In the first of a series of three articles exploring the implications of the Paterson Inquiry report, **Jill Mason**, partner and head of health and care at national law firm Mills & Reeve takes a look at the background to the case and subsequent investigation

The Paterson Inquiry report

A legal perspective

This is the first of a series of three articles looking at the report. This provides an overview but not a newsflash about what the report said (much of which was expected given the various reports that have already been published by HEFT and Spire). Instead this is a look at what lies behind the report and the circumstances that led to the scandal and subsequent inquiry. The next articles will consider insurance and indemnity, the sharing of information and employment law angles.

In December 2013 Professor Sir Ian Kennedy published his review (commissioned by HEFT) into Ian Paterson's practices.

In his Executive Summary he stated: 'It is a story of women faced with a life threatening disease who have been harmed. It is a story of clinicians at their wits end trying for years to get the Trust to address what was going on. It is a story of clinicians going along with what they knew to be poor performance. It is a story of weak and indecisive leadership from senior managers. It is a story of secrecy and containment. It is a story of a Board which did not carry out its responsibilities. It is a story of a surgeon who chose on occasions to operate on women in a way unrecognised by his peers and thereby exposed them to harm.'

Verita had also prepared a report for Spire back in March 2014 which raised similar failings.

Over six years later we have another report – this time covering both HEFT and Spire. It was patient led with The Rt Revd Graham James taking evidence from 211 patients or relatives. Paterson himself declined to be interviewed although he did provide a written statement. Amazingly some individuals refused to give evidence. The Inquiry also invited the former trust chairman to give evidence but had no response to their communications with him.

The report makes recommendations to the government rather than just to the board of a trust. Does it tell us anything new? Does it show improvements made to governance and patient care in this time frame?

It opens with an equally striking statement to that of Sir Ian: 'It is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe'

It goes on to note that: 'Paterson manipulated and lied to people. He broke the rules to facilitate his malpractice.'

The Rt Revd Graham James notes patients let down not once but at least five times - by a consultant surgeon, an NHS trust and an independent healthcare provider, wholly inadequate recall procedures, regulators and the Medical Defence Union.

Importantly, he highlights that '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.'

He highlights how Dr Mark Goldman, former chief executive at HEFT, acknowledged his part in the failings to stop Paterson. In his evidence he said: 'I don't think I'll ever be able to forgive myself'. Dr Goldman also spoke of being instructed by the chief executive of the SHA, on taking up his appointment, that if he did not deliver on finance and performance he would get rid of him and that this then set the tone for what was considered important.

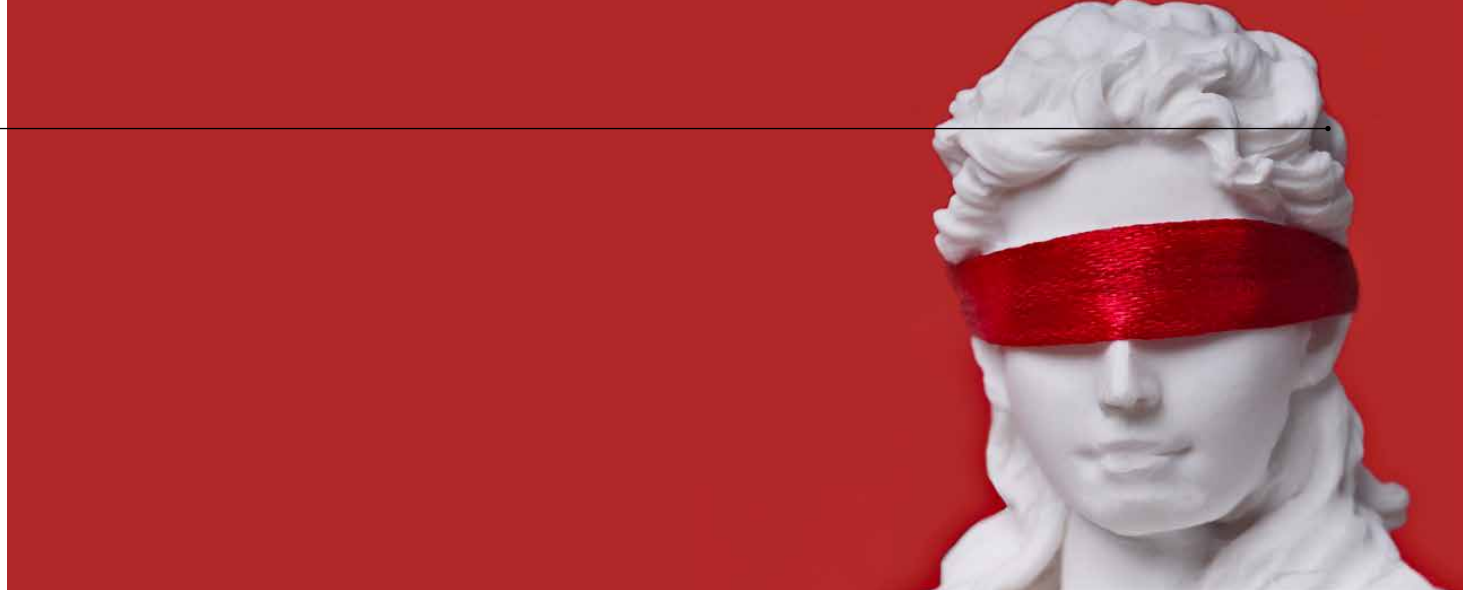
Of note is the fact that three individuals have been referred to the GMC, two to the NMC and one to West Midlands Police. Individuals in breach of their professional code of conduct by not cooperating with the Inquiry have been reported to their regulator.

