said is if Ian does not consent his own patients you will probably suspend him.’ And Ian was not consenting his own patients. I said, ‘Here’s your evidence. Suspend him,’ but he did not. ”

[N430 clinical director who worked at HEFT]

Following concerns that were raised with HEFT in 2007, Paterson continued to operate on patients until he was finally suspended by HEFT four years later.

In 2008, Martin Lee, a breast surgeon from a different trust, was invited by HEFT to observe Paterson as he performed five operations, to check his surgical technique and to ensure he was not doing cleavage sparing mastectomies. Lee observed that, whilst he did not see Paterson do any CSMs, his surgery was very quick, and that he did not pay due attention to the sterility of the procedure. He also reported some uncertainty about the completeness of the procedures. Lee told us that he does not believe his report was acted on fully by HEFT:

“ Well what surprised me because I was asked in a different context, I was asked in the context of a discussion they had been having with the Regional Director of the West Midland Cancer Intelligence Unit about, you know, outcomes of his surgery and there was a new medical director at this point, I went and had a conversation with him and one of his colleagues. I also had a meeting with them when there was a clinical governance lead and a clinical director there and I did ask well actually what is being done since this report? I think it was around about 2010 or thereabouts, and what is surprising was that actually nothing much seemed to have been acted upon. ”

[N433, Martin Lee, breast surgeon in NHS]

All the concerns about Paterson seem to have been responded to by HEFT as if they were individual isolated incidents. Hence connections were not made, and this was to the detriment of patient safety.

We heard from four managers who had worked at HEFT that there was a history of those coming into management positions not being fully briefed that concerns had been raised about Paterson.

“ Even in 2007 this was, sort of, it had, sort of, been lost somehow from the corporate memory. [So even as incoming clinical lead for the breast clinic, no one had made you aware that there were concerns about his earlier practice?] Absolutely not, no, it was a closely guarded secret. ”

[N431 healthcare professional who worked at HEFT]

“ [And when you acquired that portfolio, were you briefed at all on the concerns regarding Ian Paterson?] I was not briefed by anyone above me in the structure. ”

[N451 non-clinical manager at HEFT]

“ I was told that there had been an issue, complaints made about Paterson’s practice in 2007. As it turns out there were earlier episodes as well, which I was not briefed about at the time. ”

[N452 associate medical director at HEFT]

“ So during the handover which is pretty brief with the previous chief executive, I was aware that there had been issues with a surgeon and I was also given the impression that things had quietened down and that there had been a process followed. It was not from day one something I became aware of as a current issue. ”

[N413, Mark Newbold, Chief Executive at HEFT from August 2010 to December 2014]

This lack of information about the sustained concerns about Paterson may have affected their ability to act appropriately to keep patients safe.

We heard that there was a personal cost to the healthcare professionals who raised concerns about Paterson, with many saying they experienced bullying or aggression as a result. They were not supported in raising concerns.

“ I know a number of consultants who have complained and then when the report has gone against them, they’ve been put on to a bullying charge and some of them have never worked again. Once you get on to a bullying charge in the NHS, it’s quite difficult to come back. I think there was an element of fear and that’s why the whistle-blower protection is so important. We do have it now but we did not have it then. People said to me, “You’re the one who’ll end up in trouble.” He’s a very well recognised breast surgeon, he can’t be doing...” you know? That sort of comment was said. ”

[N442 healthcare professional who worked alongside Paterson at HEFT]

“ At various times we had arguments publicly and privately. And sometimes I had made it very clear to Paterson; he was basically expecting me to talk, to be on his side and I said, ‘No, I will not be on your side. I will not be doing anything against you intentionally.’ ”

[N399 healthcare professional who worked alongside Paterson at HEFT]

“ Because the first thing was that Goldman [Chief Executive] brought Paterson into his office and literally just showed him the letter [from clinicians raising concerns about Paterson]. So I took him to MRI, which was closed at that time and there was a keypad lock and then another closable door and we went into this office and he berated me. And I said, ‘Look, Ian, I’m sorry, I do think you have a problem with mastectomies and we’re not happy that ...’ And he said, ‘You were siding with those ...’ ”

[N402 healthcare professional who worked alongside Paterson at HEFT and at Spire hospitals]

Four of the doctors who raised concerns with the Chief Executive in 2007 were themselves subject later to investigation by the GMC, in order to determine their fitness to practise, since they had worked alongside Paterson. While we understand that this was not as a direct result of them raising concerns about Paterson, there is a belief among some that becoming visible by raising concerns increased the likelihood of them coming under scrutiny and investigation. Some spoke of the personal impact of the GMC investigating their practice.

“ that [investigation by the GMC] was the most awful thing for us. We felt, ‘Look, we’ve stuck our head out here, we collected this data in our own time, we brought it to everyone’s attention’, and then they were saying that we weren’t fit to practice. However, consultants who never reported anything were clearly fine to continue practicing. ”

[N442 healthcare professional who worked alongside Paterson at HEFT]

“ So eventually they [GMC] sent me this horrible letter which I just literally went to pieces. I was kind of well I have, you know if there had been a bus to throw under I have got, to be absolutely honest I would have done. I just felt this, my world caved in that they were saying I had done, I, this was malpractice and I could be struck off and you know, literally it was horrible, horrible, horrible. ”

[N402 healthcare professional who worked alongside Paterson at HEFT and at Spire hospitals]

We observed that many of the healthcare professionals who had raised concerns about Paterson were genuinely fearful of the consequences of doing so. Some had been reluctant to give evidence to the Inquiry, and we believe that this was as a result of their negative experience of raising concerns. They did not want to draw attention to themselves again.

Around a dozen healthcare professionals who worked at HEFT at the same time as Paterson told us that they knew at the time that others had raised concerns or complained about him. This appears to have caused some of them to feel they did not need to act on their own misgivings, as others already had done so.

“ Looking back I should have [raised concerns], but I did not. But I genuinely thought that because other people had raised them, they were not going to listen to me. ”

[N403 healthcare professional who worked alongside Paterson at HEFT]

This theme of people thinking it is someone else’s responsibility to take action surfaced repeatedly in many areas of evidence to the Inquiry.

Others who worked with Paterson felt a strength in numbers and less isolated in raising concerns since they knew colleagues had done so. This prompted a group of healthcare professionals to write to HEFT’s Chief Executive in 2007 about Paterson.

HEFT’s response to these concerns appears to have improved following the appointment of Mark Newbold as Chief Executive in 2010. On taking up his post, he was not fully briefed about concerns regarding Paterson. There appears to have been a turning point in 2011, when Newbold realised that there were serious concerns about the safety of patients Paterson was treating:

“ Some little time into my time in the trust, and it was certainly within the first six months, two things happened really. One of the oncologists approached me in the car park at Solihull, he was one of the visiting oncologists who had originally raised concerns back in the early 2000s and I knew him from a previous, he worked elsewhere and I knew him and he said to me look there are some real issues with one of the surgeons and he told me who it was and he said that he, you know, had carried out an audit... and he did not really feel anything definitive had happened and it was something that I needed to look into and he would send me the audit... So I knew that there was that concern and then at a similar kind of a time, I mean I was just settling into a new trust with quite considerable problems and challenges, I used to see complainants and I became aware that there was a number of women, they were women at the time in the Solihull area who had been operated on by Mr Paterson and who had become aware of some concerns over the surgeon but had never been contacted about follow-up and I am a clinician by background so I knew from what they were telling me that they needed to be reviewed. ”

[N413, Mark Newbold, Chief Executive at HEFT from August 2010 to December 2014]

Newbold told us that he could not understand why Paterson had not been stopped from operating at HEFT, when concerns first began to be raised in the early 2000s. When he became aware of those concerns in 2011, Newbold acted decisively, suspending Paterson and instigating a full recall of all his patients (this is explored later in this chapter). He later asked Kennedy to review what had happened and to make recommendations to HEFT.

Raising concerns in the NHS today

Following the inquiry into Mid Staffordshire NHS Foundation Trust in 2013, every NHS trust must have a freedom to speak up guardians to give independent support and advice to staff who want to raise concerns.

We heard there was limited awareness of the role of freedom to speak up guardians. Some witnesses expressed a view that their introduction had improved people's ability to raise concerns. However, this positive perspective on freedom to speak up guardians came mainly from organisations who gave evidence to the Inquiry, rather than healthcare professionals or others currently working in the NHS:

“ [Do you get information about the Freedom to Speak Up Guardian?] I am not aware of that sorry. ”

[N400 healthcare professional who worked alongside Paterson at HEFT]

“ Someone told me about that recently and I had never heard of it before. ”

[N488, healthcare professional who worked alongside Paterson at HEFT]

Protection of whistleblowers was not in place when concerns were raised about Paterson in the NHS in 2003 and 2007. However, we observed a belief among healthcare professionals that those who raise concerns or whistleblow today could still be penalised in some way, despite this protection.

UHB told us that it took concerns from its staff seriously now and encouraged them to raise concerns. Staff are told about how to raise concerns when they join UHB. The mechanisms for them to do so are explained. These include doing so through their line manager or other managers, and the role of the Trust's freedom to speak up guardian is outlined. UHB spoke of its policy of open access to the Trust executives. UHB also said that attitudes to suspending healthcare professionals about whom there were concerns had changed significantly since Paterson practised.

“ 15 years ago... it was seen as a catastrophe if you were suspended, it was seen as you were pre-judged as now people are not pleased, but they accept that it is part of the process. ”

[Dr David Rosser, Chief Executive University Hospitals Birmingham since 2018]

From the demeanour of healthcare professionals who had been suspended, it was clear they did not regard this as a neutral act.

Healthcare professionals in the independent sector

Healthcare professionals who raised concerns about Paterson in the NHS did not do so at Spire.

Paterson's inadequate MDT at Spire, and the fact that he was the only breast surgeon operating at Spire Parkway for some time, may have contributed to his poor practice slipping under the radar and not being as apparent to others as it was in the NHS. However, a consultant who reviewed Paterson's patients when they were recalled by Spire told us that in his opinion Paterson's malpractice should have been noticed by others.

“ We were coming in and looking at these patients who had been managed completely inappropriately, and that should have been picked up by the team, not just from looking at Paterson's work but also looking at anaesthetists, radiologists, the amount of work going through pathology. ”

[N478 healthcare professional who reviewed Paterson's patient at Spire hospitals]

We heard views that there could be a financial disincentive to individual healthcare professionals raising concerns about another healthcare professional in the independent sector, where they would be working together to provide care to the same set of patients.

We were told that Paterson stopped using the services of a healthcare professional in the independent sector who had raised concerns about him in the NHS.

“ We did his private cases at that time. We are the consortium for [pathology] who worked at Parkway and he stopped sending the work to us from that point onwards...When we signed the letter [raising concerns about Paterson] to the Chief Exec... [Were there any wider implications of him not sending you private work?] Well, we would have lost income but ...So, we are a partnership, so we hire our pathology services out to Spire. Spire never saw any change in it, so it did not really matter to them who was doing the pathology but our consortium as a group lost income because of it. ”

[N361 healthcare professional who worked alongside Paterson at HEFT and at Spire hospitals]

A hospital director employed at Spire when Paterson was practising there told us that they could not understand why some of the healthcare professionals who had raised concerns at HEFT in 2007, and who worked alongside Paterson at Spire, did not tell them about their concerns until Paterson was suspended in 2011.

“ When I reflect on this, I just do not know why HEFT did not tell me, I do not know why some of the consultants who knew there were issues in HEFT did not tell me. [And were these consultants who also had practising privileges at the Spire?] Absolutely. ”

[N448 Hospital Director at Spire]

“ A meeting was held on 14 October 2011. ... Various issues were raised including some of the consultants present advising that concerns about CSMs had first been raised at the Trust in 2003 but no specific action had been taken. The consultants also talked about new issues such as patients having normal scans but letters to their GPs suggested serious abnormalities, patients having unnecessary surgery, much higher numbers of patients presenting for ultrasound scans and a label of “ADH” compared to the numbers being scanned in the NHS. A list of concerns was agreed, and I committed to discuss within Spire how best to investigate the allegations. I remember feeling shocked that none of those present had brought this to my attention to me previously so that something could have been done at an earlier stage. ”

[N448 Hospital Director at Spire]

One such healthcare professional told the Inquiry that they had assumed this information was being discussed with Spire by HEFT.

“ Well, the assumption was, and I think we were told that they had discussed everything with Spire. ”

[N402 healthcare professional who worked alongside Paterson at HEFT and at Spire hospitals]

We heard conflicting accounts of whether or not the income that Paterson brought into Spire influenced the response to concerns about his practice. Two local GPs who raised a concern about Paterson with Spire in 2008 claim they were told by the hospital manager in post at the time that he could not be suspended as he brought in too much income for Spire.

“ I said, ‘I really think you need to suspend him and check out what’s going on.’ He said, ‘Oh, I can’t do that. He’s bringing in too much money.’ ”

[N358 GP working in the Solihull area]

“ He suddenly said that he could not actually stop Mr Paterson’s privileges at Spire Parkway, yeah? And I’m sure amongst the discussions that we had, that he was the ... he generated the most, sort of, turnover for his organisation. He could just not overnight suspend him. ”

[N377 GP working in the Solihull area]

This was denied by the hospital manager.

Given the conflicting accounts of what happened, we have no way of establishing the facts of this claim. Spire maintain that it would be unacceptable to fail to suspend a healthcare professional because they generated a lot of income, and told us that hospital managers who suspend a doctor’s practice now are personally contacted and supported by the Chief Executive.

Spire hospital directors told us they were unaware of any central guidance from Spire about how hospital directors should deal with and respond to concerns when Paterson was practising there.

“ In my experience there wasn’t a standard process for dealing with “concerns”. I would have concerns raised with me and deal with them as I have explained in my statement depending on the nature of the concern. ”

[N448 Hospital Director at Spire]

“ [And when concerns were raised with you, were there set procedures or protocols for you to follow as a Hospital Director? Were you given any guidance at all?] Not really. ”

[N446 Hospital Director at Spire]

This was confirmed by Spire.

“ There would have been 39 different procedures in our 39 different hospitals. Some of them would have been probably very, very, or were very, very strong and others weren't adequate. So there was no one system. ”

[N438 Spire]

There were missed opportunities to stop Paterson practising at Spire, either because concerns about him were not raised, or because when they were raised, they were not acted on swiftly or adequately.

In common with the NHS, we heard that raising concerns in the independent sector was often associated with fear or intimidation.

“ I have first-hand experience that some of those colleagues of his who knew and could have told me but did not, because they were fearful of the repercussions from him. ”

[N448 Hospital Director at Spire]

“ So, he really gets, again, pretty aggressive, and I, having known him for maybe 15 years now, having worked with him now, and having referred patients, it was very unusual. ”

[N377 GP working in the Solihull area]

As with the NHS, we were told by some who worked in the independent sector that whistleblowing could have negative consequences, or that it was not an easy thing to do.

Raising concerns in the independent sector today

The five independent sector hospital providers who gave evidence to the Inquiry told us that they had freedom to speak up guardians in place, and two of these, including Spire, said that they had plans to ensure greater awareness of their role with staff and healthcare professionals who worked at their hospitals. In line with what we heard about the NHS, those who expressed confidence in freedom to speak up guardians making a difference in the independent sector were organisations, rather than healthcare professionals themselves.

We note that while the National Guardian's Office for Freedom to Speak Up has produced guidelines in August 2019 for training across healthcare, guidance for boards is focused solely on the NHS.

Spire told us that they had put measures in place to give better support to consultants and hospital staff to raise concerns. In addition to the freedom to speak up guardian at each hospital, they have introduced a whistleblowing hotline, HR support at every hospital and ambassadors at larger hospitals. How to raise concerns and the importance of openness was included in induction training for new staff. We also heard that Spire now has a central policy for managing concerns.

The improvements that Spire have made in this area were observed by the charity Action Against Medical Accidents (AvMA).

“ Spire last year reached out to us and said, “Will you come and do some training for us?” We are well known for our work on the duty of candour. So I ran a training course for them on duty of candour, which was very well received. One of the things that I noted about that was that there were a lot of frontline staff there and their passion for trying to get things right and for increasing their understanding of how to deal with people when things go wrong was very, very apparent to me. ”

[N220. Peter Walsh, Chief Executive, Action Against Medical Accidents]

Recall of patients

As details of Paterson’s malpractice became known, both HEFT and Spire recalled patients he had treated to let them know what had happened and to assess if their treatment had been correct.

The Inquiry heard from patients recalled in both the NHS and Spire that their experience of recall was generally inadequate, not patient-focused, and lacked both pastoral support and transparency. Patients felt themselves as a problem to be solved during the recalls.

Although there have been assurances from both the Trust and Spire that they have recalled all patients who needed to be, almost a third of patients who gave evidence to the Inquiry said they had never received communication about recall, or attended an appointment.

Despite many patients describing the emotional impact this experience had on them, there was little or no counselling support available for them at the time. We heard claims from Spire and HEFT that there was counselling support in place, but it was clearly not communicated nor visible to patients. Many continue to lack full reassurance or understanding about the treatment they received from Paterson. Furthermore, we heard from patients in both sectors that there has been no meaningful apology by providers for the experience that they had been through. This is not in line with the requirement for professionals and healthcare organisations to say sorry when things go wrong (Duty of Candour), nor does it follow the guidance from NHS Resolution on saying sorry, published in June 2017.

Other witnesses described the recalls as gradual, episodic, fragmented and lengthy, with slow decision making by the hospitals involved. There was no national guidance available to staff. Especially during the earlier stages of the recalls, the process was not independent from the staff or hospitals who provided the original treatment. There was poor join-up and communication across the sectors which allowed some patients to fall between the two. The focus of the recalls appears to have been protecting the reputation of the hospitals involved, rather than the needs of patients.

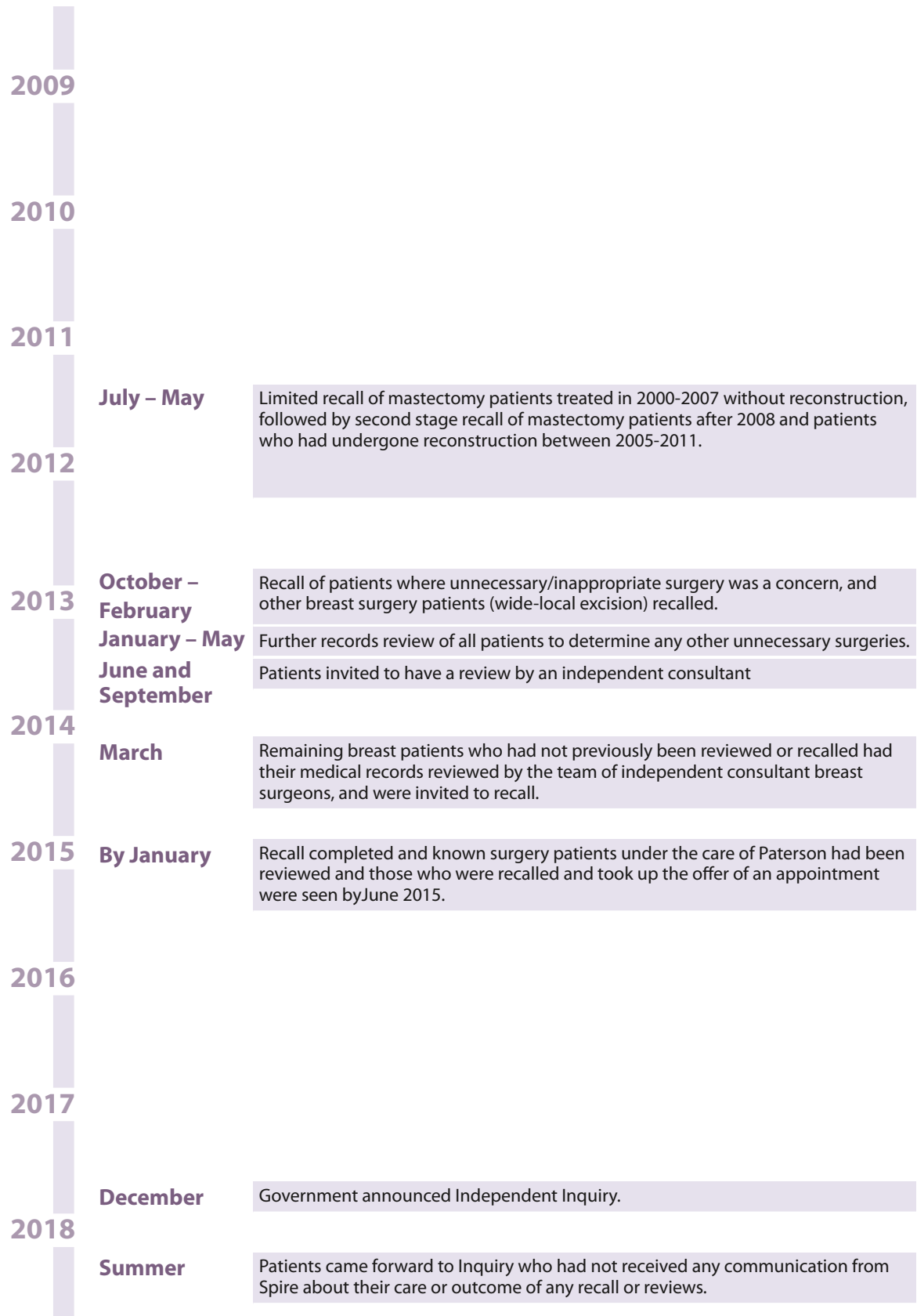
We have heard conflicting accounts of when the various stages of recall began and ended – both at HEFT and at Spire hospitals. While the dates vary by only a matter of months, they demonstrate the confusion around these processes. The variation in people’s recollection of the dates is not material to our findings. For the avoidance of doubt, the information presented in the timeline below was shared with us by managers who led the recall process, at a local level, at the time.

The recalls were often piecemeal and not well planned. The following timeline sets the scene for the next section of this chapter, in which we consider patients’ experience of the recalls.

Recall of Paterson patients by Heart of England NHS Foundation Trust

2009	Late 2008	12 patients considered at high risk of breast cancer recurrence were identified through a review process.
	June	12 patients invited to recall.
2010	July 2009 – 2010	Further review of patient notes led to recall being extended to 37 patients.
	Early 2011	Decision taken by new management team to recall all of Paterson's mastectomy patients treated at Solihull hospital. Recall then started in July 2011.
2012	January	Recall extended to include patients who had had a mastectomy with immediate reconstruction.
	March	Recall further extended to include all patients who had had a mastectomy at Good Hope Hospital.
	May	This recall closed.
2013		
2014	January	Board accepted recommendations of Kennedy report, including commitment to a full independent review of all Paterson patients.
2015	February	Virtual multi-disciplinary team set up to conduct full independent review.
2016		
2017	October	Independent review completed.
	December	Government announced Independent Inquiry.
2018	Summer	Patients came forward to Inquiry who had not received any communication from HEFT or UHB about their care or outcome of any recall or reviews.

Recall of Paterson patients by Spire



Patients' experience of the recalls

Before moving to consider patients' experience of the recalls, it is striking that almost a third of patients who gave evidence to the Inquiry told us they had not been recalled. These were evenly divided between those treated at Spire hospitals and those treated at HEFT. Those who have had no communication about the recalls include families of deceased patients who feel they would have benefitted from knowing what had happened to their family member.

Around a third of patients treated at Spire hospitals and around a quarter of patients treated at HEFT received letters inviting them to attend a recall appointment, while four patients were invited to recall during routine appointments.

Despite assurance from both the Trust and Spire that all patients who needed to be recalled had been seen, we heard from more than 15 patients treated at Spire hospitals, and several patients treated at HEFT, that they contacted the hospitals themselves when they heard the news about recalls on local media or through other sources.

“ Well like I said they were calling people back, but I was not one of the ones on the recall list, but I phoned up and said I wanted to see somebody anyway and made an appointment and I went and they put my mind at rest. ”

[Patient 305, treated at HEFT]

“ they should have been contacting people. Not the other way around. ”

[Patient 356, treated at HEFT and Spire hospitals]

“ I must say, it was very difficult to get the recall appointment set up. I was promised call-backs from Parkway and I did not get the call-back and I was told that the records would be there within a day and then they were not. So there was quite a bit of too-ing and fro-ing on the phone, etcetera. And, so that is how I came to go for a recall, it was at my own insistence. ”

[Patient 84 treated at Spire hospitals]

Both HEFT and the Spire recalls involved patients being reviewed by the same clinical staff that had worked with Paterson. Many patients felt uncomfortable with this and it added to the considerable distress they were already feeling.

“ If I were to give a bit of advice to Spire hopefully they would never have to do anything like this again. Do not put him in the same office. Do not use the same consulting room with the same chaperone nurses that you have seen in all that time... actually from a patient perspective it is so easy not to do that. ”

[Patient 2 treated at Spire hospitals]

“ well the worst part about it was I actually went out of the room, the very first person I saw was Mr Paterson, because we were in a similar area in the same clinic. ”

[Patient 19 treated at HEFT]

We heard from around 10 per cent of patients that they found out at their recall appointments that their treatment had been right and appropriate.

In the NHS more than 30 patients, and in the independent sector less than ten patients, were told at their recall appointment that they had had a CSM and were offered follow-up treatment.

At Spire, more than 30 patients found out through recall that they had had unnecessary surgery. These patients were deemed to not require further clinical treatment, and they were discharged without further care or follow-up. It appears that no thought was given to the impact on them of finding out that they had received unnecessary treatment and, in some cases, had been given an incorrect diagnosis of cancer.

“ Then he [consultant at the recall appointment] just went through everything else, all the scans. I was saying, ‘Well, all these scans that I’ve had, obviously I’m now learning I shouldn’t have had them, what’s my ongoing health?’ And he just said, ‘All you can do is wait and see how things progress.’ And that was it. I walked out of there, and they never contacted me other than send me the letter to confirm what they told me on that appointment, that I didn’t have cancer. That was it. ”

[Patient 15 treated at Spire hospitals]

“ The notes recorded by Mr Paterson grossly exaggerated the findings of the scan, giving him justification to do the operation and the new consultant did not think that prolonged monitoring of my case was necessary at all and he did not think that the operation should have been the first choice of treatment to do. There were no clinical reasons for doing, he said. ”

[Patient 27 treated at Spire hospitals]

“ I was called back by Spire. And then Spire [said] to me in the interview that my operation was totally and utterly unnecessary, there was nothing wrong with me. I did not need it, there was no biopsy, he had just done the operation regardless. ”

[Patient 43 treated at Spire hospitals]

“ I had a letter from Spire with the appointment, and they told me it was nothing to worry about, but immediately you do worry. But when I got there the doctor, he was very good. He just sat me down and talked me through what had happened, and how there was no trace of cancer whatsoever. ”

[Patient 98 treated at Spire hospitals]

Even following recall appointments, some patients remained unsure as to whether the treatment they received was appropriate, since it could not be determined through clinical examination or their patient records.

“ So the initial recall I went along, was told everything was necessary, fatty tissue. Went away clueless... Then I got a second letter for a recall that said, ‘You are a lady identified as having benign (non-cancerous breast lump),’ and I went, ‘If he’s took my breast off and I haven’t had cancer. So you are left thinking, ‘Did I or didn’t I?’ ”

[Patient 69 treated at Spire hospitals]

With few exceptions, recall was the point at which patients first became aware that their treatment had been incomplete or unnecessary. Many told us they were shocked both by the news of recall and hearing that they had received inappropriate care.

“ I was still a bit shell shocked by it all really because I had gone all those years not knowing. ”

[Patient 312 treated at Spire hospitals]

Despite the emotional impact of the discoveries patients made, there was a lack of consideration given to patients’ emotional and psychological needs in either sector. Little thought seems to have been given to the future needs of patients who were wrongly diagnosed with cancer by Paterson at Spire.

At some points during the recall exercise at HEFT, patients could access a Patient Advice and Liaison Service worker during their appointments, who would signpost them, if necessary, to appropriate services.

We also heard from patients that some fell between “gaps” in the recall process because they had moved home, transferred their care to a different provider, or their care had been delivered across sectors and settings. Patient 144 who was treated in the independent sector as an NHS patient told us:

“ I felt like the Priory were saying because I was in an NHS hospital, the NHS should deal with it, and the NHS was saying because I was operated on at a private hospital, they should have dealt with everything. ”

[Patient 144 treated at HEFT and in the independent sector as an NHS patient]

A small number of patients gave us positive reflections on parts of their recall experience.

“ I mean, in fairness, the actual recall itself was good, you know, this [consultant at recall appointment] was very sympathetic and he dealt with it as best anyone could, I think. ”

[Patient 324 treated at Spire hospitals]

However, more consistently we heard from patients that the recall process had done little to take their emotions or needs into account.

“ Possibly just a bit more, sort of, slightly more sympathetic approach. The impression I got really was that they were so overwhelmed, and the main objective was to actually treat people and, you know, right the things that had gone wrong with whatever treatment was going to be needed. But there was not much time for, you know, really talking about it. ”

[Patient 142 treated HEFT]

“ I want some counselling. Can you arrange it? I did contact them [Spire]... And they basically said that they had not got anything in place. ”

[Patient 32 treated at Spire hospitals]

A further frustration for patients was a lack of an adequate apology or accountability taken by the hospitals for the treatment that patients had received from Paterson.

“ I think at the time Spire did not want to know because they knew it was going to be a huge case and it was going to cost them a lot of money. I think that I should not have had to contact them, that they should have contacted me and there should have been this meeting. And also yes, you have the follow-up but my insurance company paid for that. But also sort of counselling follow-up and actually to show that we care. But in fact what they did instead was just say, ‘Oh, we were just renting a room to him.’ ”

[Patient 153 treated at Spire hospitals]

We note that, from 2002, the award of practising privileges by hospitals indicated that they were engaging with consultants and not just “renting a room”.

“ I felt that they were covering their backsides; that is what I felt. That they were paying lip service, because they had been told to do it. ”

[Patient 159 treated at Spire hospitals]

This lack of accountability is explored further in chapter seven.

Recall process

We heard detailed accounts of the recalls at both HEFT and Spire from witnesses other than patients. There was agreement among these witnesses that recall processes in both organisations were inadequate. Many of the issues were similar across both sectors, including a lack of openness, inadequate resourcing, and insufficient guidance. Due to the nature of Paterson's practice, and because of his inadequate record keeping and miscoding of medical procedures, as well as immediate reconstructions after breast surgery, it was difficult to assess exactly what had happened to some patients on recall. In both sectors, the recall exercises evolved and improved in terms of their breadth and independence as they developed. We heard from many involved in the recall directly, and those serving in board level roles, that decisions should have been made earlier to recall all patients in both sectors.

We heard from many witnesses that effective recalls should be led by those independent from the original care of the patients, not simply in the interests of the patients concerned, but also for the staff involved. Patients recalled by HEFT between 2009 and 2012 were seen by the existing breast care team, including staff who had worked with Paterson prior to his suspension. In addition to the distress this caused patients, we heard that this put considerable pressure on those who took on this task on top of their existing workloads. It was also uncomfortable for staff who had treated patients alongside Paterson since they found that patients were sometimes angry with them. Some staff also felt guilty that they could have done more to stop Paterson.

We heard from three healthcare professionals who had worked alongside Paterson at HEFT that Paterson himself was involved in some of the discussions relating to the earliest recall of patients, thereby jeopardising its independence.

“ Paterson in that meeting directly told everybody that he had done cleavage sparing mastectomy only on a handful of people. Mr Paterson claimed that recalling all the patients who had mastectomy under his care would cause unnecessary emotional upset to thousands of people, their lives would be destroyed, and it was wrong to do this. ”

[N399, healthcare professional who worked alongside Paterson at HEFT]

“ [consultant] would bring patients to be discussed at multidisciplinary team meeting who he had seen in recall and Mr Paterson would say, 'Why are you calling these patients back and worrying them?' ”

[N403, healthcare professional who worked alongside Paterson at HEFT]

“ But the initial recall wasn't a recall; it was really Ian Paterson policing his own patients. ”

[N431 healthcare professional who worked at HEFT]

There were similar issues at Spire where the breast care nurse who worked closely with Paterson was involved in the running of recall appointments until her own suspension from practice in 2012. A healthcare professional who was involved in early recall appointments at Spire reflected on his own part in it:

“ I think we should perhaps have had somebody that was not still doing their own private practice doing it. It perhaps should have been somebody completely independent that came in to review it, perhaps a surgeon from outside the region. ”

[N476 healthcare professional working at Spire hospitals]

We heard from three witnesses that there were difficulties around finding suitable, independent, available and experienced healthcare professionals to undertake the recall appointments for Spire. Newbold, the former Chief Executive at HEFT, similarly told us that the staff resource on patient recall was not limited by funding restrictions, but rather by a lack of available and suitable expertise within the wider system.

“ ...it was actually quite difficult to get the numbers of people reviewed in as short a timescale as we would have liked, but it was just a continual effort to find suitable expertise that was available and just continue to work through. ”

[N413, Mark Newbold, Chief Executive at HEFT from August 2010 to December 2014]

Despite the challenges in finding healthcare professionals to work on the recall at Spire, we heard that the final make-up of the team was effective and did demonstrate impartiality and independence from the original care provided.

“ In the private sector, all the notes were reviewed by a small number of breast surgeons on behalf of Spire. So, they were done independently...It was a very independent, professional review that was carried out and done well and gave equivalent results to the kind of more medical, legal reports that myself and other people would do. So, I think it was done well. ”

[N380, consultant who reviewed some patients who pursued legal claims]

“ ...initially there were a couple of consultants who were both working at HEFT as well as having had practising privileges at Spire Parkway. But as the recall process progressed, they were both stood down, because it was felt there was potentially a conflict of interest. ”

[N457, non-clinical manager at Spire]

We heard that the recalls in both the NHS and independent sector were hindered by a lack of clear process to follow. There were no national guidelines in place then and we understand that this is still the case today. A manager from Spire commented that patient recall was

“new” to the organisation, and that they were learning as they went along. We heard that Spire has since developed its own guidance for recalls, drawing on its experience from the Paterson case.

A further challenge for both Spire and HEFT was identifying which patients needed to be recalled and assessing what procedures or surgery they had received from Paterson. There was nothing in patient notes to identify if patients had had cleavage sparing mastectomies. At Spire, this was compounded by Paterson incorrectly recording operations.

“ the problem is, there wasn’t anything [i.e. in patient notes] that said this patient has had a cleavage sparing mastectomy... And so, I saw huge numbers of patients where it was impossible to say whether they had had tissue left behind or not. There is no imaging that can tell; especially if they have had a reconstruction. ”

[N380, consultant who reviewed some patients who pursued legal claims]

“ the other thing... which thwarted and slowed up the recall process, was because patients were selected by operative code, it also became apparent patients were often inaccurately coded. So the code was not reflective of the surgery that they had had, or it may have been a code applied for a higher fee, or it may have been a code applied to command a cancer to imply a cancer surgery when it was not. So, the whole coding was not a good way to go. ”

[N457, non-clinical manager at Spire]

At both Spire and HEFT, time, resource and effort were spent trying to identify which patients to recall. There was general agreement among witnesses that the recall processes took too long, and that this impacted adversely on patient safety.

At HEFT, there was a reluctance during the critical early years of the case to do a full recall of patients.

“ they were trying to keep this internal and it was quite the opposite, it should have been opened up and external. And it was resisted for at least four years. The only way to tell the extent of the problem is to actually call and look at them, there is no other way of doing it. And they tried the notes review and I put this to him. I said, you know, ‘You just don’t know, you’ve only got Ian’s word that he’s already done it, performed this on several individuals.’... And as I say later, with a change in management, obviously I think the realisation was the limited recall that had happened later was causing such a mess that they just had no choice but to offer recall to everybody. ”

[N431 healthcare professional who worked at HEFT]

“ It was more the case of how we protect the reputation of the organisation, rather than do the right thing by the patients. And I think that was evidenced when the initial recall was for 12, and the eventual recall ended up being hundreds and hundreds. ”

[N388, non-clinical member of staff at HEFT]

Similarly, managers and healthcare professionals from Spire who had been involved in the recall commented on the length of time it took to make the decision to recall all Paterson’s surgical patients.

“ I think we all recognised it was not a slick process at all. And going forward, one of the key things, my key recommendation is that you would need to look at the big picture first. That does not necessarily mean scaremongering and bringing everybody in right from the start, but we need to at least look... I think had we known at the outset there was that number of people, then resource could have been put in, and we could just say, ‘Right. Stop. We need to plan this. And we need to look at people as a whole.’ ”

[N457, non-clinical manager at Spire]

“ We heard from witnesses who had been involved in recall for Spire that there needed to be better join up between the hospitals on the recall process. A manager at Spire told us, ‘patients were between the NHS and the private sector, and really needed to have a joint approach to the recall.’ ”

[N457, non-clinical manager at Spire]

Ongoing care following the recalls

Following recommendations in Kennedy’s review of the Paterson case for HEFT, in 2015 the Trust set up an independent “virtual” MDT to review all surviving patients of Paterson who had had a mastectomy there. The aim of this “was to provide advice for each individual patient on the adequacy of their care, and to recommend appropriate follow-up”. Patients who had a mastectomy at HEFT have a care plan where necessary, funded by the NHS.

Spire told us that all patients involved with each of the recalls were provided with advice, support and follow-up, including further treatment and counselling, if required. However, patients told us that they did not have an ongoing care plan:

“ No, and that’s the worst part because I just walked out that door, and they never contacted me or spoke to me again. Apart from me asking for my notes and having a battle with them to get my notes. [So you weren’t offered any aftercare or counselling or anything?] Nothing, nothing. ”

[Patient 15 treated at Spire]

“ [When the news about Mr Paterson came out and you went for, you contacted Spire to then have a recall, what else was on offer from Spire at that point?] Nothing. Nothing at all. Nothing. [And have you been provided with any aftercare treatment since then?] All that happened was that I then went to see, a clinician who then took over from Mr Paterson and I had six monthly appointments. But that was paid for by my insurance company. [So the six monthly checkups were paid ...] Yeah. [... and that again, was arranged through Spire?] Yeah, and they were just mammograms. And after five years I asked the clinician, ‘Could I have a CT scan?’ and he said there was no need because I was not showing any symptoms. And then ironically in 2015, I was diagnosed with secondary breast cancer. ”

[Patient 153 treated at Spire]

Patient complaints

Complaints from patients about their care offers hospitals the opportunity to examine the adequacy of the treatment and care their patients receive, to apologise when it has been found wanting and to prevent recurrence.

We heard that this did not happen in a way that was thorough or adequate when patients complained about Paterson. While there were differences in the way patients complained in the NHS and the independent sector and how they escalated their complaints, the response was inadequate in both sectors.

Patients who were treated in the NHS

Most of the patients who were treated in the NHS and spoke to the Inquiry were unaware at the time of their surgery or procedures that they had had incomplete or inappropriate treatment. Concerns and complaints emerged sometime later, for example, when patients were recalled to the hospital or reports about Paterson appeared in the media.

Of the patients who told us they raised concerns with HEFT, the majority, around 20, were unhappy with how concerns were handled and the outcome of HEFT’s action.

Patients told us they found the complaints process difficult and not well signposted, and they were put off by the timescales involved when they were looking for closure.

“ And it’s very difficult for a layperson to navigate, and that’s another issue, because however many women, and at the end of the day, how many of them either had the wherewithal to employ a solicitor to look into it or had the skillsets to navigate themselves and work through the process? Very few. ”

[Relative of Patient 351 treated at HEFT]

“ Their [HEFT’s] complaint system, for instance, it says maximum 30 days. Every complaint that I’ve put in, I’ve put four complaints in, and I’ve had to wait three months for a response. No, ‘Sorry it’s taken a long time.’ They do what they like. ”

[Relative of Patient 351 treated HEFT]

“ I wrote many complaints to the Trust. I found them to be a total waste [of] time... Everyone I wrote, I had to go through their legal teams. So when they say, ‘We’ll come back to you in 15 days,’ or whatever, it would usually take about four months or something, and then it would be a pack of lies, basically. ”

[Patient 19 treated at HEFT]

Many patients said they felt HEFT was too defensive and that responses to complaints did not always address the issues raised. This led them to feel the issue was not being taken with the seriousness it deserved.

“ A letter received from the investigative board I found ambiguous. It did not address the issues raised and had inaccuracies in several comments. It is evident references to my patient notes were made but I was most disappointed with its conclusions, because in each section the board states that it was my decision to proceed, thereby absolving themselves of any blame or wrongdoing. ”

[Patient 302 treated at HEFT]

“ [And when you complained did anyone from the hospital offer to meet you at all?] No not at all, they just sent a letter saying that we are sorry that your mom has passed away and basically that we thought she would have died anyway because she had this cancer. They could not prove whether she did, or she did not have a CSM procedure or not. The letter was quite bad to be fair.....I did not feel any compassion from them, I did not feel like they cared to be honest. ”

[Relative of Patient 325 treated at HEFT]

“ I was also told I could have a meeting with representatives from the trust which I did.The attitude at that point seemed to be one of trying to ensure I did not take anything further and to protect themselves. ”

[Patient 24 treated at HEFT]

“ [And did you raise any concerns when the news came out about Mr Paterson with the hospital at all?] Oh yeah we asked them but they said it was all being looked into and that they could not go into any details, but I never heard anything, never heard a word. ”

[Relative of patient 53 treated at HEFT]

“ And then after a while I received a letter back to say they’d received it and they took it further as a complaint, and then it would go to all these different people, which it did and I waited quite a while. And then they sent a few letters back, which I was disgusted with. Disgusted. [Why was that?] Because basically they’re shoving it under the carpet. ”

[Patient 337 treated at HEFT]

A manager working at HEFT, told us that special measures were put in place to manage complaints about Ian Paterson. This included having all responses to complaints checked by solicitors:

“ It was also put in place . . . that all of these responses would need to go through a final quality assurance process via solicitors, and I always felt this was quite odd. ”

[N451 non-clinical manager at HEFT]

The same manager told the Inquiry that around 2012, HEFT did make some effort to improve its response to complaints by offering to meet patients:

“ Obviously these written responses were going via solicitors and taking a long time to churn out the other end. But then, as time went on, we would offer a meeting if there were any further questions that were not addressed via that response. ”

[N451 non-clinical manager at HEFT]

One patient was happy with how HEFT handled their complaint on the basis that the Trust apologised and acknowledged the wrongdoing. There appears to have been a reluctance to do this in other cases, which left patients and families feeling angry and frustrated.

Some patients were reluctant to complain as they feared this would have an impact on their future treatment. Some patients or relatives described the NHS as a “closed shop”, expressing a feeling that staff were sticking together to protect their own.

“ I found the NHS at times closed ranks and were a bit of a closed shop. ”

[Patient 249 treated at HEFT]

The belief among some patients and relatives that complaining would adversely affect ongoing and future treatment was keenly felt.

“ [did you ever complain to the hospital at all about the treatment?] We wanted to but mum was scared that she wouldn’t get any respite treatment if [she] needed it in the future..... she thought if she had got cancer in her other breast would they treat her if we complained. ”

[Relative of patient 237 treated at HEFT]

“ I probably should have done [complained] but it is very difficult when you are a patient. You think sometimes that if you complain you will not be treated as well. ”

[Patient 294 treated at HEFT]

As an illustration of the scale of the fear, one patient was told by someone whose identity was not disclosed,

“ Ian Paterson is a really powerful man and you need to be careful what you do because we’ll find you in a gutter. ”

[Patient 281 treated at HEFT]

The NHS Constitution is clear that the NHS pledges that “the fact that you have complained will not adversely affect your future treatment”.

UHB told us that it took a different, person-centred approach to responding to complaints today.

“ I was going to say, so we have got for patients themselves we have a Patient Relations Team, so we do not have a complaints function in our organisation, we have Patient Relations. So it is about patient advocacy and support and liaison as well as when we deal with more formal complaints and more formal patient experience. ”

[N470 Lisa Stalley-Green, Executive Chief Nurse, University Hospitals Birmingham NHS Trust]

We heard that UHB now assess all complaints to check if they indicate that a healthcare professional’s practice is not meeting the required standards. We were also told that complaints are now analysed alongside other patient experience measures to identify trends and issues.

Since 2014, doctors and nurses working in either sector have had a professional “duty of candour”, which means that they are required to be open and honest with patients when things go wrong. CQC can take action, including prosecution, against trusts that fail in this statutory duty to be transparent.

We note, with concern, that in its 2018 adult inpatient survey, CQC found that:

“Results from the survey show a decline in patients’ perceived ability to give their views. Only 15% of respondents said that they had been asked to give their views on the quality of their care during their stay, compared to 20% in 2017. This was also visible in the decrease in the proportion of patients saying they saw or were given information explaining how to complain about the care they had received, from 26% in 2017 to 19% in 2018. This is the lowest since the question was introduced in the adult inpatient survey in 2012 and indicates a meaningful deterioration.”

Patients who were treated in the independent sector

The proportion of patients and relatives who gave evidence to the Inquiry and reported they had raised a concern about their treatment appeared to be lower in the independent sector than in the NHS. Patients who did not complain said they either did not have the energy to do so or felt they would not be heard.