However, whilst he notes that checks and balances have been put in place since Paterson practiced (and which may have detected his malpractice) they are not, and our experience is that they are not, universal or uniform across the NHS and independent sectors. It is his opinion that it remains possible for poor or unsafe practice to be undetected today.

You may not have ploughed through over 230 pages! If not here are some varied, key points buried away and not necessarily flagged in the initial flurry of commentaries on the report but which will be of interest/strike a chord with readers:

Safety and Quality of Care
Chapter 4

- Paterson did not work in isolation. He was part of a team of healthcare professionals from different disciplines
- Evidence taken reveals that a witness who worked with Paterson at Spire had been instructed to destroy a substantial number of patient notes
- Hospitals should ensure that it is difficult for someone who is determined to break the rules to do so
- MPAF is being developed but much of it is voluntary and is currently untested
- NHS England is currently considering policy and guidance on MDTs



Responding when things go wrong
Chapter 5

- When things do go wrong in clinical services the response should be swift, adequate and ensure that patients are safe. Patients should be at the heart of any response. This was not the case in response to Paterson's malpractice
- He, like Professor Sir Ian Kennedy, was critical of opportunities to stop Paterson as a result of concerns being raised by healthcare professionals in the NHS being missed on a number of occasions
- 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
- Many of the healthcare professionals who had raised concerns about Paterson were genuinely fearful of the consequences of doing so
- The theme of people thinking it is someone else's responsibility to take action surfaced repeatedly in many areas of evidence to the Inquiry
- Healthcare professionals who raised concerns about Paterson in the NHS did not do so at Spire
- The Duty of Candour does not appear to have been fully complied with by either organisations or healthcare professionals. Interestingly however AVMA has subsequently delivered training on the topic to Spire
- With regard to complaints, it is noted that HEFT was too defensive and that responses to complaints did not always address the issues raised. All responses to complaints were checked by their solicitors. Despite that complaint responses did not explain the role of the Ombudsman. Spire too was described as unresponsive and dismissive of its responsibility for the care patients had received

Working with others to keep patients safe
Chapter 6

- Some of the key organisations responsible for keeping patients safe did not take appropriate and swift action. Sometimes they were too quick to dismiss the problems as historical and failed to recognise disturbing patterns. Paterson could have been stopped from practising in 2003 and should have been stopped in 2007 not 2011
- It is difficult for any system to cope with any healthcare professional who chooses to deliberately mislead or lie and that Paterson was not unique in this

Governance, accountability and culture
Chapter 7

- Even in June and November 2019 Bishop James found Spire's website to be misleading in its representation of the relationship it has with its consultants giving the impression that they are employed and that Spire is therefore responsible for them and their actions
- The professional most heavily criticised in evidence was the breast care nurse. Bishop James refers to a sense of passing the buck and a question regarding professional curiosity. That had devastating consequences for patients
- The Inquiry's clinical panel was of the view 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. The Inquiry was not reassured that changes since the time of Paterson would have addressed the action or inactions of others partly because of the power of the prevailing culture
- 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

The government is to provide a full response to Bishop James' report 'in a few months' time'.

Nadine Dorries, Parliamentary Under Secretary of State for Patient Safety, Suicide Prevention and Mental Health, commented that 'patient safety is a continual process of vigilance and improvement. The Inquiry does not jump to a demand for the NHS and the independent sector to invent multiple new processes but to actually get the basics right, implement existing procedures and for all professional people to behave better and to take responsibility'. She calls for action across the NHS and its regulatory bodies and the same determination to change in the independent sector.