Compared with patients treated in the NHS, a smaller proportion of patients who had been treated at Spire told us that they were worried that complaining would affect the quality of treatment they received in the future.

The majority of patients who complained about their care in the independent sector did so when they were recalled by Spire to review the treatment they had had from Paterson, or when the concerns about him became public. Like patients treated in the NHS, the majority were not aware they had received incorrect treatment at the time.

Among the patients and relatives who raised concerns with Spire, the majority did not feel these were handled well. Spire was described as unresponsive and dismissive of its responsibility for the care patients had received.

“ So I was very disappointed, and I wrote to Spire and got no response at all but thought, ‘Well, it’s only me. They’re not going to bother.’ ”

[Patient 107 treated at Spire hospitals]

“ [have you made a complaint to them officially?] Yes, we have and, as a result of that, we have had something wishy-washy, have we not? ”

[Patient 87 treated at Spire hospitals]

“ [Just to ask you what your expectation was of Spire at that point when you made the complaint?] I expected them to come back with an official response. I expected them to have done an investigation, and I expected them to have given me the result of that investigation. I also expected that if they had found anything wrong, that there would be an apology, and I also expected that there would be some signpost just to what to do, as in, ‘We are really sorry, this is messed up. If you want to make a claim ... you know, ‘... this is where you need to go,’ and whatever. I didn’t get that. ”

[Patient 32 treated at Spire hospitals]

Patients mentioned there was not a clear route to complain and they did not know where to go if they were not satisfied with the outcome of their complaint.

Spire told us of work they had done to improve their patient complaints processes since Paterson practised. We heard that every patient who complains is now offered a face-to-face meeting and that patients are given a leaflet explaining Spire's complaint process. We were told that patients are informed about the option of escalating their complaint to the Independent Sector Complaints Adjudication Service (ISCAS) if they are unhappy with how Spire has responded. Spire also told us that they now audit samples of responses to complaints, centrally.

The “duty of candour” to be open and honest with patients when things go wrong, was extended to include all care providers registered with the Care Quality Commission in April 2015.

Pursuing a complaint with a third party or escalating it

Some patients told us they resorted to legal action as a last resort after failing to get a satisfactory response from HEFT or Spire. Their experiences of doing this are explored further in this chapter when we examine claims for compensation.

Aside from those who sought to sue for compensation, a minority of patients pursued their complaint with a third party, or escalated it.

Patients treated in the NHS have the right to refer their complaint to the Parliamentary and Health Service Ombudsman to investigate and make a final decision if it has not been resolved by the NHS Trust and it is within the Ombudsman's time limit. The Ombudsman looked at four cases, but none of the cases went beyond an assessment of the issues.

Patients we met who were not satisfied with HEFT's response to their complaint did not escalate their concern to the Ombudsman. HEFT was required to make patients aware of this option. Copies of HEFT's response to patients who had complained, and which were seen by the Inquiry, did not explain this option to them. Patients did not appear to know about the role of the Ombudsman and there seemed to be a serious lack of transparency and information in this area. The Ombudsman suggested that, in common with other European countries, there could be a single ombudsman for public service issues, so that members of the public would know who to go to.

Unlike patients treated in the NHS, patients treated in the independent sector have no recourse to the Ombudsman if they are not satisfied with the response to their complaint, since the Ombudsman is prevented by legislation from looking at private patient complaints, including for those patients who have been treated in NHS private patient units. Private patients did not mention the Ombudsman, though the low level of awareness of the Ombudsman's role more generally does not necessarily suggest that private patients were aware they had no recourse to the Ombudsman's office.

ISCAS may adjudicate on complaints if patients treated in the independent sector are unhappy with the hospital's response to them. However, independent sector hospitals do not have to subscribe to ISCAS. Patients treated in the independent sector do not have a right to independent investigation or adjudication of their complaint. Spire did, and does, subscribe to ISCAS. Only one patient who spoke to the Inquiry had referred their complaint to ISCAS and they found it to be a poor experience:

“ I have taken my case to the Independent Health Care Advisory Service. I had had a panel with Queen’s Counsel and two expert witnesses. It was not like this [giving evidence to the Inquiry]. You go into a room and you are in the naughty chair and you are in front of female Queen’s Counsel. You had a breast surgeon there and you had the oncologist there. The opening statement from the adjudicator as we were walking into the room, ‘I do hope you realise that the consultants are being interviewed by their peer group today. They’re going to be feel very uncomfortable’. And I thought we have lost before we have even got in. The whole conduct of that meeting was to try and trip us up. ”

[Patient 68 treated at Spire hospitals]

Around 20 patients told us they had raised concerns about Paterson with the GMC, the body that regulates doctors in the UK. Patients who complained to the GMC spoke of their complaints either being dismissed or not receiving any response. Only one patient told us they were happy with how the GMC handled their complaint. We discuss the response of the GMC to Paterson in more detail in chapter seven – working with others to keep patients safe.

By comparison, one patient who complained to the NMC (the body that regulates nurses in the UK) reported that they felt happy with the process on the basis that they were kept informed and treated with respect. This patient had also complained to the GMC and reported the opposite experience there.

Some patients approached their Member of Parliament and the Secretary of State for Health with their concerns, but this was as a last resort since they did not know where else to go.

Claims for compensation

As the extent of Paterson’s malpractice across the NHS and independent sector emerged, many patients began to seek compensation for what had happened to them. Just over half of patients who gave evidence to the Inquiry had claimed compensation, these were split almost equally between Spire and HEFT. We heard from patients that their decisions to seek compensation were often difficult ones.

For NHS patients, claims for compensation are managed and paid by NHS Resolution (formerly NHS Litigation Authority). For private patients, claims can be settled by the private healthcare provider or healthcare professionals directly, or from others acting on their behalf, e.g. a solicitors’ firm, insurer or medical defence organisation.

We heard that the typical basis for patients to seek compensation was under a “conditional fee agreement” with one of the law firms which became involved in litigation on behalf of patients. In general terms, the way such agreements work is that no legal fees are payable, unless the claim is successful, when the bulk of fees are then recovered from the other side. This funding arrangement enabled many patients to pursue and secure compensation when they otherwise would not have been able to afford to do so. The number of patients involved meant that their cases were brought together in what is known as a class action.

We heard from some patients that they had positive experiences of the legal process, finding it smooth and an opportunity to gain more understanding about the treatment they had received. However, for others it was a frustrating and lengthy process, which further added to their already difficult experiences:

“ [have you taken legal action?] Yes. And I had compensation from the Mr Paterson pot, but we are still fighting Dr [oncologist who worked with Paterson]; that side of it. That is taking a very, very long time. ”

[Patient 87 treated at Spire hospitals]

The decision to make a claim

We heard from patients that the decision to pursue a claim was frequently a difficult one. Some told us that healthcare professionals signposted and encouraged them to make a claim during their recall appointment meetings. Others saw local advertising for solicitors' firms inviting them to seek compensation. We heard that for the vast majority of Paterson's patients, seeking compensation felt like a last resort to take action against what they had been through, and to bring some closure.

We heard from some patients that they were “out of time” since claims had to be made within three years, beyond which they were ineligible for compensation:

“ I cannot get a solicitor to take my case. I have never heard from Spire. So, I feel very let down and very anxious. [And why will the solicitors not take your case?] They said that the time has gone too long, but emotionally I could not deal with it beforehand. I only feel stronger now, and now it is too late. ”

[Patient 283 treated at Spire hospitals]

Experience of the process

Patients who went through the litigation process were reviewed by independent medical experts. We heard that for some patients this involved a physical examination and documentary review, while for others their cases were reviewed on the documents alone. We heard evidence from two medical experts who had reviewed Paterson's patients as part of their claims for compensation. One had reviewed around 350 patients and the other around 200 patients.

Following their reviews, patients received detailed reports from the experts describing and commenting, so far as possible, on the treatment they had received from Paterson. For some patients who had not received clear information or advice at their recall appointments, this was a much-needed opportunity to get clarity and understanding. Many patients who gave evidence to this Inquiry talked through their reports to explain what they had been through, as this was the only clear, objective record of the medical care they had received.

Payment of compensation took a long time. In the NHS, we understand that this was because of the high number of patients who had claimed compensation and the time it took to process these claims. So far, NHS Resolution has paid £17m in compensation to patients Paterson treated in the NHS.

We understand that patients who were treated at Spire had to wait longer for their payments, because of legal disputes concerning which party, if any, was liable for Paterson's actions in private practice.

In 2013, the Medical Defence Union (MDU), the organisation that provided clinical indemnity cover to Paterson in the independent sector, threatened to withdraw his cover (and eventually did so), meaning that it refused to make money available to compensate patients. Private patients did not have an immediately available alternative source of compensation. Spire told us that in other than a few exceptional cases, it was not able to enter settlement discussions with patients until the criminal proceedings against Paterson had concluded. This had the potential to leave private patients uncompensated, solely as a consequence of the sector within which they had received their treatment. This was a huge potential unfairness and added to patients' feelings that they had been let down by the system.

A solicitor acting on behalf of patients commented to us that dealing with the MDU and Spire in this case was the most frustrating experience of their legal career. The MDU would not respond to communications and Spire would not accept responsibility. The solicitor's frustration grew to the extent that in March 2015 they organised a demonstration with patients outside Spire Parkway to draw attention to the case.

Following Paterson's criminal conviction in April 2017, approximately 750 of his private patients brought civil proceedings claiming compensation for the pain, suffering and financial losses they suffered as a result of Paterson's actions.

As well as the action against Paterson, proceedings were brought against Spire Healthcare and HEFT, primarily for failing to pass on information to Spire about Paterson's activities. Paterson admitted liability in most of the lead cases. However, Spire and HEFT denied liability.

Paterson's civil trial was initially due to take place in October 2017. In September 2017, the defendants to the claim jointly established the Ian Paterson (Liability to Private Patients) Compensation Fund. A fund of around £37m was available to compensate Paterson's private patients, of which Spire contributed £27.2m. This settlement was approved by the High Court at a hearing in October 2017. As part of that approval, Justice Whipple set aside a proportion of the fund to provide compensation for any former private patient who had yet to bring a legitimate claim. Such claims needed to be made before 30 October 2018.

The role of medical defence organisations (MDOs)

MDOs, of which there are four in the UK, are organisations set up to provide financial and legal support to health professionals working outside the remit of the Clinical Negligence Scheme for Trusts, the compensation scheme for the NHS which is administered by NHS Resolution. These organisations are able to provide legal representation to their members in claims brought by patients, cover the associated legal costs and pay damages to patients, if and when appropriate. For example, the latest figures set out in the MDU's 2018 annual report show that they hold capital and reserves amounting to nearly £404m and have over 450 employees. However, MDOs are not subject to financial conduct regulation and the indemnity cover they provide is discretionary. The discretionary nature of the cover, combined with the lack of clarity about whether private healthcare providers are vicariously liable for healthcare professionals' actions, means that there are potential gaps in clinical indemnity in the independent sector which do not exist in the NHS. This risk does not appear to be transparent to private patients at the point that they choose to have their treatment in this sector.

In the case of Paterson, the Medical Defence Union (MDU) applied their discretionary powers to opt-out of making contributions to the patients' compensation fund, since Paterson's activity was criminal.

We were disappointed that the MDU, unlike other MDOs, did not attend an evidence session:

“ *I am advised that I should not give evidence on behalf of the MDU which relates directly or indirectly to the issues arising out of the case of Mr Paterson, without the consent of Mr Paterson himself, and the consent of any third party whose rights to privacy might be adversely affected by the giving of this evidence. These constraints on the evidence which I could provide are I believe so extensive that I would not be in a position to give anything but very limited and restricted evidence.* **”**

[Christine Tomkins CEO for MDU]

However, on request, they did respond to general questions about medical indemnity, in writing.

The patients who spoke to us about MDOs told us that their understanding was that the MDU had threatened to withdraw cover in relation to Paterson because his malpractice was deemed criminal activity. For the patients concerned this was a serious failure of the system to provide adequate support to them when they had been through significant trauma. In effect, it meant that the most serious malpractice is that which is least likely to attract compensation from an MDO.

The majority of non-patient witnesses told us that the current system for insuring and indemnifying independent clinicians in the private sector was not fit for purpose. They believed it required reform to ensure that patients harmed in the NHS and private sector do not face different prospects of receiving compensation, solely as a consequence of the sector within which they are treated:

“ the discretionary nature of the system at the present time is of concern. And the exclusion when there’s an allegation of criminal activity is [of] concern because both of those two issues can result at the present time in a patient potentially not being compensated. **”**

[N474, Steven Luttrell, Medical Director BMI]

“ The final big area which I am sure will come up is around indemnity cover for doctors. It cannot be right that, as was shown in the Paterson case, that when something goes really wrong suddenly the cover is not there anymore. **”**

[N195 Alex Perry, Chief Executive of BUPA]

Other witnesses noted that the current system of indemnity cover for healthcare professionals working in the independent sector is unregulated, and told us that this was impossible to justify.

“ I do not know whether these organisations are fully regulated in a financial setting or not, and, you know, as a CEO of a healthcare provider do I really need my legal team to become experts in this or not or should that market indeed be regulated more closely so that that cover is in place. ”

[N418 Dr Andrew Jones, Chief Executive of Ramsay]

“ So someone at the centre should define what adequate and appropriate indemnity cover is at each level for individual health professionals and at the corporate level, either in the private or NHS's care.When we pose these questions, when there is a variety of stakeholders around a table and we say, 'Oh, something needs to be done.' Very often we get 'Yes, you are absolutely right.' And we said, 'Well, which one of you are going to do it?' The Department of Health said, 'Well, it is not our job because all we do is set policy.' The regulators say, 'Oh no, no, we are regulating the standards of care, that is not one of the things we do.' Health professional regulators say, 'No, that is not for us.' Well, it is beyond my pay grade to make decisions about who it should be. The Department of Health should insist upon it and it should be clear within the system who is responsible for that. ”

[N220 Peter Walsh, Chief Executive, Action Against Medical Accidents]

Some witnesses also commented that greater clarity is needed as to whether and when healthcare providers should be held vicariously liable for the healthcare professionals working from their premises, since it currently appears that different organisations take different stances in relation to their own responsibility to ensure patients are appropriately compensated for avoidable harm:

“ we have got significant indemnity cover as an organisation.We have single episode amounts and an aggregate figure. So, if there was to be that situation, Nuffield Health would step in to cover that insurance and it sits in my world, my part of the business, and we have just significantly upped those limits in order to make sure we are appropriately covered if we should get that kind of incident. Because, fundamentally, we do not want patients exposed. ”

[N417, Caroline Smith, Chief Quality and Assurance Officer, Nuffield]

In the event of the MDO and the independent healthcare provider failing to provide cover, some witnesses thought there was a need to provide an industry-wide “safety net” so that patients were never left uncompensated, similar to the way the Motor Insurers' Bureau operates in relation to unidentified and/or uninsured drivers who cause harm:

“ If somebody bashes into your car while you are standing still, or is an uninsured driver, I think we need a similar sort of system in the medical indemnity, medical insurance field whereby you top slice all insurance premiums so that you have a central pot that is always available for patients if they do find themselves in that situation. ”

[N417 Nuffield]

“ I almost want to say it shouldn't be the patient's problem. We need to deal with that problem, you don't want to add another concern to a patient that's going into a hospital that is now wondering, 'If something goes wrong will I be covered?' because I believe that will compromise the patient. My view is we should resolve this matter; it shouldn't be a patient concern. ”

[N474 Karen Prins, Chief Executive, BMI]

“ That is why we think there should be some kind of safety net, so if for some unforeseen reason there is a danger of a patient or family going uncompensated because of a gap in the system, there should be a contingency fund that makes sure that cannot happen. ”

[N220 Peter Walsh, Chief Executive, Action Against Medical Accidents]

MDOs themselves told us that the attraction of the current system was that discretion could be applied flexibly. NHS Resolution told us that CNST is also discretionary, but they have never used discretion to refuse to indemnify a trust.

We also heard that there was an appetite for the publication of data relating to healthcare professionals' indemnity arrangements, which would allow patients to find out whether a healthcare professional treating them had adequate and appropriate indemnity cover in place. Witnesses commented that, although the GMC advises that consultants should have adequate insurance, this was neither clearly defined nor rigorously enforced and therefore there is arguably a lack of appropriate checks and balances in the current system.

The role of private medical insurers

Private medical insurance enables people to pay a regular, usually monthly, premium to be able to access independent healthcare. Some patients told us that they had private medical insurance through their employer and others told us that they paid for their policy directly.

Whatever the route of cover, patients thought that the private medical insurance companies were providing some oversight for the treatment that was being provided. The roles and responsibilities in planning and commissioning healthcare services in the NHS through Clinical Commissioning Groups (CCGs) is clear. The roles and responsibilities of private medical insurance companies in “commissioning” services was not clear to patients we saw.

The Inquiry heard from around three quarters of patients treated in the independent sector about their experiences of having private medical insurance for the treatment they received from Paterson. In many cases, they told us about things which should have triggered alarm bells with the companies that provided the private medical insurance.

One patient told us that Paterson proposed to her that he would say he had carried out treatment that had actually been undertaken by a plastic surgeon who was not on the private medical insurance company's approved list, so that she could get a reconstruction paid for by her private medical insurance company. Another patient told us that Paterson advised her to lie to her private medical insurance company in order to get them to pay for treatment.

Many witnesses who were not patients mentioned the coding of treatments paid for through private medical insurance as an issue. We heard that Paterson frequently coded a procedure as cancer when it was not, therefore attracting a higher fee. If it was cancer there was also less likelihood of ongoing treatment being questioned. Paterson denied miscoding procedures in this way. Some patients commented that their invoices did not always match the treatment they had received. Some patients also said that their private medical insurance premiums had been adversely affected by the incorrect diagnosis of cancer remaining on their file. We asked private medical insurers how they would rectify this. They told us that they would consider making a correction but acknowledged that it was not always easy to obtain confirmation of a patient's position from the NHS. The incorrect diagnosis of cancer, referred to in Chapter 4, also adversely affected other areas of some patients' lives, for example, employment checks and travel insurance.

“ Paterson had never told me any of the lumps I had were cancerous, he had coded them as cancerous and that that would have a higher remuneration. ”

[Patient 160 treated at Spire hospitals]

“ I rang up about a specific invoice because I thought, 'I didn't see Mr Paterson that day, and I didn't see anyone.' The only person I saw was [nurse who worked with Paterson]. I rang up, and I said to Bupa, 'It's okay, you've paid the invoice, but I just wanted to know...,' because it didn't give you on the information sheet what it was for. And they said, 'Oh, it's for your prosthesis from the nurse.' And I didn't have one. ”

[Patient 140 treated at Spire hospitals]

“ I found out that he claimed for a breast cancer surgery thing, but in actual fact what he had actually done was more like a biopsy. ”

[Patient 346 treated at HEFT and at Spire hospitals]

“ lots of the codes he had used, like the revising the scar and that, he was putting down as cancer operations because he was getting more money. [So he was actually coding them differently for payments?] Yes. And like I would not have known because all I did was ask him for a code for BUPA to authorise. But I do not understand why BUPA did not see how much they were paying him, how many operations he was doing. ”

[Patient 183 treated at Spire hospitals]

The frequency with which we heard such accounts from patients led us to believe that there were inadequate checks and balances in place to verify private medical insurance claims at the time when Paterson was practising. We were told by private medical insurance companies that this generally could not and did not happen now, due to changes in how codes are checked. However, we remain puzzled to understand how this would have prevented Paterson incorrectly coding procedures. Private medical insurance companies told us that there is an increased appetite to challenge consultants now if they spot, or are told about, concerns by others.

We heard that where private medical insurers looked back at data relating to Paterson, they did not feel that they would have been able to identify him as an outlier.

“ We actually received an anonymous letter into us, advising us of the concerns that had been raised about Mr Paterson and his practice, and a copy of the newspaper article that that was referring to. So, following that, we conducted a review of billing history, and whilst we had some inclination that there may have been a degree of overtreatment; so looking at the proportion of patients that received treatment that were referred to him, the volumes that we had were really too small to give us any statistical certainty of that. ”

[N190 Aviva]

“ I mean it is billing data so it is consultants saying, 'I did a [procedure] on this date.' Now, you think in the Paterson case, could that type of data identified what was going on? I think probably not. ”

[N195 Alex Perry, Chief Executive, BUPA]

“ So to make it concrete, obviously after the Paterson case, we looked at our data, because we thought we want to make sure there are not any more like him. And all I can say is either there was a lot like him, or he was not detectable to us from the data. And I think it highlights some of the issues that are limiting for us. So I would say they only need two things that you could conceivably say he stood from the data were, (a) he did a lot. And that actually, in our experiences, well possibly a worrying sign, but just working hard does not make you a bad person, and secondly, something that I discovered was either a lot of breast surgeons are doing a lot of breast surgery on people without having done any pathology prior to the surgery, or a lot of people are having the pathology in the NHS and we are not seeing it. He was in the top quartile in terms of invisibility of pathology. But he was not in any way an outlier. ”

[N191 AXA PPP]

We were surprised that Paterson was not detectable as an outlier, given the very large number of procedures he was carrying out almost entirely in one hospital, let alone the number of procedures he was undertaking on individual patients, including many costly diagnostic tests such as PET scans. Spire told us that they would welcome early sharing of concerns by private medical insurers, so that they can take timely action.

While the private medical insurance companies who gave evidence to the Inquiry told us they have large amounts of data, some said that because they are regulated by the Financial Services Authority rather than as a provider of health services, they are prevented from sharing it, unless there is potential fraud.

However, others have pointed out that where private medical insurers have a responsible officer, this brings a duty to share concerns, if not data. Similarly, doctors who are registered with the GMC and who work for private medical insurance companies will also have a duty to raise concerns if they are worried about the practice of another doctor, in line with “Good Medical Practice”, the GMC code of conduct.

“ Each of the insurance companies have a Medical Director who each have a Responsible Officer, they have legal responsibility currently to share information in relation to any concerns they have about doctors. That is a good medical practice guidance from the GMC. So again, as I said before, I think a lot of the tools are already there, it is the application of those tools that is really, really important. And people just need to be reminded of their legal responsibilities in relation to patient care. ”

[N417, Nuffield]

“ I notify them [private medical insurance companies] each time that I have suspended or withdrawn practising privileges from a consultant at the time, but all I get is the end result of a long series of concerns that just result in a consultant’s practising (inaudible) recognition by the insurer being withdrawn without any understanding of why. And that makes me uneasy because they have a Responsible Officer and theoretically there is a duty to share concerns openly both ways, and I sense that is not happening downstream. ”

[N438 JJ de Gorter, Chief Medical Officer Spire]

CQC told us it had observed an improvement in private medical insurers sharing information, since the introduction of memorandums of understanding (MOUs) with them to improve this in 2018. However, it is too early for us to make meaningful observations as to whether these MOUs will help improve patient safety.

How private medical insurers were compensated

Patients had insufficient information about the discretionary nature of MDO cover, and they also had inadequate information about how money would be paid once compensation had been agreed.

Many of the patients we heard from were angry and frustrated because they perceived that private medical insurance companies unfairly took a proportion of the funds agreed for their compensation.

“ The insurance company took out of my money what they’d paid Paterson, which is unfair because they should have chased him for that money. I didn’t commit fraud, and I was the one that was left with terrible scarring and had to then find money to have reconstruction. I didn’t ask for any of that to happen to me. ”

[Patient 15 treated at Spire hospitals]

“ That out of the money that was being compensated between several parties, it was not just one party, I think there was three parties, I think, including BUPA. And this is what annoyed me with BUPA. I thought, ‘How dare they?’ We went through everything and now they are taking a chunk out of the money and as I say, it was not about the money. ”

[Patient 312 treated at Spire hospitals]

“ We had to pay Bupa back. And we had already paid them once by, like, his insurance. ”

[Patient 67 treated at Spire hospitals]

In many patients' perceptions the private medical insurance companies, therefore, appeared to have been paid twice, firstly through their premiums, and then by being compensated out of patients' compensation for treatment they had funded that was not necessary. Patients did not want private medical insurers to be compensated out of their damages as they felt let down by them and betrayed by their lack of oversight.

However, we were told by Irwin Mitchell, Shoosmiths and Thompsons solicitors that the insurance companies' losses were included in the claims in addition to their clients' own losses. We were told that this mechanism for recovering the insurance companies' losses was discussed with their clients at different points during the claim process. They told us that their clients were told that the insurance companies' claims would be in addition to their own claims and not deducted from their compensation.

Aviva and Bupa, two companies who provided private medical insurance for patients of Paterson, told us that responsibility for explaining how an insurance company's losses are recovered within a patient's claim rests with the patient's solicitor.

It is a complicated issue and it was evident to us that the situation was not clear to patients because they saw the insurance companies' claims as being a deduction from their own compensation, rather than as an increase in their initial claim. Since the situation did not seem to have been adequately explained to patients, patients suffered unnecessary distress, anger and irritation.

Many patients who were victims of Paterson's malpractice only discovered what had happened to them when they were recalled by the hospitals. The recall appointments were disturbing and at times traumatic for some patients. The response to patients who complained was inadequate in both the NHS and the independent sector. Added to this, there were gaps in medical indemnity cover, which meant that private patients had to fight to be compensated for what had happened to them.

The inadequacy of the response to Paterson's malpractice by the system in both the NHS and the independent sector has meant that patients have been traumatised several times over, and some may not still even know the risks with which they live.

What we have learned

When things go wrong, the response should be swift, adequate and ensure that patients are safe. There were a series of failures to respond well – in both Spire and HEFT – and a sense of responsibility to do the right thing for patients was lacking.

Patients felt that both their recall and the reaction to their complaints were dealt with too slowly.

It was difficult for patients to raise concerns at HEFT and with Spire. There was a lack of information and transparency to support them in doing so. Routes to escalate concerns were not visible to patients.

The response to patients who raised concerns was inadequate in both sectors. It was defensive, not patient-focused on an individual basis, and did little to recognise the distress, worry and anger patients were experiencing.

There is inequity between patients treated in the NHS, who have a right to escalate a complaint to the Ombudsman for independent investigation, and private patients treated in the independent sector, who do not have this right. Moreover, private patients appear to be unaware that they do not have this level of protection.

Opportunities to stop Paterson practising in response to concerns raised by healthcare professionals in the NHS were missed on a number of occasions, and for a sustained period of time. Connections were not made between individual incidents, to the detriment of patient safety.

There is a strength of feeling amongst healthcare professionals that raising concerns will come at a personal cost to them. This perception continues, despite recent measures to empower and protect healthcare professionals and other staff who raise concerns.

The recall of patients was generally inadequate, not-patient focused, and lacked transparency in both the NHS and independent sector. Due consideration wasn't given to patients' emotional and psychological needs in either sector, and the particular needs of patients who were wrongly diagnosed with cancer by Paterson at Spire were ignored.

We are not convinced that all patients who should have been recalled have been contacted. UHB has gone some way to rectifying this by reviewing all Paterson's surviving mastectomy patients and providing them with ongoing care, where necessary. This has not been replicated by Spire.

There is a lack of guidance to the healthcare sector on good practice when recalling patients for review of their care following adverse incidents.

Many patients made claims for compensation as a last resort. They had mixed experiences in doing so. In the NHS, claims were settled quickly, with liability sorted out in the background. This was not the case in the independent sector where disputes about who was liable delayed payments being made to patients, causing them further distress. There is no safety net for private patients in the independent sector where indemnity cover for doctors is discretionary.

The MDU used its discretion to withdraw cover in relation to Paterson because his malpractice was deemed criminal activity. This was a failing of the system to provide adequate support to patients when they had been through significant trauma.

Private medical insurance companies funding care for patients at Spire, told us that they did not and could not spot any concerns about Paterson from the data they collect. We were surprised by this, given the high number of procedures and diagnostic tests he carried out in a single hospital.

CHAPTER SIX – Working with others to keep patients safe

In the last chapter, we examined how the hospitals involved failed to address the concerns which were raised about Paterson. We also looked at how patients' claims for compensation were handled by the medical defence organisations and others, and the role of private medical insurance companies. But the failure to spot Paterson as an outlier did not end with the hospitals, insurance companies and medical defence organisations.

While this inquiry gives patient evidence priority, this chapter deals with the wider health system which should keep patients safe. Much of it will not, and should not, be obvious to patients themselves as they are treated. They simply trust it is in place. A significant number of Paterson's patients lost confidence in the wider system once they discovered what had happened and found the various parts of that system unresponsive. It added to their distress. The patient evidence quoted in this chapter is informed by hindsight and the distress they have known. In the case of Paterson, failures and gaps across the system allowed patients to come to harm over many years.

Whilst patients want their confidentiality about their own information to be respected, they expect enough information about them to be shared by the NHS, the independent sector and others to make sure the quality of their care is high. They also expect information about doctors, especially where there are concerns, to be discussed and shared, and prompt action taken.

Some of the key organisations responsible for keeping patients safe did not take appropriate and swift action. We examine their actions in this section. We also consider how they failed to work together, each thinking it was another organisation's responsibility to act. Sometimes they were too quick to dismiss the problems as historical and failed to recognise disturbing patterns.

In this chapter, we examine these failings and consider whether improvements have been made since Paterson was suspended in 2012. We cover:

- sharing information and concerns between hospitals in the independent sector and the NHS
- sharing information and data with and between other organisations
- the role of specific organisations, namely the CQC, GMC, NMC and the PSA.

Sharing of information

There are two different types of information which may be shared between organisations:

- a. information about a specific healthcare professional or patient to support their care
- b. general information about a group of patients. This can be linked to spot trends and in particular to identify a doctor who is out of step with his or her colleagues in their practice.

It is clear that in both cases, the use of information did not help prevent Paterson from giving the poor care described in chapter four. Hospitals and other organisations did not effectively share information, and in some cases requests for information were rejected or the information that was shared was wrong. Sometimes, the data was available but there was a lack of curiosity about it.

Sharing information and concerns between the NHS and the independent sector

Patients expect key information about their medical history and treatment to be shared between those responsible for their care, starting from a first appointment with a GP, through to specialist diagnosis, treatment and follow-up. They expect NHS Trusts to talk to each other, as well as to the independent sector. Many of the patients we spoke to were surprised and disappointed that this did not happen.

Sharing information and concerns with GPs

When a patient's journey through health services starts with an appointment with their GP, this is where patients would first expect accurate and appropriate information to be held, provided to them and shared with other relevant professionals. In chapter four, we looked at referrals to Paterson by local GPs, and we know that much of the information they held about Paterson as a healthcare professional was inaccurate or incomplete. We heard from UHB:

“ What is difficult though is the GPs will not know, you know, if we are thinking could GPs have done more to stop Paterson. You know, at the time he was the number one person. They were all referring to him, because the word on the grapevine was that he is excellent. And you know, that is where their wives were going it is where our consultant's wives were going, our staff were going. And so that sort of reputation is quite a dangerous tool, if you like. But trying to replace it with data is also so difficult, because by the time we get it out there it is out of date. ”

[N470, University Hospitals Birmingham Trust]

Patients would then expect information to flow back to their GPs following their treatment at the hospital, and many patients spoke to the Inquiry about this. There were instances where information was either not shared with the GP or the information was incomplete, making it difficult to identify concerns. We heard of cases where incorrect information appears to have been deliberately provided to the GP by Paterson, who had said something entirely different to the patient.

“ I never got copied on any letters that he sent to my GP, and it was only when I then saw [healthcare professional working on patient recall]) when the review happened that I realised that there was a lot of discrepancy in what he was telling my GP and what he was telling me, and what the report said, it did not add up. ”

[Patient 2 treated at Spire hospitals]

“ He wrote a similar letter to my GP. It was just pitted with lies. You could challenge it and it was just not worth the paper it was written on. The one thing I did say to him, I do not know where it came from because I knew he was lying. ”

[Patient 68 treated at Spire hospitals]

“ I truly believe if my GP had access to my records, to my scans, to my mammogram, I truly believe he could have been stopped earlier. The NHS patients, their results go to your GP. Whereas Spire don't have to send anything to your GP. My GP wasn't aware of half of this until it all came out, and I went to see her and said I didn't have cancer. She was as shocked as I was because she had absolutely nothing there where she could have looked and thought, 'Well, that doesn't look right. I need to look into that.' ”

[Patient 15 treated at Spire hospitals]

We heard from Newbold, former Chief Executive at HEFT, about the local measures for dealing with information sharing with GPs at the time:

“ We did not have any formal forum for involvement with GPs. Obviously on a case by case basis all the information like any information in a hospital record is available to GPs, but there was not any other reason to do anything more formal than that from my recollection. ”

[N413, Mark Newbold, Chief Executive at HEFT from August 2010 to December 2014]

We know that there were challenges nationally in sharing patient information with GPs in a timely way. In 2009, CQC's national survey on “the right information, in the right place, at the right time” stated:

“The most common concern we found was the need for hospitals to improve the quality and timeliness of information sent to a patient's GP when they are discharged from hospital. Most GPs who responded to a survey conducted by the NHS Alliance believed that this compromised the safety of patients.”

It was not only GPs, but also patients themselves, who did not routinely have access to information about the care they received while at hospital. Failure to provide information to both the patient and their GP disempowered them, removing their ability to have full control over their care. Writing letters directly to patients is in keeping with both the NHS Constitution and GMC's Good Medical Practice, which states:

“you must give patients the information they want or need to know in a way they can understand”.

We understand that process has changed since Paterson was practising, and that GPs now sometimes, but not always, receive letters after every appointment. Increasingly, letters from hospitals are addressed to patients and copied to their GP (following the Academy of Royal Medical Colleges *Letters to Patients* guidance in 2018), but even then they are often written in medical language which is not always easy for patients to understand.

We note that it is difficult for any system to cope with any healthcare professional who chooses to deliberately mislead or lie, and that Paterson is not unique in this.

Sharing information between HEFT and Spire

It is unclear to us who owns medical records – the patient or the hospital. We heard that in the independent sector, consultants own their records. However, we note that in its Scope of Registration 2015, CQC clarifies that where hospitals offer practising privileges to doctors, it is the hospital that takes responsibility for ensuring the essential levels of quality and safety are met, and the hospital owns the medical record.

We were told about the way in which private patient information and patient records were shared between HEFT and Spire, and we have looked at the quality of medical records in chapter four. Where private patient information was shared between the hospitals, it appears to have happened informally, generally by Paterson himself taking patient notes from one hospital to another, rather than as a matter of routine. This was not unique; it is custom and practice that private patient notes are not shared between the NHS and independent sector. In the independent sector, private patient records are owned by the consultant. The Paterson case has highlighted how this can put patients at risk of harm where that consultant does not document or share accurate information in an appropriate way:

“ Because I can't believe the NHS didn't speak to the private sector, and vice versa, and they sorted it out. And the one thing that stands out for me, because we've had things like this before, when somebody's not very well, what they tend to do, is a team get together and talk about it. From what I can gather, it was left to him to talk to himself about it. And I think that's absolutely awful. ”

[Relative of patient 110 treated at Spire hospitals]

The failure to share patient information across the hospitals on some occasions led patients to have multiple and repeated tests, which would not have been necessary had the information flowed from the NHS to the independent sector or vice versa. We heard in evidence from patients that in the majority of cases their pathology reports were only seen by Paterson and the breast care nurse, although Paterson denies this. In one case, we heard that Paterson refused to share pathology results with another consultant:

“ [A consultant surgeon] has written to Mr Paterson to get the pathology of the lump removed on my leg, to understand the history of it, and he was refused. And he was quite annoyed about that, for it to have been refused, but Mr Paterson said that he was my doctor, this is what [a consultant surgeon] told me, he was my doctor, he had treated me, that there was no need for anybody else to get involved. And again, in hindsight, you look back... and, in your own mind, you know that doctors share records. Even in the private sector, they should still share records. ”

[Patient 2 treated at Spire hospitals]

When asked, Paterson said he had no recollection of refusing to share pathology results with other consultants.

The 2009 CQC national study, *The right information, in the right place, at the right time*, highlighted the challenges around sharing information between the NHS and independent sectors:

“the sharing of personal information between health professionals and with staff working in non-NHS settings (independent healthcare, social care and local authorities) is more problematic. There are technical barriers posed by systems which are not integrated (such as lack of access to NHS email systems by independent sector providers and social care providers) and also the lack of streamlined documentation such as standard discharge summary templates and referral letter templates.”

It remains the case that it is not mandatory for patient records to be shared between NHS and independent sector hospitals. However, we heard from Spire:

“ if the decision to treat was made in an NHS environment then the notes would come across with the patient with all their health information. ”

[N438, Alison Dickinson, Group Clinical Director, Spire]

We also heard evidence that there have been some improvements in sharing of information across the sectors, but these have not been implemented at a national level.

For example, the Benenden Hospital in Kent has worked with others in the area to establish a local intelligence network to share issues of quality and safety across hospital providers in both the NHS and independent sectors. We heard that this was done in response to the concerns raised by the Paterson case.

Local groups, such as the Partnership Assurance Group in Birmingham, which has been introduced in response to Paterson, provide a mechanism which enables the sharing of information and concerns by responsible officers in the NHS and independent sector:

“ So, in response to Kennedy, one of the things that [the medical director] did was introduce the Partnership Assurance Group, PAG, where he basically met the hospital manager and the governance teams from our two biggest local providers, which was Spire Parkway and Spire Little Aston. And then BMI found out about that and asked if they could join. And that is an improving relationship, and we certainly share information with them very readily. ”

[N470, University Hospitals Birmingham Trust]

The role of “responsible officer” is discussed later in this chapter.

Sharing concerns across HEFT and Spire

If any concerns are identified relating to the doctors or nurses who may treat them, patients expect these to be raised through the correct channels and dealt with to keep them safe. This is particularly important where the patient, and the doctor, move between the NHS and the independent sector.

Patients did not believe that concerns about Paterson had been shared between HEFT and Spire. This is vividly illustrated by the pattern of events.

“ They need to be more accountable and they need to share what their findings are. It needs to be shared from the NHS to the private sector because if the NHS had shared with the private sector his work career, then maybe the private sector might have known what they were taking on, perhaps, although they take no responsibility and that is another issue. ”

[Patient 43 treated at Spire hospitals]

There was a failure to clearly communicate concerns between the NHS and independent sector. A former hospital manager from Spire told us that the first time she heard that HEFT had concerns about Paterson’s practice was on 4 January 2008, when they received a letter from Goldman, the Chief Executive to inform them that there were potential problems with his NHS breast practice, and as a result they were restricting certain aspects of Paterson’s surgical practice at HEFT.

“ In this case I first knew about the concerns when I was formally written to, but I would have expected the Trust to have picked up the phone to advise me of the issue prior to this. It was important to me to have established relationships with the Trusts that had consultants working with us, so that easy notification was facilitated and there were lots of instances over my time as a hospital director where I had notification about concerns from other trusts and also where we had identified potential concerns within Spire, when I picked up the phone to the relevant Trust, so that we could make sure we looked at the total practice.. ”

[N448, a hospital manager at Spire]

The former hospital manager told us that they met with Paterson on the same day they received the letter from HEFT. He continued to defend his CSM technique but agreed that he would mirror the restrictions imposed by HEFT at Spire. The manager pointed out to us that:

“ as most of Mr Paterson’s practice was in the NHS it was normal for the Trust to investigate. ”

[N448, a hospital manager at Spire]

We heard conflicting evidence regarding which organisation then made the next contact, but understand that there was a meeting between the Medical Director at HEFT and managers at Spire Parkway on 14 July 2009. The HEFT Medical Director gave an update on their reviews into Paterson and informed the manager at Spire Parkway that his rates of cancer recurrence were within normal parameters. This was followed by correspondence from HEFT, which confirmed this. Reassured by this information, Spire managers made a decision not to investigate further, as their patients had been included in the audit undertaken at HEFT.

There was no further communication from HEFT regarding Paterson until Friday 13 May 2011, when the manager at Spire Parkway received a telephone call from a newly appointed Medical Director at HEFT. He advised her that Paterson had been suspended from HEFT but was not explicit about the reasons, or clear whether the suspension related to Paterson’s clinical performance, behaviour or to specific patient safety concerns. We heard that the communication from HEFT was fragmented and limited. Spire limited Paterson’s practising privileges in May 2011 so that he did not undertake breast surgery after May 2011 and stopped all surgery in June 2011. HEFT terminated his employment in April 2014.

The former Spire hospital manager told us that none of the consultants working at Spire Parkway alongside Paterson (some of whom served on the hospital’s Medical Advisory Committee) raised concerns with them about his clinical breast practice at the time, or mentioned that he performed CSMs. They referred to a meeting they had in October 2011 with a number of consultants, after Paterson had been suspended. They came to tell them about concerns they had about him at the time. When they asked one of the consultants why he did not mention this earlier, he replied, “without any proof and with his character it would have been too difficult to do so”. They told us that if they had been told of concerns before 2011, they would have acted earlier. It was unclear at the time and remains unclear what the threshold is for identifying an issue as a concern.

Goldman, the Chief Executive of HEFT from 2001 to 2010, told us that the only occasion when concerns about Paterson were shared with the independent sector through him was in 2007:

“ There was no contact whatsoever with the private hospitals. The only contact that we had with the private hospitals that I can point to with confidence was the fact that I wrote to them in 2007 when we suspended Ian Paterson from carrying [out] anything but the standard procedure, not doing shaves and mastectomy, and one or two other things, I think, at the same time. I wrote to them all and I phoned the chief executives or whatever they were called. ”

[N416 Mark Goldman, Chief Executive of HEFT from 2001 to 2010.]

Responsible officers (ROs)

We heard evidence from many witnesses about the role of the responsible officer. This is set out in the Medical Profession (Responsible Officer) Regulations 2010. A responsible officer must have been a medical practitioner for the previous five years. They are responsible for evaluating doctors' fitness to practise and making recommendations about the revalidation of doctors to the GMC. Responsible officers are expected to share concerns about a doctor's practice with responsible officers in other organisations where the doctor may work. Responsible officers were introduced after the period that Paterson practised.

We heard broad agreement from witnesses that the responsible officer regulations had led to improvements in the independent sector:

“ The introduction of the Responsible Officer system has substantially improved the oversight of consultant performance and the sharing of information relating to concerns between organisations. ”

[N474, BMI]

NHS England, the GMC, Nuffield and Spire told the Inquiry that the responsible officer role is improving the sharing of concerns, with Nuffield noting that as a result, exclusion or suspension of a doctor in one sector was virtually always mirrored in the other.

NHS Resolution commented that the introduction of responsible officers and guidance from NHS England had helped facilitate the sharing of information between the private sector and the NHS. They also said that it was “quite rare for the independent sector to come to us about somebody that we are not already aware of”.

Conversely, we also heard that communication within the responsible officer network is variable, that the medical director role is too demanding to give enough attention to concerns raised by others, and that improvements in communication have been more substantial within the independent sector, rather than between the NHS and independent sector. We also heard from some witnesses that they are not currently using the responsible officer role to ensure effective sharing of information and concerns, although it is available to them. Cigna is a private medical insurer that limits its members' choice of consultant:

“ it's clear that there is no formal process in place for sharing information about individual doctors and their fitness to practice or whether they are under investigation or being suspended and when we asked them about the responsible officer mechanism they replied: 'it's not something we're doing.' ”

[N196, Cigna]

While we heard from these witnesses that the introduction of the responsible officer role has had some positive impact, and that they have a role to play in sharing concerns between organisations, we also heard that this must not be considered as a single silver bullet to address the issues around shared concerns.

“ While the events of the Paterson case preceded the implementation of the Responsible Officer Regulations, we do not believe that existence of the Regulations in themselves is enough to prevent a similar case occurring in the future. ”

[N423 NHS England]

Although there is evidence that the introduction of the responsible officer role has had some benefit, we are not convinced that Paterson’s malpractice could not happen now because of the existence of responsible officers. The Inquiry also believes that sharing of information and concerns must be the responsibility of all those who hold information and concerns, and not only a single nominated individual. We do not believe that responding to systemic failures in healthcare should be the responsibility of one person.

Sharing concerns and information across the wider health system

This section describes what witnesses told us happened, and what should happen, to ensure that the right information is shared with the right people and organisations at the right time to keep patients safe. Patients expect the system as a whole to work for their benefit.

“ I have to say, as a patient point of view we really didn’t care two hoots about the system so as long as it works. ”

[N6 Patient support group lead]

Sharing of information by private medical insurers and medical defence organisations (MDOs)

The role of private medical insurers and MDOs was discussed in chapter five.

Private medical insurers told us they are only permitted to share information about specific cases in relation to counter fraud, criminal acts or serious medical inappropriate behaviour. However, they failed to do this in the case of Paterson. They were regulated at the time of Paterson by the Financial Services Authority, and now by the Financial Conduct Authority, which sets different standards from those set for the health regulators.

The focus of the limited information shared by private medical insurers with other organisations is on a case-by-case basis, rather than based on the sharing of all information to enable links to be made with other data sources to identify outliers. However, medical insurers did tell us that they do some analysis to flag potential issues. IHPN told us that they are currently in discussion with private medical insurers about how information can be effectively shared with providers for patient safety purposes on a voluntary basis.

The MDOs who provided evidence told us that data is not routinely shared by or with them, although they may on occasion share information relating to individual consultants, with the member’s consent.

Sharing of information about groups of patients

In addition to information shared between organisations about specific healthcare professionals or patients, the sharing of information about a set of patients with key national bodies can help hospitals and others spot a doctor's malpractice. There was a lack of curiosity about the available data. Most of the evidence we heard was about the current picture and plans for the future, rather than what was in place at the time.

There is limited information currently collected about private patients, compared with the NHS. We heard from independent hospital providers that they are frequently not considered in national patient safety plans and initiatives, and are rarely able to submit information about quality and patient safety into national clinical audits, clinical registries or other data collections to enable comparison and benchmarking alongside NHS providers. Where they are able to submit data alongside the NHS, this is often on a voluntary basis. There seems little reason to regard private and NHS data as different. Multiple witnesses, including IHPN, HCA, Healthcode, the Royal College of Surgeons and Spire told us that there should be a single repository of all data, although this conviction was not centred on its availability to patients:

“ A particular issue private providers face is that we are not reliably notified by NHS Trusts if restrictions have been applied on an individual's scope of practice, or if their scope has narrowed or changed. One means of addressing this would be to create a single national repository of information about every doctor including their scope of practice, location of practising privileges, designated body and other critical consultant performance data; this should require the participation of both NHS Trust and private providers and be hosted by the professional regulator in the UK, the General Medical Council. ”

[N438 JJ De Gorter, Chief Medical Officer, Spire]

“ We also strongly support the IHPN's call for a single dataset or repository about a consultant's whole clinical practice to be available to the independent or NHS hospitals where they work. This could include information about a consultant's practising privileges, indemnity cover, scope of practice, identity of Responsible Officer and appraisal status. Access to such information would help to ensure that concerns about a doctors' conduct or performance are quickly identified and shared with the relevant bodies so that appropriate action can be taken promptly. ”

[N1 Derek Alderson, President, Royal College of Surgeons]

We were told that some progress has been made collecting private healthcare data through the Private Healthcare Information Network (PHIN), with mandatory collection to meet the Competition and Markets Authority (CMA) Private Healthcare Investigation Order 2014. To date, however, progress in the collection and publication of information about private healthcare providers and individual consultants' private practice has been slow and with a limited scope of data collection compared with the NHS. There are no penalties in place for independent sector hospitals who do not submit the data. We note CQC will review how providers are complying with the CMA Order during inspections of independent sector hospitals.

Significantly, we were told that there was little analysis of the data :

“ And I think whenever data is collected, it needs to serve a purpose. You should not just collect data for collection’s sake, it should serve a purpose. And I should be able to go on there [PHIN], and look at it and analyse the data. Patients should be able to go on it and look at the data and actually should mean something to them. I do not think it does, at the moment, so I think it has got a journey to go at the moment. ”

[N417 Mahmood Shafi, Medical Director, Nuffield]

Many private healthcare providers do submit limited data to Healthcode as the clearing house for billing and reimbursement for private medical insurers, but it is not currently used in relation to quality of care.

Several witnesses also told us about the Acute Data Alignment Programme (ADAPt), a joint programme between NHS Digital and PHIN, which is seeking to align information standards and data collections across private healthcare and the NHS, which should make more comparable information available to regulators to support the inspection regime, to patients for transparency purposes and to providers to help benchmarking and improvement of services.

However, PHIN noted that:

“ ADAPt will take the process of alignment as far as is possible within the bounds of current legislation and regulation, but it is possible that some changes may ultimately be helpful or required. If approached with care, we believe the removal of some of the differences that persist in the application of legislation to private healthcare would be welcomed and could also reduce the burden of data collection. ”

[N155 Matthew James, Chief Executive, PHIN]

Barriers to information sharing

Several witnesses told us that data protection is a barrier to sharing information between organisations and cited particularly the General Data Regulation Protection (GDPR). GDPR was not in place when Paterson was practising. However, we believe this is a misinterpretation of the regulation, and that sharing of information to maintain patient safety is an important exemption within the legislation. Furthermore, failure to share vital information which could promote patient safety is a breach of the Caldicott principles, established in 1997 to protect patient confidentiality within the context of the increasing use of information technology in the NHS:

“The duty to share information can be as important as the duty to protect patient confidentiality.”

We also heard that the commercially-sensitive nature of private healthcare data is a barrier to sharing of information. We were also told that the data collected in the NHS and private sector is not always easily comparable, with different coding structures used in each sector.

We noted that the reason some patients choose to have private healthcare is to protect their privacy and confidentiality and prevent their confidential information from being shared with the NHS or their GP.

We have concluded that there is confusion about individual organisations' responsibilities, data protection legislation and commercial confidentiality, and that this stands in the way of the timely sharing of information to protect patients.

The role of specific organisations

There are a number of organisations across the health system that play a role in ensuring that patients are safe and receive good quality care, including the CQC, GMC and NMC.

This section looks at what the Inquiry was told about these organisations by patients and others, and considers how, despite heavy regulation, Paterson was not stopped from harming patients.

The health and care system is a large, well-resourced and complex network of organisations. There are nine organisations set up as regulators of health professionals, including the General Medical Council and Nursing and Midwifery Council. Alongside these organisations, the Care Quality Commission regulates health and care services. The Professional Standards Authority scrutinises and oversees the regulators.

Regulatory Organisation	Annual operational budget (18/19) £:	Number of staff:	Breakdown of budget:
General Medical Council – annual report 2018. Please note the figures shown relate to the period from 1 January to 31 December 2018	109.9 million	1,236	<ul style="list-style-type: none"> • 55% managing complaints about doctors • 19% revalidation and managing the medical register • 9% education & training for doctors • 8% supporting doctors with their practices • 9% managing the organisation
Nursery and Midwifery Council – budget report 2018-2019	92 million	798	No breakdown
CQC – 2018-2019 annual budget report	234 million	3,210	<ul style="list-style-type: none"> • 41% inspection • 35% monitoring • 10% registration • 8% other activity • 3% independent voice • 3% enforcement • £10.3 million spent on capital investment – funded by grant-in-aid from DHSC
Professional Standards Authority – 2018-2019 annual report	4 million	40	

Care Quality Commission

CQC regulates and monitors health and care services to ensure that they are safe, effective, compassionate and of high quality. CQC was established in 2009, replacing the Healthcare Commission (HCC).

As far as we have been able to establish, neither the CQC nor the HCC identified concerns regarding failures in patient safety at HEFT or Spire Parkway while Paterson was practising.

The role of CQC in ensuring safety was not visible, understood or recognised by patients who gave evidence to the Inquiry. The chairs of the two groups set up to support patients of Paterson, felt strongly that CQC did not look out for patients or engage with them. One of these had complained to CQC about the Paterson case.

There was different regulation of both sectors until 2010 with Care Standards solely applying to the independent sector. From 2010, the Health and Social Care Act (Regulated Activities) Regs 2010 and its associated essential standards applied to both the NHS and the independent sector. From 2015, the inspection key questions were similar in both sectors. Despite this, there are still differences in how CQC regulates inspects and monitors both sectors.

Whilst CQC told us that it applies the same principles to the NHS and the independent sector, there were differing views about whether this was the case. For example, in the independent sector, corporate boards are excluded from CQC inspection. This means that assessment of corporate leadership under CQC's "Well Led" domain may not give an accurate picture of leadership capabilities and culture. CQC told us they are now planning to pilot corporate board level inspection with one independent sector provider.

A CQC requirement to provide regulated health and care services is that private hospitals should have a "registered manager" in place, who is suitably qualified and competent to manage services. NHS providers do not have "registered managers". We heard differing accounts of how robust was CQC's process for appointing registered managers in the independent sector, from a nod through, an open book examination, to a searching interview.

CQC told us that registered managers are appointed following an interview process.

CQC told us that patterns of concerns which emerge through complaints or whistleblowing may now prompt them to carry out an inspection. Equally, any reports commissioned by an NHS Trust (such as the Wake Report) would now be shared with CQC, even if an inspection was not planned, whereas this was not the case at the time of Paterson.

We heard that the regulatory landscape is disjointed, with insufficient linkage between CQC and the other regulators. We note, with regret, that the CQC's Chief Executive did not attend the evidence session with the Inquiry. This was out of line with other regulators whose chief executives fully engaged with us. We do not believe the CQC approached the Inquiry with the level of seriousness and priority we would expect from an organisation that was in existence when Paterson was practising, and which patients felt had let them down.

General Medical Council

The GMC is the professional regulator for doctors and is responsible for registering and ensuring doctors are fit to practise. Around a third of 100 patients, healthcare professionals and organisations talked to us about the role of the GMC and the actions taken by them in the Paterson case. Both former patients and other witnesses appear to have been very dissatisfied with the approach and actions taken by the GMC. They questioned why, despite the first complaint about Paterson being raised with them by a patient in 2007, the GMC did not suspend Paterson until 2012.

“ The General Medical Board, I blame them because not only did I bring it to their attention, xxx [a health care professional] brought it to their attention years ago. So it’s not a case of he did this and then he didn’t do anything, and then 15 years later I put a complaint in. The General Medical Board put their head in the sand. They didn’t do anything. ”

[Patient 89 treated at Spire hospitals]

Patients told us that they were hindered or prevented from raising concerns about healthcare professionals with the GMC for a variety of reasons, including the ‘five-year rule’, where the GMC will only investigate if the incident took place within the last five years, unless it is in the public interest. Patients also said the GMC did not make the pathway clear in how it would receive complaints. When patients were persistent enough to make a complaint, there were concerns over the time taken to deal with it.

“ It takes them months to answer an email, but you just have to keep sending them so that eventually they’ll reply to you. ”

[Patient 15 treated at Spire hospitals]

“ So if somebody complains, you’re not told anything. You’re not told the truth because it’s a big secret. ”

[Patient 19 treated at HEFT]

In some cases, the police investigation delayed handling of patient and doctor complaints. The GMC informed us that they were asked to pause their investigation by West Midlands Police and the Crown Prosecution Service:

“ it was in response to that request from the police that we paused. And, of course, from our perspective as a professional regulator with an objective to protect the public, the fact that the doctor was not in practice during that period meant that there was no risk to patients that arose from that ongoing suspension. ”

[N338 Charlie Massey, Chief Executive, General Medical Council]

We also heard concerns that the organisation was “not proactive” and “not fit for purpose” and “not robust enough”. One patient commented on sharing of information within the organisation as unsatisfactory:

“ And he said, ‘Well, you need to give us some evidence about [a plastic surgeon working with Paterson]’, and I said, ‘Well, no problem, but I’ve already made a statement to you which talks about X.’ ‘Oh, have you?’ So, what is the point in making these statements if they do nothing with them? ”

[Patient 281 treated at HEFT]

In our own early dealings with the GMC for this Inquiry, we similarly experienced a disjoint in communication between different parts of the organisation.

We also heard from healthcare professionals about their experiences with the GMC. Four healthcare professionals and managers told us that they did not raise concerns about Paterson to the GMC, with one GP commenting that it did not seem like a viable route for doctors:

“ I still feel that I don’t think most GPs would take that route. ”

[N377 GP working in the Solihull area]

Four of the doctors who raised concerns with HEFT’s Chief Executive in 2007 were themselves subject to investigation by the GMC. This, and the impact it had on them, is discussed in more detail in chapter five.

Several witnesses talked about the impact of the GMC failing to act when concerns were first raised with them in 2007. UHB commented that the lack of action by the GMC hindered the ability of HEFT to act at the time, and Newbold, former CEO at HEFT said:

“ I contacted the GMC but they were not willing to consider suspending his registration unless we as a trust suspended him. It would have been much easier if it was the other way around ... ”

[N413, Mark Newbold, Chief Executive at HEFT from August 2010 to December 2014]

UHB told us about issues relating to the threshold and scope for raising concerns with the GMC:

“ We (UHB) have had a few people who we have removed, who have not actually been reportable, because the GMC have taken a view it is an employment issue not a professional issue. ”

[Dr David Rosser, Chief Executive University Hospitals Birmingham since 2018]

Two witnesses told us that the GMC lacks sufficient data to be able to understand or act on quality of practice. UHB told us that GMC records fail to highlight poor practice:

“ I can give you a bunch of examples of things that I consider really serious, people I’ve sacked actually, to be blunt, who, if you look at their GMC record today, you will see nothing. ”

[Dr David Rosser, Chief Executive University Hospitals Birmingham since 2018]

We heard some positive reports about the role of the GMC in setting standards, and in particular its guidance, “Good Medical Practice”, and the introduction of the Employer Liaison Service which works with responsible officers, medical directors and medical managers to support doctors to meet its standards. We heard from two patients that the GMC were proactive in sharing their concerns with the NMC. We also heard from other organisations that they have good engagement with the GMC.

The GMC told us that because of the different statutory base for the regulators it was sometimes difficult to share concerns in a seamless way, although they were confident that this did happen. They also told us about their emerging concerns protocol:

“ The Emerging Concerns Protocol which can lead to an RRP establishes a process for earlier sharing of concerns, and for discussions between partners that might be of relevance to them. It aims to facilitate sharing of this information at an early stage, so that links between concerns can be made, and a wider system view of the issue can be established. ”

[N338 GMC]

Nursing and Midwifery Council

The NMC is the professional regulator for nurses and midwives. It registers them and makes sure that they are fit to practise. The role of the NMC is not visible to patients and very few of them mentioned the organisation.

Although only a small number of patients told us they had raised concerns with the NMC, their experience of doing so was generally positive:

“ I’ve actually had lots of response. They have been fantastic. By comparison with the GMC, this is an outfit that works. ”

[Patient 19 treated at HEFT].

One witness found the NMC unwilling to engage with her since she was acting on behalf of others and did not have a personal complaint.

The NMC’s role in holding its professionals to account was highlighted and compared favourably to that of the GMC. We heard that there was a cultural difference between nurses and doctors and that nurses were thought to be “good at holding each other to account”. Despite this, no nurses raised concerns with the NMC about the issues relating to Paterson’s practice, including the nurses who worked with him.

A patient support group lead told us that she tried to raise a concern with the NMC about some of the nurses relating to this case, but commented that they:

“ were very unwilling to engage with me at all, because I didn’t have a personal complaint, so they wouldn’t engage with me as part of saying, ‘Well, look, this is on behalf my group.’ So that didn’t really help. ”

[N7 Patient support group lead]

UHB provided positive feedback on the NMC’s role in holding its professionals to account, compared to the GMC:

“ it’s a cultural thing, nurses are good at holding each other to account and doctors are not. It is no more complicated than that, to be honest I cannot conceive of any logical reason why nurses should be more harshly held to account than doctors. ”

[Dr David Rosser, Chief Executive University Hospitals Birmingham since 2018]

Professional Standards Authority

The Professional Standards Authority (PSA) oversees the organisations that regulate health professionals. It was set up in response to Kennedy’s report into children’s heart surgery at the Bristol Royal Infirmary, which identified inadequacies in the regulatory system. The PSA told us that they have three functions: to review the performance of the regulators; to review every decision about a healthcare professional’s fitness to practise; and to provide policy advice on professional regulation:

“ It is not a performance management of regulators, and it is not a regulators regulator, although it sometimes gets described in that way. It is an oversight body... its purpose is to try to ensure that regulation tilts towards public protection as opposed to professional self-interest, which was the concern, both at the time of the Bristol Inquiry and the also at the Shipman Inquiry that it was still tilted too much towards the professions rather than towards public protection. So, it has an overarching responsibility to promote the health, safety and wellbeing of patients in the public. ”

[N411 Christine Braithwaite, Director of Standards and Policy, PSA]

The PSA told us that they cannot act in relation to an individual case, and that they were not heavily involved in the Paterson case.

We are concerned that there is a mismatch between the PSA’s assessment of the health regulators and what we heard from patients and other witnesses about those organisations. The GMC, for example, scored a full 24 out of 24 in the PSA’s performance assessment (2018-19). PSA told us that this score reflects the meeting of standards as reported to Parliament, but there is still scope for those organisations to improve in terms of overall performance for patients:

“ the primary purpose of these reports is to assure parliament that the regulators are meeting a requisite standard. And they are, in the case of the GMC, they have been judged to have met the requisite standard. That does not mean to say there are not still areas of improvement for them. Particularly if you are asking regulators to go on a journey to continuous improvement. ”

[N411 Christine Braithwaite, Director of Standards and Policy, PSA]

There is a whole jigsaw of organisations involved in regulation to keep patients safe, but despite numerous organisations and substantial resource, there was a failure to keep patients safe in the case of Paterson. We were not assured through the evidence we heard, that the PSA has the mandate or power fully to grip the system. The PSA reflected:

“ rethinking regulation is far too complicated to start. You can start designing today, with having a fragmented system like the one we have got. We certainly think that you can no longer separate out the person from the workplace, so our professional regulation and system regulator split is not ideal. From that point of view. Yes, thinking about it, I am not quite sure exactly what that would look like, but we could certainly be asked to think about what role we might play in bringing about better coordination and coherence between the system, given the situation. ”

[N411 Christine Braithwaite, Director of Standards and Policy, PSA]

In its response to the consultation on Promoting Professionalism, the Government has said it is looking at the role of the PSA to ensure there is sufficient public protection in relation to fitness to practise cases. The Government also said it will put in place measures to support openness and transparency, including the requirements to update family members on the progress of fitness to practise cases.

Paterson’s membership as a Fellow of the Royal College of Surgeons and as a Fellow of the Royal College of Surgeons of Edinburgh.

Being a Fellow of the Royal Colleges confers a certain status on doctors, and one in which many patients have faith. Following his conviction, both Colleges held disciplinary hearings about Paterson and withdrew his fellowship.

What we have learned

The Inquiry has learned the following:

Whilst things have improved in relation to sharing concerns and sharing information since the time of Paterson, and continue to do so, it would be wrong to say that systems in place today would identify and stop another Paterson at an early stage.

The information shared about private healthcare has improved but is still limited in scope, not universally submitted by all private healthcare providers, is not available to the public and cannot currently be easily compared alongside NHS data.

There were many instances where information was either not shared with the GP or between providers, or the information was incomplete, making it difficult to identify concerns.

There is still some confusion as to when concerns should be shared and what the threshold should be.

The responsible officers framework is more likely to result now in sharing issues, but the independent sector told us the NHS was poor in relaying concerns to them.

The independent sector is not considered in national patient safety plans and initiatives and is excluded from submitting data alongside NHS providers for many national clinical audits, clinical registries and other national data collections.

There are barriers to information sharing, including information governance considerations, commercial sensitivity and differing standards which need to be overcome.

The healthcare system is regulated by the CQC, NMC and GMC. However, despite this regulated landscape, Paterson's malpractice continued over a sustained period within the context of concerns being known about him at HEFT since 2003. All the regulators appeared to be waiting for someone else to act. It is our view that in this case, the regulation of the healthcare system failed.

The regulators (GMC, NMC, CQC) and the PSA have told us that it is less likely to happen now. From the evidence we have heard, it is our opinion that this is not the case.

The roles of the different regulators need to be more clearly explained to the public and each should improve its patient focus and ensure better signposting of patients to the appropriate body.

CHAPTER SEVEN – Governance, accountability and culture

The Inquiry heard that patients were not safe under the care of Paterson in either the NHS or the independent sector and that when this became known, the response from HEFT, Spire and others responsible was inadequate. This is discussed in more detail in chapters four and five.

HEFT and Spire each had managers and healthcare professionals who had direct and individual responsibilities for patient safety. Some of these sat on the board as executive directors and were responsible and accountable for what happened in the organisation. Others, who were not board members, nevertheless had a shared accountability and a responsibility to make sure that patients were safe at the hospitals.

In this chapter, we examine how effectively the boards of HEFT and Spire responded to Paterson’s malpractice. Alongside this, we consider how individuals in the hospitals and the wider community acted in response to Paterson. We do this by looking at three areas:

- Corporate accountability - the extent to which HEFT and Spire accepted responsibility for what had happened to patients of Paterson and what steps they took to keep them safe.
- Individual accountability - how individuals who were, or who should have been, aware of Paterson’s malpractice responded to it.
- The prevailing culture in the hospitals and wider community.

Corporate accountability

Hospitals in both the NHS and independent sector are managed at the highest level by boards of directors. Non-executive directors provide independent oversight and constructive challenge to the executive directors on the board. The chair of the board is responsible for ensuring the board is accountable for governing the organisation. There are differences between boards in the NHS and independent sector.

Patients who spoke about accountability for their care told the Inquiry that HEFT and Spire did not demonstrate responsibility for what had happened.

NHS

The role of boards in the NHS is to develop the strategy for the organisation; hold the organisation to account for the delivery of the strategy and seek assurance that systems of control are robust and reliable; and shape a healthy culture for the organisation (NHS Leadership Academy 2013). There is a requirement for chief nurses, directors of nursing and medical directors of NHS trusts to be full members of the trust board and to be able to vote on decisions the board makes.

We heard that there had been problems with governance at HEFT for some time:

“ Probably within the first month [in 2016] I had a fair idea that this was possibly the worst Trust I had set foot in... I had to gain the confidence of people because there was a culture of ‘we’ve said things in the past and not been listened to.’ ”

[N74 Dame Julie Moore, former interim Chief Executive of HEFT 2015 to 2017]

Moore also described witnessing at her first board meeting “a board at war with itself”. This was echoed by the Right Honourable Jacqui Smith, the chair of UHB, which merged with HEFT:

“ So there was a board where I think there had been a breakdown of the relationship between the non-exec directors and the executive directors. ”

[N470 Right Honourable Jacqui Smith, Chair of UHB since 2015]

There was a feeling that the HEFT board had been remote during the time that Paterson practised at the Trust, and that there was a disconnect between the board and HEFT’s healthcare professionals and front-line staff.

As described in detail in chapter five, concerns about Paterson’s conduct and clinical practice were first raised in 2003 by an oncologist who worked alongside him. HEFT responded by asking Wake, a senior clinician at the Trust to investigate. HEFT’s response to his investigation in 2004 was inadequate, and it did not act on all the information in his report. After further concerns were raised in spring 2007, the Medical Director and the Chief Executive set up an investigation under disciplinary procedures. In December 2007, six healthcare professionals who worked alongside Paterson were so worried about his clinical practice and patient safety, they wrote to the Chief Executive of HEFT to raise their concerns. Following this, HEFT asked Paterson to stop doing CSMs. In 2008, Lee was invited by HEFT to observe Paterson and produce a report; he did not believe his report was acted on fully by the Trust. Concerns about Paterson were responded to by HEFT as if they were isolated incidents and on each occasion the opportunity to stop Paterson was missed.

The Inquiry heard there was a lack of transparency in the board’s response to the case. This view was expressed by three healthcare professionals who had directly raised a concern about Paterson and by two healthcare professionals who had been brought into HEFT to examine Paterson’s practice and behaviour:

“ I think in some ways the Chief Executive is very powerful, and I’m not sure – I have no idea what the board knew. I’ve no idea, I couldn’t tell you even now what the board knew. How would I know, who would tell me? I’m only a simple clinician, no one would tell me what the board knows or what the board doesn’t know. ”

[N442 a healthcare professional who worked with Paterson at HEFT]

The Chief Executive and Medical Director in post at the time told us that concerns about Paterson were reported to the HEFT board between 2007 and 2010, and that the board never advised a different course of action from the one being taken:

“ There are a number of occasions when documents were taken to the Board or the matter was referenced. I think the first occasion it went to the Board was in September 07, you recall that [the healthcare professionals] letter raising the issue occurred in mid-July and, I think, probably September was the first occasion that we had to take something to the Board. And the matter then came to the Board from time to time right up to the time I left. ”

[N416 Mark Goldman, Chief Executive of HEFT from 2001 to 2010.]

“ The Chairman and I had a meeting once a week which was an open meeting, he didn’t want it minuted, he didn’t want anyone there and we would speak openly to each other about issues in the Trust and I brought the issue of Ian Paterson to him on many occasions. So, the Chair was aware of what we were doing. There were other moments when it came to the Board, the Board never, at any time, advised us against what we were doing and, notably, the Chairman advised the Board, after I’d left the Trust, that he was confident in what had happened. ”

[N416 Mark Goldman, Chief Executive of HEFT from 2001 to 2010.]

“ The Board were regularly updated with it... The Board would have had update reports at various times when key events were happening and when we needed advice on certain things. I had one-to-ones with the Chairman on a monthly basis as before. We had a non-exec from the Board [Anna East] who worked with us on the case. ”

[N414 Ian Cunliffe, former Medical Director of HEFT from 2007 to 2010]

UHB has been unable to locate documentation at the Trust to support these claims, other than a draft copy of a report to the Board dated June 2009. We invited the former chairman to give evidence but had no response to our communications with him.

We heard that the board had other distractions at the time that concerns about Paterson were raised with the Chief Executive, including merger with other hospitals and high-profile safety issues, for example, HEFT was the only trust where a patient died after being given the drug amphotericin and this was the cause of a national alert about the drug:

“ At the same time we sadly had a series of very nasty untoward incidents. We missed a non-accidental injury who then came in dead. I think that was in June. We had Amphotericin overdose of two patients who sadly both died and that was in July. Then in August we had a 15-year-old who had an appendicectomy, then developed peritonitis and it was not spotted until she died. So suddenly the Trust, having gone from this sort of real high one suddenly had this real wake-up call that we had got some serious incidents going on. ”

[N445 senior manager at HEFT]

Consequently, concerns regarding a single consultant, which were being dealt with under HR processes and not as a patient safety issue, did not receive significant attention from the board. However, we are surprised at the lack of curiosity this suggests on the part of the board, given that Paterson was the subject of many reviews during this period.

When he gave evidence to the Inquiry, Goldman acknowledged his part in the failings to stop Paterson practising and apologised to patients:

“ I’ve not previously had an appropriate opportunity to speak out to the many patients of Ian Paterson who suffered at his hands. I recognise there’s nothing I can say or do now to change what happened to them and, I acknowledge this and I’m profoundly regretful for that fact. And I also recognise that I can’t alleviate the horrible physical consequences which they see daily, and it will forever serve as a long-term reminder to them of those events. And I recognise, I personally, cannot remove the physical and emotional burden from them which they will carry forever. As the Chief Executive of Heart of England Foundation Trust at the time of these events, I believe I made decisions in good faith, which were intended to ensure the safe practice of all the doctors and nurses within the Breast Service but, it is now clear that these were unsuccessful, and I would like to apologise to all the people who were affected during that period for the failure of those measures. And I regard today as an opportunity for me to assist this Inquiry and to learn the lessons beyond the work of Ian Kennedy. I gave evidence to Ian Kennedy in May 2013 and I stand by my comments at that time, which were actually made entirely from recollections because I’d already left the Trust, but it’s some years later now and I think it’s an opportunity for me to add further details which have emerged since and, particularly with reference to any misunderstanding or inaccuracies within the documented history. And I know and respect that many of Ian Paterson’s victims will actually never be able to forgive me for the part I played and the failure to contain Ian Paterson’s malpractice and his criminal activity and, frankly, I don’t think I’ll ever be able to forgive myself. ”

[N416 Mark Goldman, Chief Executive HEFT from 2001 to 2010.]

He has not acknowledged this before, and we are pleased to report in full what Goldman has said to us.

Newbold, Chief Executive at HEFT between 2010 and 2014, took responsibility for protecting patients when he became aware of the seriousness of the Paterson case in 2011. He suspended Paterson, contacted the GMC, initiated the full review of patients and commissioned Kennedy to review what had happened to understand why Paterson had not been stopped from practising sooner.

“ Well it was a difficult one because part of the board, particularly the executive team of course had been part of the previous process and so, you know, it was not necessarily welcome that the new chief exec was raking this up again. Equally I had a new medical director, initially an interim, X who was already in the Trust and subsequently Y who I appointed. Both of whom felt strongly like I did that actually this, a lot more action needed to be done... Then a new chair, about a year later, Lord Hunt, Philip Hunt who came in, who felt like me that we should not only leave no stone unturned but that we should be completely open about looking into what had happened and that we owed that to the patients. So as a core trio we were pretty, you know, if the chair, chief exec and medical director and the board then, you know, that was, became then the board policy so we followed that. ”

[N413 Mark Newbold, Chief Executive of HEFT from 2010 to 2014].

Newbold also commented on the lack of involvement of non-executive directors:

“ in the early days before I was there, there was a board lead, a non-exec lead for the Paterson issues but they were not particularly kept up to date and certainly the wider board was not fully aware. ”

[N413 Mark Newbold, Chief Executive of HEFT from 2010 to 2014].

As far as we have been able to establish, neither the CQC nor the HCC identified concerns regarding failures in patient safety at HEFT or Spire Parkway while Paterson was practising. HEFT was considered to be a high-performing trust.

Prior to 2011, the senior leadership and board at HEFT did not take appropriate action to protect patients from Paterson’s malpractice and keep them safe, despite there being concerns about him as early as 2003/04. This changed in 2011 and again in 2015 when UHB was responsible for HEFT.

We heard that on acquiring HEFT, the senior leadership team at UHB made changes, designed to improve governance and accountability:

“ So we reviewed the governance. I, frankly, got rid of most of those [seven] subcommittees. We took responsibility back to the board. I put a much stronger focus on the idea that this was a unitary board, because this breakdown in relationship between the exec directors and the non-exec directors was, for me, coming from the experience that I’d come from, quite shocking. It was dysfunctional. It meant that people didn’t share information on the board in the way in which I certainly had been used to and I would have expected to happen. ”

[N470 Right Honourable Jacqui Smith, chair of UHB since 2015]

We also heard about measures intended to improve the visibility of senior leaders and the board:

“ So now as the merged board, every month we probably go and visit four or five different wards or areas of the hospital unannounced. ”

[N470 Right Honourable Jacqui Smith, chair of UHB since 2015]

In 2015, the board of UHB did appear to take responsibility for Paterson’s surviving mastectomy patients, through its review of their treatment and ongoing care and by communicating this to them.

Independent sector

There are different governance models in the independent sector and it is a complex picture. All independent hospital providers are required to have a nominated individual for the organisation and registered managers at each hospital site to comply with CQC regulatory requirements. The nominated individual and registered managers are responsible for safety and quality of services. At Spire, local hospital directors were the registered managers. Whatever governance model independent sector hospital providers choose, they have the same responsibility to follow regulations intended to keep patients safe.

“ The role of boards, including of independent sector hospital providers that are listed companies, is to ensure the company’s prosperity by collectively directing the company’s affairs, while meeting the appropriate interests of its shareholders and relevant stakeholders. ”

[Standards for the Board, Institute of Directors 2018]

We heard that in the independent sector there was a requirement to balance commercial considerations and generating a financial return for shareholders, with quality and safety:

“ In a public company, that will have shareholders at the top of the list, I think that is strictly the way it works. I am always very clear in saying, that is fine, but I think patients are at the top of that list, and we should act as if that is the case. And that will also be in shareholders’ interests. So this reflection on what our responsibilities are is a live one. ”

[N438 Justin Ash, Chief Executive of Spire since November 2017]

The Centre for Health and the Public Interest, in its evidence to the Inquiry, commented on the income that Paterson generated for Spire.

“ We would argue that the activities of Ian Paterson in providing unnecessary care were, in part, a product of this reliance on consultants as the main drivers of revenue to private hospitals. Put very crudely, from a private hospital’s business perspective the provision of overtreatment or unnecessary care to patients, whilst a significant reputational risk, is also additional revenue. And we would argue that the financial incentives which run through the current system weigh against any of the current measures designed to prevent this. ”

[N466, Centre for Health and the Public Interest]

Typically, in the independent sector, the chief nurses or directors of nursing and medical director are not full members of the board and do not have the right to vote on decisions the board makes. Spire’s chief nurse and group medical director attend board meetings but are not members of the board.

Patients expected there to be systems in place at Spire that would have effectively monitored Paterson’s clinical practice and stopped unsafe practice. Witnesses were left with the impression that this was not the case and that he merely “rented a room” from Spire, and they were not accountable for him.

“ in fact, what they did instead was just say, ‘Oh, we were just renting a room to him.’ ”

[Patient 153 treated at Spire hospitals]

“ I would have thought that if I rented a room here for any purpose whatsoever I would have thought that it would be monitored, and I would have to prove more or less what I was doing here and show some sort of accountability for it because I could be, you know, running anything couldn’t I? I do think the hospitals were too casual with what was going on underneath their roof. ”

[Patient 112 treated in the independent sector]

“ It never crossed my mind that Paterson was almost renting a room. I just thought he was part of the process. So, then when they had fences, ‘Well, you know, he’s not an employee. He’s just somebody that’s ...’, well you think, ‘Yeah, that’s why he’s called a consultant and maybe I should have thought that one through’. But it is not clear at all. ”

[Relative of patient 87 treated at Spire hospitals]

“ They’ll [Spire] take your money for all these years, as a private patient. But then if things go wrong. And they’re just not interested. ”

[Patient 356 treated at HEFT and at Spire hospitals]

“ they [Spire] did not take any responsibility. No. I mean they even said to the point that Paterson was not employed by them, which is ridiculous. I mean that is something that has got to be changed. He is a contractor, he is not an employee, so he can just come in and out. ”

[Patient 174 treated at Spire hospitals]

“ Spire was not responsible, and they were saying that he only rented the rooms, it was nothing to do with them. ”

[Patient 61 treated at Spire as an NHS patient]

There was a feeling that Spire’s corporate team had been remote from the management of its Parkway Hospital, and that the executive team and board were not visible at local hospital level. We heard that the hospital directors were having regular calls with De Gorter (Spire’s medical director) as the Paterson story began to break in the media, but that decision making fell to the local team:

“ [And for you and the other manager, the two of you took the decision to suspend him, what was the impact on you of taking that decision at the time?] I think he told me people were going to die of cancer. [And were you given any support in taking that decision at all?] Only from the other manager. ”

[N446 a senior manager at Spire]

The Inquiry heard that the role of the Medical Advisory Committee (MAC) at independent sector hospitals is advisory and not executive, and that its effectiveness depends to some extent on the quality of the relationship between the MAC, the hospital director and the matron or director of clinical services, with accountability falling to the hospital director as registered manager:

“ I know they are obviously medically qualified, and they are professionally regulated, but your MAC Chairman is not paid to do it, they are probably one of your high earners, you kind of pick them because you get on with them, and you think you can work with them, but they are either positively or negatively conflicted against everybody they are supposed to be overseeing. And I think there is no independence on the MACs. ”

[N496 senior manager at Spire]

The MAC at Spire advised Spire Parkway management team on issues regarding Paterson’s practice:

“ I found it so difficult to stop the colonoscopy practice. As a MAC Chair you are an advisor, you do not have any operational activity, apart from the four of five meetings you have a year. And a review of what happens. So the Hospital Director’s role is to enact what we tell them. That did not happen over that year and a half period. And any action to actually curtail the consultant’s privileges has to go through the Hospital Director, the MAC advises.”

[N443 former clinical manager at Spire]

Spire told us of changes it had made to improve governance of its MACs, including greater interaction from the centre of the organisation with local MACs to ensure consistency, regular MAC chairs meetings, standard MAC agendas, GP representation on MACs, changes to MAC chair appointments, with chairs now being appointed by the hospital director for a four-year term, and annual appraisal for MAC chairs.

Accountability for responding to the Paterson case fell to local hospital directors. Ash, CEO of Spire, told us that today he would ring and offer support to hospital directors who had done the right thing and suspended a consultant. We heard from Spire that it did not have a clear set of guidance and rules for escalation at the time Paterson was practising, and that there was little emphasis on consultant oversight and compliance at corporate level prior to the introduction of responsible officer regulations in 2011.

We heard from Spire’s local managers in post at the time that they were not aware if the Paterson case had been discussed at board level and did not receive any feedback to suggest this was the case. Spire told us that its board was not aware of the Paterson case until 2011, and then it was in the context of a passing comment about his suspension. The full impact of the case was not recognised by the board until the Verita report in 2014.

Spire did not take action to protect patients by suspending Paterson for some weeks after he was suspended in the NHS. De Gorter, Spire’s Medical Director admitted that it was wrong for Paterson to continue to practise there when he had been suspended in the NHS:

“ It was quite categorically a mistake, and you know, for my contribution to that I apologise unreservedly, but we’ve learned the lessons from that, and that couldn’t happen today.”

[N438 JJ de Gorter, Chief Medical Officer Spire]

Spire issued a statement of apology in 2014. However, many patients who spoke to the Inquiry said that they did not receive an adequate apology. In giving evidence to the Inquiry, Ash, Spire’s Chief Executive, acknowledged that Paterson should not have been able to harm patients and stated that he was sorry that it happened:

“ Well, if I could just start by saying I am so very sorry those things happened at Spire. Spire is very sorry those things happened at Spire it shouldn't have happened. The first thing I would say, can I just reiterate we are really very sorry that this happened. It should not have happened. We feel it, whether or not one was here at the time, reading the testimonials and reading it you can only be moved, and we are really both sorry, recognise it should not have happened, and really very personally, as well as an organisation, committed to taking all the learnings we have so far, putting everything in place to avoid this being possible again. ”

[N438, Justin Ash, Chief Executive of Spire since November 2017]

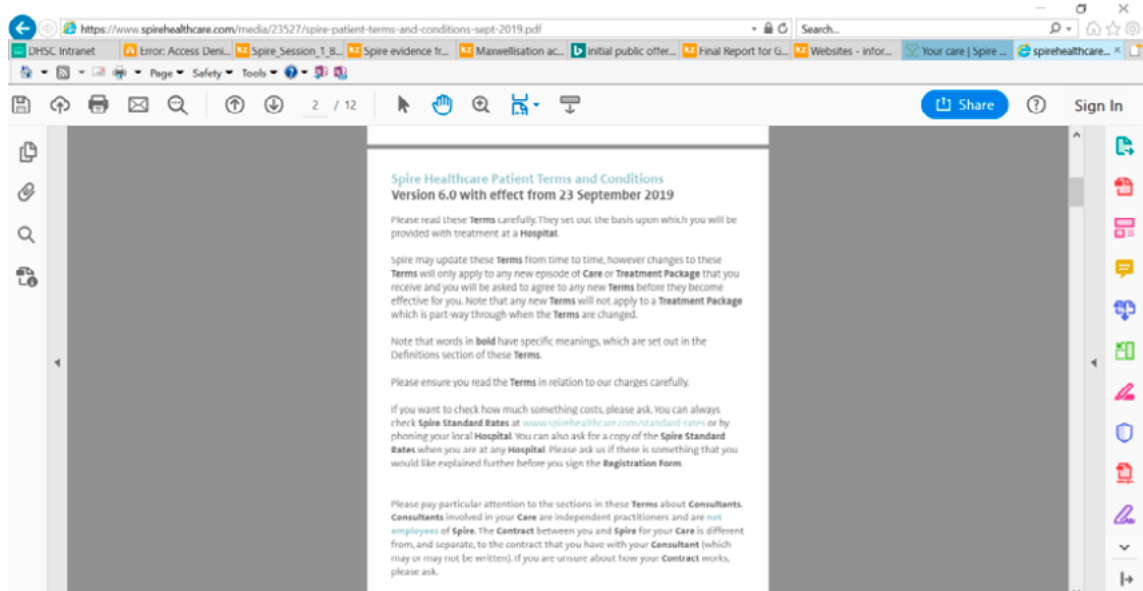
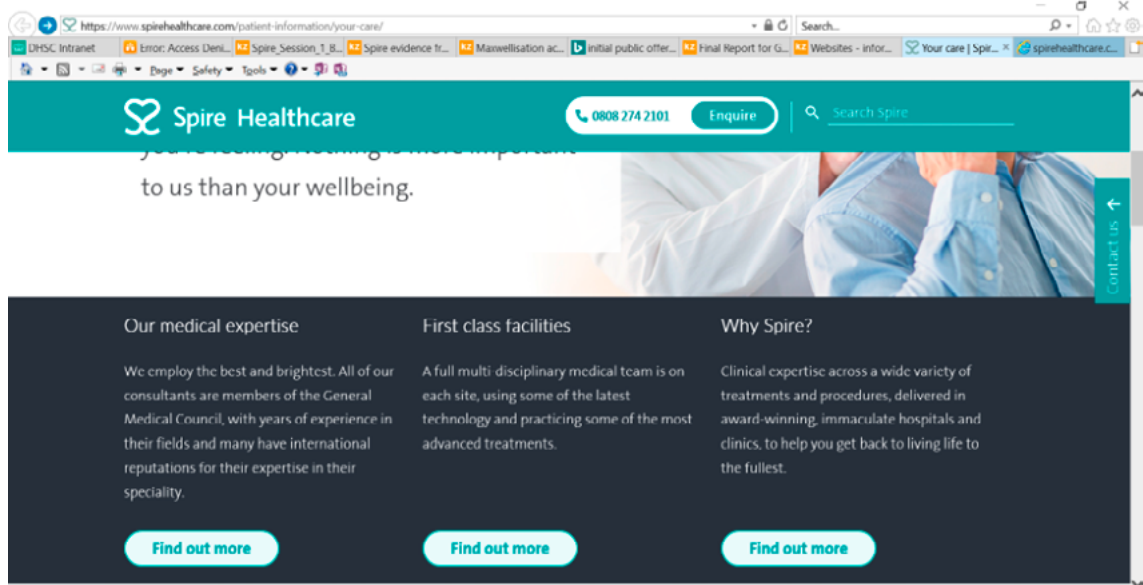
De Gorter, Spire's group medical director did apologise for the failure to protect patients and for his part in that:

“ I feel terrible especially having learnt of the harm that came to patients subsequently and I apologise, I apologised at the time and I apologise now to patients we have seen and the patients we will continue to see, because the distress that was caused through that and in part our failure to have strong governance and oversight to something we deeply regret and I personally regret, because I was in post at the time. ”

[N438 JJ de Gorter, Chief Medical Officer Spire]

Spire has not reviewed all patients of Paterson, contacted them and provided them with an ongoing care plan.

We checked Spire's website in June 2019 and found it to be misleading in its representation of the relationship it has with consultants who practise there, giving the impression that they are employed and that it is therefore responsible for them and their actions. By September 2019, the page still referred to employing the best and brightest consultants. This was clarified under the patient terms and conditions, which stated that consultants were independent contractors and not employees of Spire. However, even in November 2019 this clarification was not prominent on the Spire website, with the result that the Inquiry still considers this to be misleading.



Spire told us that it had made changes to improve its governance in response to the report it commissioned from Verita into the Paterson case. Spire described that its board focused on reporting rather than assurance prior to the Verita report in 2014:

“ There has been a sea change, really, I mean, the whole governance framework for the company was completely overhauled, the ward to board framework was put in place, I mean taking it from the bottom of the shop really thinking about what the accountabilities are and the responsibilities are within the hospital we have a governance committee that [the Chair of the local Spire MAC] chairs and that has a member of every department who attends, I attend. We have a doctor who sits on that group who is also on the medical advisory committee. ”

[N438, Spire]

Individual accountability

As a registered professional, we would expect Paterson to have followed his professional code of conduct. All healthcare professionals have a professional duty of care set out through their codes of conduct, as well as a personal and moral duty of care to keep patients safe. The NMC Code of Professional Conduct and GMC's Good Medical Practice set out professional duties for nurses and doctors. Professionals are responsible for keeping patients safe. In the independent sector, registered managers are also individually accountable, as set out in CQC regulations, and have a role to play in keeping patients safe.

Patients have an expectation that they will receive safe and appropriate care from the team looking after them. They expect the team to work together and to provide a joined-up and consistent approach to their care. Therefore, where one member of that team has provided inappropriate and unsafe care, patients often feel let down by all of those involved. We heard from many patients that they now feel that they have lost their trust in all health professionals as a result of this experience.

A third of patients said that they believed other individuals working there will have been aware of what was happening at HEFT and Spire, and that they had a responsibility to raise concerns. We heard from patients that healthcare professionals appeared to know what was happening but "turned a blind eye" or appeared not to be concerned by what they saw:

“ when he [an anaesthetist working with Paterson] come into the room he said, 'I have operated on you before, have I not?' And I said, 'Yes, a couple of times,'... and you could see that he was pondering something as he walked away... and looked back at me and said, 'But you have never had cancer, have you?' I said, 'It has always been precancerous,' and I saw his face change, and he walked away, but he never said anything directly to me. ”

[Patient 2 treated at Spire hospitals]

“ The theatre staff would have seen that on the form I'd signed for a wide local incision. The people in pathology would have known because what's removed is sent off to be weighed. So surely somebody should have thought, 'Well, wide local incision, and we've got three-quarters of a left breast.' Why didn't anybody say then? ”

[Patient 15 treated at Spire hospitals]

“ 'Could I have a silicone implant?' And she [plastic surgeon] said, 'Oh, yes,' she said, 'You have got a good mound of breast tissue there for me to work on,' and I said, 'Oh, I have not,' I said, 'I have not got any breast tissue,' I said, 'It is just fat,' and she did not say anything. ”

[Patient 270 treated at Spire hospitals]

While some NHS patients were reassured by the findings in Kennedy’s report that healthcare professionals were doing what they could to raise concerns, others continue to feel that they could have done more. We look at the issues around raising concerns in more detail in chapter five.

Some patients told us that they believe that other healthcare professionals colluded with Paterson’s malpractice, and that others should be investigated for their part in the case.

“ I mean, I cannot remember but I know there is a law that if you are in a group and somebody commits a crime, and you are there, and you are part of that group and you do nothing, you are culpable. ”

[Patient 153 treated at Spire hospitals]

We understand patients’ distress that some professionals did not act in line with their duty of care to patients. As discussed in chapter two, we have referred three individuals to the General Medical Council, two to the Nursing and Midwifery Council and one case to West Midlands Police, in line with the Inquiry’s terms of reference.

We heard some evidence that healthcare professionals highlighted concerns directly with patients. Some patients felt that staff may have been trying to warn them about Paterson’s malpractice:

“ [Consultant oncologist] obviously, I feel [he] knew, because I felt he was trying to sort of ... The way he was with me, I felt like he was trying to tell me something. ”

[Patient 263 treated at HEFT]

“ But anyway, that night, you know when you’re in hospital and it goes very, very quiet and nothing is happening, and the nurses have got not a lot going on. One nurse could see that I was wide awake so came and sat by me. She brought a chair, and she sat for some time. I was lying down trying to sleep but couldn’t. I said to her, “I can’t understand this. The last thing I was expecting was to have a lump.” And she said, “Keep asking questions.” And I said, “Really?” And she said, “Yes, keep asking. Make sure you keep on at him what’s gone on. Keep asking questions of people.” ”

[Patient 19 treated at the HEFT]

“ I told my friend. At the time her partner was a [consultant]... and they met at my house. I came downstairs into the lounge and the [consultant] said, ‘I can’t say why, it’s confidential, but don’t go near Paterson. I’ll organise for you to see my colleague at The Women’s Hospital (an NHS hospital) in Birmingham next week.’ ”

[Patient 125 treated at Spire hospitals]

Others told us that some healthcare professionals talked openly of their concerns about Paterson once the investigation was underway and the case was in the media. We heard from two patient witnesses that one healthcare professional suggested they seek compensation from HEFT for what had happened to them under Paterson's care:

“ But, I remember being at an appointment after she'd had the letter with [consultant oncologist]... and we said, 'Oh we've had this letter', and, you know, 'Should we sue, we don't know what to do.' And he turned around and he just pushed his glasses up and he said, 'My dear, sue the fucking arse off them.' Those were his words. They all knew what was going on, everybody did, and they did nothing and he personally wrote to the Trust and was told, basically, 'Keep your nose out, you're not the surgeon.' ”

[Relative of patient 491 treated at HEFT]

We also heard in patient evidence that some healthcare professionals had challenged, or questioned treatment recommended by Paterson:

“ [Companion – we then went to the oncologist, I mean I was with [patient 331], and we walked into his office, and we have not even sat down, and he said, 'why have you not had a mastectomy?' And she said, 'Because Mr Paterson said I did not need it.' And his words were, 'If you were my wife, you would have had it done by now.' ”

[Companion of Patient 331 treated HEFT]

We heard some suggestions that healthcare professionals changed their own professional or clinical practice in response to Paterson's, including oncologists increasing the chemotherapy or radiotherapy treatments for patients where they were concerned about increased risk of recurrence:

“ So he [the oncologist] said that he had actually upped chemo and radiotherapy because he wasn't happy with the procedure that was happening. ”

[Relative of patient 491 treated at HEFT]

However, many of the healthcare professionals we spoke to told us that their own clinical practice did not change because of Paterson.

Some patients told us that they no longer feel they can trust their GPs, especially if that GP had referred them to Paterson directly. We heard other accounts of GPs questioning Paterson's practice:

“ I went to see my GP..and I told her I was going up every day to have this pack done, and she went crazy. She said, ‘It couldn’t have come back so quick.’ And I said, ‘It did. He said.’ She kept saying, ‘No, you’re wrong.’ And I kept saying, ‘No, you’re wrong? This doctor’s the best, really.’ And she said, ‘I need you to listen to me. Don’t have nothing else done until you come and see me first.’ But that was too late then. I’d already had the surgery. I wish maybe I’d had have. You don’t think that a doctor’s going to do... ”

[Patient 140 treated at Spire hospitals]

Some witnesses questioned the actions of pathologists and radiologists who would have had access to test results. However, we heard from some clinical witnesses from other specialities of healthcare, that these professionals could not be expected to identify the issues, given the limited extent of the information they would see:

“ They do not know what the pathology is, and you cannot expect the radiologist to chase up every single pathologist and every single request they get, it is just not possible. So they then do the mammogram, thinking it is a perfectly reasonable thing to do, and the patients are told so they think it is perfectly reasonable. So it is only one person in the middle that is controlling all this, and that is the difficulty. ”

[N476 healthcare professional working at Spire]

The Inquiry’s clinical panel advised us that as healthcare professionals have become increasingly specialised, they should know what is reasonable to expect of the others with whom they practise. The Panel’s view was that members of a breast care MDT need to have appreciation and knowledge of the work of all the professions in breast care, so that they could question another member’s contribution.

We note that if the MDT had been fully functioning in either the NHS or the independent sector at the time Paterson practised, professionals would have had the opportunity to challenge him there.

We heard from many witnesses that they would have expected the plastic surgeons and anaesthetists to have known of the issues and to have raised them accordingly, particularly where these professionals had been working regularly with Paterson over a number of years:

“ So, [plastic surgeon] came up and spent, this would be about 1999; she spent a year in Manchester working with a colleague of mine learning reconstructive surgery before she qualified and came back to Birmingham, before she got a consultant job in Birmingham. So she knew full well what clearance of margins were, she’d worked in a breast multidisciplinary team. When she was reporting to the GMC she told the GMC she was only a wee plastic surgeon, she’d never been trained in any breast surgery, which was a lie. ”

[N379, consultant who reviewed some patients who pursued legal claims]

The Royal College of Anaesthetists told us that they would expect anaesthetists to be aware of what surgery had been consented for, and any deviations from that.

The professional most heavily criticised in evidence was the breast care nurse, with many witnesses questioning why the nurses who worked with Paterson did not do more. Nurses, as “patient advocates” have a duty of care to patients to keep them safe. We heard from two healthcare professionals who had worked with Paterson at HEFT who said that they did not raise concerns about Paterson’s practice, because they believed that others “knew what he was doing”, and that they did not need to raise concerns themselves. This echoes issues previously discussed, that there was a sense of “passing the buck” and pointing the finger at others who were expected to intervene, even if the healthcare professional concerned did not.

We witnessed a strong belief from patients treated at Spire, and their relatives, that the breast care nurse who worked with Paterson there must have known of his malpractice and aided him in this.

“ she [breast care nurse] was to me a very important cog in his wheel in the sense that you’d have a session with Paterson who would conclude that you needed this or whatever, and then you would get ... he’d disappear out, he’d perhaps go to his next client or wherever he went, but you’d have a few minutes then with [breast care nurse]. And [she] would then go in the hard sell ”

[Relative of Patient 28 treated at Spire hospitals]

“ Not like [breast care nurse] and Mr Paterson. Like she’s sitting on the table swinging her legs, while he’s telling you what ... She was infatuated with him, and I think he knew that. And he played on her. No excuse for what she did though. Doesn’t make any difference who he is. She could have put a stop to it as well. ”

[Patient 140 treated at Spire hospitals]

“ And she [breast care nurse] escorted me to the funeral... We couldn’t go on our own. It wasn’t right so she would have to come with us... and she didn’t want us to talk to the family because it wouldn’t be right. ”

[Patient 140 treated at Spire hospitals]

“ I asked the question, ‘How long should I wait before having surgery?’ [breast care nurse] said... Obviously she’s got my age, and at that time I was a single mum, and she said, ‘You haven’t got time to waste, unless you want your son to lose his mum.’ So, I signed. ”

[Patient 15 treated at Spire hospitals]

“ She [breast care nurse] was like this, on the one hand she was, ‘What a lovely nurse. You can just phone her up. She will tell me what is going on,’ you know, but, no, all the time she was actually making sure we were all on board and that Paterson was looked after. ”

[Patient 69 treated at Spire hospitals]

The breast care nurse who worked with Paterson at Spire died in 2017. She had been suspended by Spire in June 2012 and was later dismissed from her post. A number of patients told us that they had reported her to the NMC. We understand that the NMC was investigating her fitness to practise but that it had not completed its enquiries at the time of her death.

We heard conflicting accounts from healthcare professionals about their understanding of Paterson’s practice at the time, and the extent to which they regarded it as appropriate. While we heard from nurses that “everyone knew”, some professionals told us that they were unaware that Paterson was performing inappropriate treatment until formal investigations were underway. There is, therefore, a question regarding professional curiosity and the extent to which other medical staff would be expected to know about the treatment being provided by the lead breast consultant:

“ [So, were you aware of him doing what has now become known as the cleavage sparing mastectomies?] It was not really a secret, it was open, everybody in the team knew. . . So, you know it was openly known within the team that there were issues surrounding margins, but Mr Paterson always said that he was taking all the breast tissue, he was leaving only breast fat. . . Because so many consultants had gone to the Trust, raised concerns and nothing had been done. Why were they going to listen to me? And I was the newest member of staff. ”

[N403, healthcare professional who worked alongside Paterson at HEFT]

The Inquiry’s clinical panel’s view was that, while it can be difficult to raise concerns about healthcare professionals in a different discipline or who are senior, healthcare professionals should know what is reasonable to expect of each other’s practice. Members of a breast care MDT need to have appreciation and knowledge of the work of all the professions in the pathway and this is supported in their professional framework through MDT update training.

The care pathway for a patient should be visible and integrated at the MDT meeting, where it would be reasonable for a radiologist to question if surgical treatment did not align with imaging. Oncologists should undertake a physical examination of the patient before beginning post-operative treatment, and should have noticed and acted if there was a large amount of tissue left after a mastectomy.

While the patient evidence tells us that there was a clear sense that individuals should have done more to prevent Paterson’s malpractice, the evidence we heard from healthcare professionals sets out why this was challenging for many to do.

Although we have heard that processes and systems have changed since the time of Paterson, we are not reassured that these would have addressed the action or inactions of others at an individual level, partly because of the power of the prevailing culture.

Culture

CQC recognises the importance of culture in healthcare and considers this when it is inspecting hospitals. One of the questions it asks of all care services is:

“Are they well-led: the leadership, management and governance of the organisation make sure it’s providing high-quality care that’s based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.”

In this section, we consider how Paterson’s behaviour, people’s attitudes to him and the organisational and wider culture in which he operated may have influenced how individuals and organisations responded to him.

In 2009, Paterson became patron of Solihull Breast Friends, a support group for women with breast cancer, and we heard several accounts of the high regard he was held in by the local community as the “go-to” breast surgeon.

“ I discovered a problem, went to my GP. She said that I needed to be seen, and I elected at that point to be seen privately. She described Ian Paterson as the GP’s surgeon of choice. I had no prior recollection or knowledge of Mr Paterson, and I saw him within a few days, at Parkway. ”

[Patient 5 treated at Spire hospitals]

We were told that Paterson was idolised or worshipped by some of his patients.

“ so many people went to listen to God, as they all said, you know, they would all go and he would stand up there and I do not know, everybody was, like, sat there, like, looking sort of in awe of him. ”

[Patient 309 treated at HEFT]

“ We had him in tears at one of the balls, saying how privileged he was to have the role, because he was president [of Solihull Breast Friends]. He’d come. He’d give lectures. You had every confidence in him. He was a very charismatic person, and he put you at ease. He made you feel calm as if nothing was a problem. Everything could be sorted out, would be sorted out. ”

[Patient 188 treated at Spire hospitals]

Paterson often portrayed himself to patients as being the one who could “save them”. We were struck by this inappropriate and misleading self-description.

“ And he was always saying that, he could spot cancer, he could tell that he got everything and it was, you know, he said, ‘That was it. You are sorted.’ ”

[Patient 309 treated at HEFT]

“ And so I asked for a second opinion and he said, ‘No.’ He was the best person there was in the country, let alone the region. And there is no other opinion to be had. ‘Mine is the greatest opinion.’ ”

[Patient 7 treated at Spire hospitals]

We heard that patients were afraid of waiting a long time for treatment, particularly if they believed they had cancer, and that there was a lack of information available to them on their options for treatment and the reality of how long they would have to wait within the NHS. Our enquiries have shown that waiting times were not excessive at the time and this was confirmed in evidence to the Inquiry:

“ [Paterson’s private practice] was always a bit of a surprise to me when there was a two week wait for cancer. Why there was still a substantial private practice in it ”

[N415 Mark Gannon, Medical Director of Surgery at HEFT between 2001 and 2006.]

We heard that Paterson exploited this fear and used it to direct patients to pay for treatment in the independent sector:

“ But he said he would need to do the lymph nodes, and I said, ‘Yeah, that is fine, when can we do that?’ And then he ummed and ahed, and said, ‘Well it is going to probably be about six to eight weeks on the NHS, is there any way that you could fund private?’ And I just thought, ‘Yes,’ you know, I wanted to know if the lymph nodes were involved. ”

[Patient 273 treated at Spire hospitals].

We heard examples of Paterson making inappropriate comments to patients or behaving inappropriately towards them. This behaviour appears to have been tolerated by patients even though they did not always feel comfortable with it:

“ I mean, little things like when I was waiting for the operation, I would be lying on the thing and he could come in and tickle my feet, you know, which was all part of him. ”

[Patient 34 treated at Spire hospitals]

“ But the one thing I didn’t like about him, I have to say, it sounds horrible, was the way he went [makes noise]; rubbed his hands before the breast examination. ”

[Patient 371 treated at Spire hospitals]

“ Some inappropriate things that he said. I was 52, and I said, ‘Oh, a mastectomy,’ and he said, ‘Do not worry,’ he said, ‘A pretty young thing like you, I can make you look okay,’ and I thought, ‘That is not right.’ But at the time you are under so much stress ... ”

[Patient 270 treated at Spire hospitals]

Paterson denied that he behaved inappropriately to patients.

Throughout the course of the Inquiry, we heard of two sides to Paterson’s character. Patients’ descriptions about him were often about his personality rather than his clinical competence. On one hand, the over-familiar and charming character, and on the other, that of a somewhat vindictive and cold person. We heard that Paterson could be controlling and manipulative towards patients and others, and that the culture he worked in enabled this behaviour.

“ And after what he told me about the cancer can come back while you’re sleeping, if he’d have said to me, ‘Look, you’ll have to have a scan every day,’ I would have said, ‘Yeah, okay, I’ll have it every day.’ It had stopped me sleeping then. I only sleep for so many hours and wake up, just in case. ”

[Patient 140 treated at Spire hospitals]

“ Then I think I started to raise some concerns outside. I started speaking to the Sutton Coldfield Breast Friends, because I knew the chairperson there had some influence. He got wind of that, so he sent me a very threatening letter in which he told me I was going to die if I did not do what he said; that my disease was metastasized to my chest walls, or one of my major organs. ”

[Patient 68 treated at Spire hospitals]

“ He said about the infection, ‘You must come back here because we can sort it out here. If you go to your GP, she’s only going to send you back here because you must remember you are a private patient now.’ So in other words, ‘You can’t go running back to the NHS. You’re here.’ ”

[Patient 15 treated at Spire hospitals]

Some patients gave accounts of how they experienced both sides of his personality.

“ I went to every session but one, the session I missed he turned to [my wife] and said, ‘Oh, the rottweiler’s not here today then.’ And that’s because I was there to support [my wife] obviously, but to ask questions right, the patient can’t really think. He hated being challenged in any way, shape or form. ”

[Relative of Patient 28 treated at Spire hospitals]

“ Obviously, when I went back for my results I took my husband. When I walked in, because he was a very pleasant, kind man, as I thought, it was a big smile until he saw my husband, which I did notice and thought quite odd at the time. ”

[Patient 366 treated at Spire hospitals]

Some healthcare professionals who worked alongside Paterson at HEFT did not think there was anything unique about the culture of the hospital that permitted his behaviour. We did not hear evidence to suggest that they were curious about how appropriate or usual this behaviour was in a hospital setting.

“ I didn’t think there was anything unique about Heart of England NHS Foundation Trust, the only thing that was unique, was him, Mr Paterson. He was a unique person. I haven’t seen anybody doing this kind of thing in my life...and therefore you don’t even think that someone would do something so wrong to the patients. ”

[N399 healthcare professional who worked alongside Paterson at HEFT]

“ I wouldn’t say that Heartlands at that time was unique. I think there is certainly, or has been a culture in the NHS, yeah, of just, I think, trying to keep a lid on things ‘cause it’s just one more hassle in all the other hassles and, you know, looking into somebody’s practice or patient recall is quite an onerous and expensive issue. ”

[N431 healthcare professional who worked at HEFT]

Others, however, thought that there was a culture of bullying at HEFT that made it difficult to challenge poor behaviour.

“ And basically, we used to get bullied into doing anything he wanted, so it was a very difficult atmosphere of a team not working as a team. I think that is what happened. ”

[N463, healthcare professional who worked with Paterson at HEFT and at Spire hospitals]

“ my previous boss....had terrible sight problems. She had a progressive sight disorder and he frequently referred to her needing a guide dog or a white stick. He lacked empathy or emotion, I believe he looked at any sign of illness or emotion as a weakness. So, my uncle died, and I went to the funeral and it just happened to be on the Thursday which is breast clinic, you do not take time off on a Thursday unless you are on holiday. So, the next time we went to MDT he said in front of the whole team, ‘No close family members died today then?’ So, again you can just see the measure of the man, you know, he is a psychopath. ”

[N403, healthcare professional who worked alongside Paterson at HEFT]

This behaviour was witnessed by others, who did not challenge him and who tolerated it. People worked round him. The personal cost to healthcare professionals who raised concerns about Paterson is discussed in more detail in chapter five.

Paterson appeared approachable and popular in the wider community:

“ I mean, most consultants are quite courteous, but, you know, it’s sometimes difficult to approach them. Sometimes you leave messages, they may ring after two or three days. Things like that. But he was absolutely approachable at any time, yeah? He also was very generous, because he would invite GPs to his VIP boxes to see football, to see cricket, to network. And so he really was a friend, you know, and built a reputation of a leading breast surgeon in Solihull. ”

[N377 GP working in the Solihull area]

When concerns about Paterson surfaced in the media, we heard that there was disbelief among some patients and that the disquiet about his practice was considered by some as vendettas by some of his colleagues who were jealous of him:

“ And I asked him, I sat opposite him, and I said, ‘Mr Paterson, I had read this in the paper, can you tell me number one, is it true, and number two, did you do that to me?’ Because you want to know these things. And he said, ‘I can categorically tell you I did not do that to you. This is just a vendetta against me by somebody that I won’t say the name of. When I get my evidence together, then that person will be in court.’ ”

[Patient 227 treated at Spire hospitals]

“ And she [patient’s GP] actually said to me, ‘Would you mind if we don’t talk about this only I’m very concerned that there’s a bit of a witch hunt going on,’ which I felt was to shut me up. ”

[Patient 154 treated at Spire hospitals]

There was a belief that the go-to surgeon they knew and who had treated them could not be responsible for the widespread malpractice that was being reported. We heard evidence that Paterson and one of the colleagues with whom he worked closely at Spire fuelled this belief to enhance his reputation:

“ We had an email sent by one of the patients who was in the Breast Friends to one of our breast care nurses and that email from [a breast care nurse in the independent sector] was basically saying, this was way back, ‘Trust could not find any evidence that Paterson had done anything wrong and Mr Paterson was exonerated by the investigation.’ ”

[N399 healthcare professional who worked alongside Paterson at HEFT]

“ She [breast care nurse] said it was nothing to do with Mr Paterson. There was another doctor that was jealous of his work and trying to bring him down. ”

[Patient 140 treated at Spire hospitals]

In considering the culture of the hospitals Paterson worked in, it is of note that financial considerations were at play in both the NHS and independent sector.

Some witnesses told us that the priorities in the NHS were to balance the books and achieve performance targets, including those related to waiting times and lists, and that these sometimes obscured issues of quality and safety. At the time, these priorities were set by the Department of Health, and are now managed by NHS England. One of the witnesses drew attention to an article he had written:

“ It is something that I really strongly believe about the NHS that it is really very badly managed from the government down...I gave a couple of examples in the article from an NHS England Board meeting, and I showed that the risk register was all red, and the report about it was all beige. And then a clip of the actual meeting where everyone is saying how wonderful things were, just to illustrate that it starts at the top. And people responded to the article by saying ‘that is what it is like in my part of the world’...And the target culture, the having to achieve the financial and the performance targets, all at the same time, and if you fail them you are publicly humiliated, effectively, either by going to Monitor or going to the region and having an in depth review of your practice...it is a bullying structure from the top. ”

[N452 associate medical director at HEFT]

Goldman, HEFT Chief Executive 2001 and 2010, told us that on taking up his appointment, he was told by the Chief Executive of the Strategic Health Authority that if he didn’t deliver on finance and performance, he would get rid of him. This set the tone for what was considered important:

“ So, I met with [Chief Executive] at the SHA, not too many miles away from here actually, and we were having a cheerful conversation and we were talking about finance and performance and I said ‘Well, you know, what happens if I just can’t deliver those, those things to your satisfaction?’. He said words to the effect ‘Well, I’ll just get rid of you. ”

[N416 Mark Goldman, Chief Executive of HEFT from 2001 to 2010.]

We also heard from our clinical panel:

“As austerity has hit, there has also been an increasing focus and national direction on finances and targets, this is reinforced by the reporting requirements from national bodies, i.e. NHS England, NHS Improvement and Public Health England, which can also be a burden. Boards are often accountant and retired clinician heavy.”

Independent sector hospitals that are public listed companies are driven by the requirement to ensure the company's profitability makes a return for shareholders, while balancing this against safety and quality. Within this commercial culture, Paterson had a large private practice that generated significant income for Spire. He was, however, able to slip under the radar at Spire in terms of his malpractice and offending.

We were struck by a lack of curiosity from those in charge while Paterson was practising at HEFT and Spire. We heard about him being a larger than life figure, who could be both charming and controlling. Paterson was revered by some in the community. It was known that he had a difficult relationship with many of his colleagues. Paterson should have been visible at HEFT, not least since he was the subject of various reports regarding his clinical practice and behaviour. He should have been visible to Spire since he earned a significant amount of money for the company. We believe there was a notable lack of curiosity about him from those running both HEFT and Spire, and that this was sustained for many years.

From the evidence we heard, we believe the culture set from the top was one of avoiding problems by managing them as isolated incidents, with a lack of critical thinking about what the real issues were. It was convenient for Paterson to be characterised as a unique rogue by those who worked with him and those in charge – this lack of curiosity was to have far-reaching and devastating consequences.

It is our opinion that it would be unwise to dismiss him as a one-off, given the evidence we have heard.

What we have learned

The boards of HEFT and Spire were remote from front-line healthcare professionals and patients when Paterson was practising, and for some years afterwards.

Clinical leadership at board level is lacking in listed companies operating in the independent sector.

Paterson could have been stopped from practising in 2003, and should have been stopped in 2007 rather than 2011.

There is inequity in the treatment of patients at Spire Parkway and surviving mastectomy patients treated at HEFT. Patients treated at HEFT have had a review of their case, had this communicated to them and have been provided with ongoing care, if necessary. This has not been the case for patients treated at Spire Parkway.

Paterson exploited patients' fear of waiting for treatment and their fear of having cancer. There was little information available to patients to help them understand the reality of how long they would need to wait for NHS treatment.

Paterson behaved in ways that were not acceptable or were inappropriate in a hospital or clinical setting. This behaviour appears to have been tolerated and we did not hear evidence that he was challenged by some healthcare professionals who should have done so.

There was a lack of curiosity about Paterson from his colleagues and those in charge of HEFT and Spire for a sustained period of time. This had devastating consequences for patients.

Recommendations

We note that there were many regulations and much guidance in place during Paterson's years of practice. It is significant that a lot of these were disregarded or ignored by Paterson and others. There is no single legislative or regulatory fix which would ensure safety for all patients in the future. In making these recommendations, we assume that existing regulations and guidance will be followed and enforced. The recommendations which follow arise from evidence that we have heard in the course of the inquiry.

Information to patients

We heard from patients that much of the information they received about Paterson was unreliable, and the result of hearsay and an inflated local reputation. Patients had no means of independently testing or verifying the information they received. We heard that patients would welcome a single source of information relating to each consultant's practice. This was endorsed by a significant number of witnesses, including those who had a managerial or clinical responsibility for consultants.

We recommend that there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector.

Patients told us that Paterson had given information about them in the letters he sent to GPs which was different from what he had said at their consultation, but they had not seen these letters at the time. Such letters are routinely sent to GPs after consultation or treatment but are not always written in a way which is easy to understand.

We recommend that it should be standard practice that consultants in both the NHS and the independent sector should write to patients, outlining their condition and treatment, in simple language, and copy this letter to the patient's GP, rather than writing to the GP and sending a copy to the patient.

There are differences in how the NHS and the independent sector are organised. In the independent sector, consultants are not usually employed by the private hospitals, and have to make their own arrangements for clinical indemnity. In addition, most private hospitals do not have intensive care units on site. Patients who require intensive care, or have need for emergency treatment, are usually transferred to an NHS hospital. These differences were not apparent to patients who spoke to the Inquiry at the time they chose to be treated privately by Paterson.

We recommend that the differences between how the care of patients in the independent sector is organised and the care of patients in the NHS is organised, is explained clearly to patients who choose to be treated privately, or whose treatment is provided in the independent sector but funded by the NHS. This should include

clarification of how consultants are engaged at the private hospital, including the use of practising privileges and indemnity, and the arrangements for emergency provision and intensive care.

Consent

We heard that patients often felt under pressure to decide to go ahead with surgery. Their options for treatment, including the risks associated with any procedure, were not explained clearly to them before they gave consent for surgery. This was out of line with existing guidance, which sets out that patient consent must be voluntary, informed, and that the patient must have the mental capacity to understand what they are consenting to. Even in the case of patients who need surgery quickly, the Inquiry's clinical panel advised us that patients need a short period of time to reflect on their diagnosis and treatment options to ensure they are giving informed consent for their treatment. We understand that the GMC is also considering this issue.

We recommend that there should be a short period introduced into the process of patients giving consent for surgical procedures, to allow them time to reflect on their diagnosis and treatment options. We recommend that the GMC monitors this as part of 'Good Medical Practice'.

Multidisciplinary team (MDT)

Every patient with breast cancer should have their case discussed at an MDT meeting, in line with up-to-date national guidance. CQC considers this as part of the "safe" and "effective" domains of its inspection framework for independent hospitals providing acute service.

We heard that while Paterson was practising at Spire, decisions about patients' treatment were not discussed at properly constituted MDT meetings. Independent sector providers have told us of changes they have made to improve compliance with guidance in this area. We also heard that patients who are treated in the independent sector may have their treatment discussed at MDT meetings in the NHS, but that the quality of those discussions varied.

We recommend that CQC, as a matter of urgency, should assure itself that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings, including in breast cancer care, and that patients are not at risk of harm due to non-compliance in this area.

Complaints

Patients we saw who were treated in the NHS were not satisfied with HEFT's response to their complaints, and did not appear to know about the role of the Parliamentary and Health Service Ombudsman (PHSO). Private patients treated in the independent sector have no recourse to the PHSO and are directed to the Independent Sector Complaints Adjudication Service (ISCAS), if their hospital subscribes to the service. Private patients did not appear to know of this option.

If the hospital does not subscribe to ISCAS, the patient will not have access to independent investigation or adjudication of their complaint.

We recommend that information about the means to escalate a complaint to an independent body is communicated more effectively in both the NHS and independent sector. We recommend that all private patients should have the right to mandatory independent resolution of their complaint.

Patient recall and ongoing care

We recognise that when Paterson was operating, Solihull Hospital was run by Heart of England NHS Foundation Trust (HEFT). However, the following recommendation is about the current and ongoing care of patients treated by Paterson, so it is addressed to University Hospitals Birmingham NHS Foundation Trust and Spire (UHB).

Although there have been assurances from both the Trust and Spire that they have recalled all patients who needed to be, we heard from almost a third of patients who gave evidence to the Inquiry that they have never received communication about recall or attended an appointment. We heard from relatives of deceased patients who had not been given information about the appropriateness of their care.

We note that the Trust reviewed, in 2015, all surviving patients of Paterson who had a mastectomy at HEFT. The aim of the Trust's review was to provide advice for each individual patient on the adequacy of their care, and to recommend appropriate follow-up. Patients who had a mastectomy at HEFT have a care plan, where necessary, funded by the NHS. To date, we heard from patients that there has not been an ongoing treatment plan appropriate to their health needs at Spire, although Spire do not accept this.

We recommend that the University Hospitals Birmingham NHS Foundation Trust board should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen.

We recommend that Spire should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen, and that they should check that they have been given an ongoing treatment plan in the same way that has been provided for patients in the NHS.

Improving recall procedures

We heard from patients recalled by both HEFT and Spire that their experience of recall was generally inadequate, not patient-focused, and lacked transparency. Patients were often treated as a problem to be solved during the recalls. We also heard that there were no national guidelines to follow at the time, and we understand that this is still the case today.

We recommend that a national framework or protocol, with guidance, is developed about how recall of patients should be managed and communicated. This framework or protocol should specify that the process is centred around the patient's needs, provide advice on how recall decisions are made, and advise what resource is required and how this might be provided. This should apply to both the independent sector and the NHS.

Clinical indemnity

Medical defence organisations cover the costs of claims and damages awarded to patients. However, they are not subject to financial conduct regulation, and the indemnity cover they provide is discretionary. The Medical Defence Union used its discretion to withdraw cover since Paterson's activity was criminal. This left patients without cover.

In the event of the medical defence organisation and the hospital failing to provide cover, some witnesses thought there was a need to provide an industry-wide "safety net" so that patients are not left uncompensated.

Other witnesses noted that the current system of indemnity cover for consultants working in the independent sector is unregulated, and told us that it should be regulated.

We recommend that the Government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals, in light of the serious shortcomings identified by the Inquiry, and introduce a nationwide safety net to ensure patients are not disadvantaged.

Regulatory system

In 2018/19, the Care Quality Commission, the General Medical Council and the Nursing and Midwifery Council, had a total annual budget of over £435m per year, and between them employed over 5,200 people. In addition to this, the Professional Standards Authority for Health and Social Care employed a further 40 people with an annual budget of £4m, raised by fees paid by the regulatory bodies it oversees.

Despite the scale of the regulatory system, it does not come together effectively to keep patients safe. We also heard that it is not accessible or understood by patients. We do not believe that the creation of additional regulatory bodies is the answer to this.

We recommend that the Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry.

Investigating healthcare professionals' practice and behaviour

We heard from senior managers and healthcare professionals in both the NHS and the independent sector that Paterson could and should have been suspended by HEFT earlier than he was, given that concerns first began to be raised in the early 2000s. HEFT used the HR process to investigate him, even though the concerns relating to Paterson from 2003 related to his clinical practice. Goldman told us that he was following legal advice and existing guidance in investigating the concerns, using an HR process.

We also heard that some of the healthcare professionals who had raised concerns at HEFT in 2007, and who worked alongside Paterson at Spire, did not tell Spire about the concerns until Paterson was suspended in 2011. Goldman told us that he felt he acted appropriately in response to the concerns raised.

We recommend that if, when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional. If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.

Corporate accountability

We heard that many patients treated at HEFT, and many treated at Spire, did not feel that the hospitals took responsibility for what had happened. In the NHS, consultants are employees and the NHS hospital is responsible for their management, and accepts liability when things go wrong. The situation is very different in the independent sector where most consultants are self-employed. Their engagement through practising privileges is an arrangement recognised by CQC. However, this recognition does not appear to have resolved questions of hospitals' or providers' legal liability for the actions of consultants.

We recommend that the Government addresses, as a matter of urgency, this gap in responsibility and liability.

We also heard that patients felt that they did not receive any meaningful apology from the hospitals. We understand that apologising was conflated with admitting legal liability. Despite the historical guidance on being open and saying sorry and, more recently, the statutory Duty of Candour, we were provided with no evidence to show how boards accept and implement accountability for apologising.

We recommend that when things go wrong, boards should apologise at the earliest stage of investigation and not hold back from doing so for fear of the consequences in relation to their liability.

Adoption of the Inquiry's recommendations in the independent sector

We heard from witnesses that, while the independent sector shares a regulatory system with the NHS, it has a different governance model. Therefore, it is not possible for the Government to require the independent sector to implement all the recommendations it accepts. Where good practice is implemented in the NHS, it is often voluntary in the independent sector. Where the independent sector does adopt best practice, it is often slow and decisions to adopt such practice focus on innovation and flexibility, rather than keeping patients safe.

We recommend that, if the Government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector's workload (i.e. private, insured and NHS-funded) if independent sector providers are to be able to qualify for NHS-contracted work.

List of Appendices

- Terms of reference
- Team members
- Witnesses
- Glossary

APPENDIX 1 – Terms of Reference

1. A central objective of the Inquiry is to afford former patients of Ian Paterson, and their families, an opportunity to tell of their experiences, and to be heard. The Inquiry will be informed by their concerns and it will examine and seek to learn from what happened to them, both in the independent sector and in the NHS.
2. The Inquiry will consider issues raised in previous relevant reports about Ian Paterson, but does not intend to revisit the evidence that led to his conviction.
3. The Inquiry will review the circumstances and practices surrounding Ian Paterson as a case study, and consider other past and current practices, so as to draw conclusions in relation to the safety and quality of care provided nationally to all patients. The issues it will consider include:
 - A. a comparison of the accountability and responsibility for the safety and quality of care received between the independent sector and in the NHS; including the roles of hospital providers and others in appraising, reporting, considering concerns and monitoring as regards healthcare professionals' activity levels, conduct and performance;
 - B. how and when information is shared between the NHS, independent sector, and others, including concerns raised about performance and patient safety;
 - C. the arrangements for assuring that healthcare professionals maintain appropriate professional standards and competence, including appraisal, revalidation, scope of practice, and the role of hospital providers, professional and quality regulators, and other oversight bodies;
 - D. MDT working, including a comparison of practice in the NHS and the independent sector;
 - E. the role of independent sector insurers, medical indemnifiers and medical defence organisations (including sharing of data);
 - F. the arrangements for medical indemnity cover for healthcare professionals in relation to all patients receiving care in the independent sector, whether such patients are medically insured or their treatment is NHS-funded or self-funded;
 - G. the means by which patients are referred from the NHS to the independent sector by individual healthcare professionals, including the role of NHS waiting times in relation to that practice;
 - H. the adequacy of the response to patients following adverse incidents, including clinical recall, in both the independent sector and the NHS; and
 - I. any other significant matters that may arise during the course of the Inquiry.
4. The Inquiry will be restricted to matters concerning the treatment of patients in the independent sector and the NHS in England.
5. The Inquiry will:
 - A. produce a report which will provide an overview of the information it has reviewed, and which will set out any findings of fact it has made and its recommendations;

- B. compile an annex to the report detailing the experiences of patients and their families; and
- C. if information is obtained in the course of the Inquiry, report any instances of apparent collusion or other conduct of concern (including conduct that indicates the potential commission of criminal or disciplinary offences) to the relevant employer(s), professional or quality regulator(s), and/or the police for their consideration. The Inquiry does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability.

APPENDIX 2 – Team members

Members of the Inquiry team

The Right Reverend Graham James, Chair of the Inquiry (December 2017–February 2020)

Rebecca Chaloner, Secretary to the Inquiry (December 2017–February 2020)

Kate Ward, Deputy Secretary to the Inquiry (January 2018–February 2020)

Jane Pawson, Engagement Lead (February 2018–February 2020)

Peter Burgin, Policy Lead (September 2018–February 2020)

Paula Jeffery, Support Policy Officer (June 2018–November 2019)

Nita Kabarria, Support Policy Officer (August 2018–February 2020)

Helen Hamilton, Policy Lead (January 2018–May 2019)

David Hill, Research Policy Officer (April 2018–January 2019)

Paul Croft, Data Analyst (seconded from NHS Digital on part-time basis, April 2019–July 2019)

Katie Kennington, Policy Manager (seconded on part-time basis for approximately three months)

Legal representative

Duncan Henderson, Specialist Legal Adviser (July 2018–Dec 2019)

Sophie Beesley, Legal Counsel (July 2018–Dec 2019)

Grace Boorer, Junior Legal Adviser (April–Oct 2019)

Fiona Reid, Legal Adviser (March 2018–July 2018)

Independent advisors

Karen Harrowing, Quality Systems & Pharmacy Consulting

Alex Kafetz, Managing Partner, Director of Insight and Strategy, ZPB Ltd

Stephen J Collier, Non-Executive Director and Chair of Workforce at St George's University Hospitals NHS FT

Clinical panel

Charlie Chan – Consultant Surgeon, Nuffield Health Cheltenham Hospital and St Joseph’s Hospital, Newport

Jennifer Gattuso – Consultant Surgeon, University College London Hospital Foundation Trust (retired October 2019)

Dr Rachael Liebmann – Consultant Histopathologist, Queen Victoria Hospital, Sussex

Anne Rigg – Consultant Medical Oncologist, Guys and St Thomas’ NHS Foundation Trust, London

Dr Nisha Sharma – Lead Clinician Radiology, Leeds Teaching Hospital NHS Trust, Leeds

Nikki Snuggs – Matron, Breast Unit, Royal Marsden Hospital, London and Surrey

APPENDIX 3 – Witnesses

Following the patient evidence sessions, other witnesses were invited to give evidence to the Inquiry. In the main, witnesses were cooperative at coming forward to provide evidence. We heard evidence from a total of 118 witnesses.

Over the course of 113 evidence sessions, 105 witnesses gave oral evidence to the Inquiry.

- 104 had to face-to-face sessions with a panel from the Inquiry
- 1 had a telephone interview.

13 witnesses provided evidence in writing.

The 118 witnesses included:

- 54 individuals who worked at HEFT or at Spire, including both clinical and non-clinical staff
- 14 individuals who were able to provide evidence on the wider context of Paterson’s practice
- 50 organisations that were directly involved in the Paterson case, or that were part of the wider healthcare system.

Table of organisations that provided evidence

1. Academy of Medical Royal Colleges (written evidence)	2. Access Legal Solutions	3. Action Against Medical Accidents
4. Association of Breast Surgery (ABS)	5. Association of British Insurers (ABI)	6. Aviva
7. AXA PPP	8. British Association of Surgical Oncology (BASO) (written evidence)	9. British Medical Association (BMA) (written evidence)
10. BMI Healthcare Ltd	11. BUPA	12. Care Quality Commission (CQC)
13. Centre for Health and Public Interest (CHPI) (written evidence)	14. Cigna UK HealthCare Benefits	15. CS Healthcare (written evidence)
16. The Exeter (written evidence)	17. Federation of Independent Practitioner Organisations (FIPO)	18. General Medical Council (GMC)
19. HCA Healthcare UK	20. Healthcode (written evidence)	21. Healthwatch England

Table of organisations that provided evidence		
22. Independent Healthcare Providers Network (IHPN)	23. Independent Sector Complaints Adjudication Service (ISCAS)	24. Irwin Mitchell
25. Medical and Dental Defence Union of Scotland (MDDUS)	26. Medical Defence Society (MDS)	27. Medical Protection Society (MPS)
28. NHS Confederation	29. NHS Digital	30. NHS England
31. NHS Improvement (written evidence)	32. NHS Resolution	33. Nuffield Health
34. Nursing and Midwifery Council (NMC)	35. Parliamentary and Health Service Ombudsman (PHSO)	36. Patient Advice and Liaison Service, UHB (PALS)
37. Private Healthcare Information Network (PHIN)	38. Professional Records Standards Body (PRSB)	39. Professional Standards Authority (PSA)
40. Ramsay Health Care UK	41. Royal College of Anaesthetists	42. Royal College of General Practitioners
43. Royal College of Ophthalmologists (written evidence)	44. Royal College of Physicians (written evidence)	45. Royal College of Surgeons
46. Royal College of Surgeons of Edinburgh	47. Spire Healthcare	48. Thompsons Solicitors
49. Transform Group	50. University Hospitals Birmingham NHS Foundation Trust (UHB)	

Those listed below were invited to provide evidence to the Inquiry, and we think could have provided useful insight, but declined to come forward:

- Mrs Chien C Kat, Consultant Plastic, Reconstructive & Aesthetic Surgeon, worked with Paterson both at HEFT and at Spire hospitals.
- Dr Talaat Latif, retired Consultant Oncologist, worked with Paterson at Spire hospitals.
- Hemant Ingle, Consultant Breast Surgeon, worked with Paterson at HEFT.
- Slater and Gordon Lawyers.
- Liz Gumbel, Clinical Negligence and Personal Injury claims, Counsel.
- The Patients Association.

APPENDIX 4 – Glossary

GLOSSARY

Source: NHS website, MacMillan website, Cancer Support website, Kennedy report.

Benign – non-cancerous breast conditions which are unusual growths or other changes in the breast tissue. They do not spread to other parts of the body.

Biopsy – a small piece of tissue or a sample of cells is removed and examined under a microscope.

Breast reconstruction – surgery to rebuild a breast after an operation.

Chemotherapy – chemotherapy uses anti-cancer (cytotoxic) drugs to destroy cancer cells. It can be given alone or with other treatments. It is most commonly given as an injection into a vein, through a “drip” or as tablets or capsules.

Cleavage sparing mastectomy (CSM) – terminology used by Paterson, but not a recognised procedure.

Clustered calcification – small calcium deposits that develop in a woman’s breast tissue.

Colonoscopy – a procedure used to check inside the bowels.

CT PET scan – positron emission tomography (PET) scans are used to produce detailed 3-dimensional images of the inside of the body. A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.

Ductal carcinoma in situ (DCIS) – a form of breast cancer. DCIS needs to be treated but as it remains in the ducts the prognosis (outlook) is good.

Endometriosis – a condition where tissue similar to the lining of the womb starts to grow in other places in the body.

Epidural – an injection in the back to stop you feeling pain in part of your body, commonly given for pain relief in childbirth and in some types of surgery.

Fine needle aspiration – a biopsy which is often used to take cell samples from organs or from lumps that are below the surface of the skin.

Flap of skin – fat, and sometimes muscle, from another part of your body (the donor site), used to create a breast shape.

General anaesthetic – general anaesthesia is a state of controlled unconsciousness. During a general anaesthetic, medications are used to send you to sleep, so you’re unaware of surgery.

Haematoma – a localised collection of blood, where blood seeps from broken small veins. It can be caused by injury to the area or surgery.

Hysterectomy – a surgical procedure to remove the womb (uterus).

Local anaesthetic – involves numbing an area of the body using a type of medication called a local anaesthetic.

Local excision – the removal of diseased tissue is removed, but the remaining breast is left.

Lumpectomy/lumpectomies – surgery where the cancer and a border of healthy tissue is removed, but the remaining breast is left.

Lymph node – small glands that help remove bacteria and other waste from the body. If it is known that breast cancer has spread to them, the lymph nodes in the armpit will be removed during surgery.

Macmillan nurses – Macmillan breast cancer nurses support people and help them to make informed decisions about treatment and care.

Malignant – a cancerous disease or growth, can spread to different parts of the body.

Malignant melanoma – type of skin cancer that can spread to other organs in the body.

Mammogram – X-ray of the breast.

Margins – the edge or border of the tissue removed in cancer surgery.

Mastectomy – removal of the breast, leaving behind a flat chest wall.

Medical Advisory Committee (MAC) – MACs are part of the governance of independent hospitals.

Multidisciplinary team (MDT) – the group of professionals from different clinical disciplines who meet together to discuss the diagnosis and decisions regarding treatment of individual patients with cancer.

Non-invasive breast cancer – Non-invasive cancers stay within the milk ducts or lobules in the breast. They do not grow into or invade normal tissues within or beyond the breast.

Oncologist – a doctor who treats cancer and provides medical care for a person diagnosed with cancer.

Pathology report – outlines the diagnosis of a condition after examining cells and tissues under a microscope.

Pre-cancerous cells – cells that have grown abnormally, causing their size, shape or appearance to look different from normal cells.

Psychiatrist – a medical doctor who specialises in the diagnosis and treatment of mental health conditions.

Psychologist – a professional who helps diagnose, treat and support people who have emotional and behavioural difficulties.

Radiotherapy – uses specialist X-ray equipment to destroy cancer cells.

Lipoma – small, soft, fatty lumps that grow under the skin, not cancerous but may be removed through a small incision.

Suspicious calcification – calcifications that are irregular in size or shape or are tightly clustered together.

Tamoxifen – a hormonal drug used to treat breast cancer, womb cancer and sometimes other cancers and conditions.

Thyroidectomy – an operation that involves the surgical removal of all or part of the thyroid gland.

Ultrasound – (sometimes called a sonogram), a specialised scan that creates an image of part of the inside of the body. It can help diagnose types of cancers or guide doctors on taking a biopsy.

Vascular surgeon – diagnoses, treats, and manages conditions of the blood vessels (arteries and veins)

Wide excision – a surgical procedure to remove an area of diseased or abnormal tissue or skin, including an amount (a margin) of normal tissue to prevent spread.

