Neutral Citation Number: [2020] EWHC 3299 (Comm)

Case No: CL-2016-000099

IN THE HIGH COURT OF JUSTICE
BUSINESS AND PROPERTY COURTS OF ENGLAND AND WALES
COMMERCIAL COURT (QBD)

Royal Courts of Justice, Rolls Building
Fetter Lane, London, EC4A 1NL

Date: 10/12/2020

Before:

HIS HONOUR JUDGE PELLING QC
SITTING AS A JUDGE OF THE HIGH COURT

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Between:

SPIRE HEALTHCARE LIMITED	**Claimant**
- and –	
ROYAL & SUN ALLIANCE INSURANCE PLC	**Defendant**

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- -

Mr Daniel Shapiro QC and Mr David Myhill (instructed by **CMS Cameron McKenna Nabarro Olswang LLP**) for the **Claimant**
Mr Graham Eklund QC and Mr Nicholas Broomfield (instructed by **DWF Law LLP**) for the **Defendant**

Hearing dates: 3- 5 November 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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HIS HONOUR JUDGE PELLING QC SITTING AS A JUDGE OF THE HIGH COURT

HH Judge Pelling QC:

Introduction

1. This is the trial of a claim by the Claimant ("Spire") against the Defendant ("RSA") under a policy of insurance underwritten by RSA by which RSA insured Spire in respect of its predecessor's liabilities for the acts and omissions of those employed or providing medical or surgical services at hospitals operated by Spire ("Policy").

2. This claim is essentially an aggregation dispute in which Spire maintains that the claims in respect of which it is entitled to cover under the Policy were consequent on or attributable to two separate original causes and RSA maintains that they are all attributable to a single source or cause. If Spire is correct it is entitled to recover up to £20 million whereas if RSA is correct then it is only liable to pay Spire £10 million. There are other issues that arise or arose at the start of the trial though they were later conceded. By the time closing submissions were delivered, only Issues 1,2,3 and 9 as set out in the Agreed List of Issues remained to be decided. I refer to those issues in detail below, having set out the relevant background so as to make them intelligible.

Background

3. The claims, the subject of this dispute, arise from surgery carried out on private patients at two hospitals operated by Spire - known respectively as "Little Aston" and "Parkway" - by Mr Ian Paterson, who at the time was a Consultant Breast Surgeon employed by the Heart of England NHS Foundation Trust ("HEFT"). Mr Paterson was suspended from practice in 2011 by the General Medical Council ("GMC") over concerns about the manner in which he had performed mastectomy procedures on patients suffering from breast cancer.

4. It is not necessary in this judgment to explore the technical issues relating to mastectomy procedures in any detail. It is sufficient to note that it was universally accepted by all professionals in the relevant field at the relevant time that if a mastectomy was clinically indicated (because a diagnosis of breast cancer had been made) all breast tissue should be removed in order to eliminate or reduce the risk of a recurrence of breast cancer and the consequent risk that it would metastasise through the blood or lymphatic system to form tumours in other parts of the body.

5. Notwithstanding the universal practice being as I have described, Mr Paterson developed the practice of performing sub-total mastectomies ("STM") (which he described as "*cleavage sparing*" mastectomies), which involved leaving some breast tissue behind. It is common ground that to perform such procedures was negligent. In most if not all cases where Mr Paterson performed this procedure he failed to obtain informed consent from the patient either by not explaining what he planned to do or failing to explain the risks associated with what he planned to do. Why he developed this practice has never been adequately explained. The two possibilities identified in the evidence were either that which he identified (an improved cosmetic appearance) or because the procedures were rushed and the presence of unremoved tissue went unnoticed. Mr Paterson adopted this practice both in his NHS and private practices.

6. This method of proceeding had first been detected in 2007 by NHS officials at HEFT. Those NHS officials sought and received from Mr Paterson an assurance that he

would stop performing STMs but by 2011 it had become apparent that he had continued to perform such procedures. The GMC placed restrictions on Mr Paterson's practice in consequence and, in August 2011, Spire suspended all Mr Paterson's practising privileges at its hospitals. The GMC thereafter suspended Mr Paterson from practice.

7. Following his suspension, in October 2011, it was discovered that Mr Paterson had also engaged in what Spire characterises (correctly) as "… *a quite different, and utterly abhorrent strand of conduct, carrying out unnecessary surgical procedures – typically wide local excisions ("WLEs") – where there was no clinical indication for the surgical procedure undertaken.*" Mr Paterson's methodology was to falsely report pathology test results as indicating the presence or a risk of the presence of cancer, obtain consent for treatment on the basis of this falsely reported pathology and then perform unnecessary surgery and follow up treatment for which necessarily no informed consent had been obtained. This course of misconduct occurred almost exclusively in relation to private patients, for which Mr Paterson claimed fees either from the patients themselves or their insurers.

8. This led to Mr Paterson being charged with offences under sections 18 and 20 of the Offences against the Person Act 1861 and tried in the Crown Court at Nottingham before Jeremy Baker J and a jury, where he was convicted of 17 counts under s.18 and 3 counts under s.20. He was sentenced to 15 years imprisonment, later increased on appeal by the Attorney General to the Criminal Division of the Court of Appeal ("CACD") to 20 years. In his sentencing remarks, Jeremy Baker J said:

> "57. Inevitably, the effect of carrying out the unnecessary procedures upon these individuals, has varied from one to another. However, it is clear both from listening to their accounts during the trial, and subsequently having considered their victim impact statements, that the physical, and particularly psychological effect upon each of them, has been profound.
>
> 58. All of them have suffered the pain and discomfort associated with surgery, whilst some have suffered the debilitating longer-term effects of complications arising from the unnecessary procedures; especially those who have undergone mastectomies with immediate subcutaneous reconstruction.
>
> 59. All of them have been left feeling violated and vulnerable, whilst some have suffered prolonged psychological conditions, including post-traumatic stress disorder, anxiety and depression, which has required professional intervention and treatment.
>
> 60. All of them have been left with physical scarring to their bodies, and those who underwent mastectomies have had their breast tissues removed. The one man who was affected by this type of procedure has spoken eloquently of the effect that this

> procedure has had upon him, and it is probably difficult to overstate its psychological effect upon the women to whom it took place, which is best encapsulated by one of the victims, who puts it in these terms,
>
> > "Now and probably for the rest of my life, when I look in the mirror I see a victim of Paterson, who took away part of being a woman."
>
> 61. In addition to economic losses caused to some of these individuals, either from the cost of the operations themselves, or the psychological impact on their employability, the other effect which is common to all these individuals has been their loss of trust in others, including the medical profession, and the reputational harm of your conduct may well extend beyond those immediately affected."

As Hallett LJ observed in the course of delivering the judgment of the CACD:

> "The jury's verdicts mean that they were satisfied that over a period of 14 years, in respect of ten patients (nine women and one man) the offender deliberately misrepresented the contents of pathology, exaggerated the risk of cancer and advised and carried out unnecessary surgery including mastectomies."

9. About 750 former patients of Mr Paterson commenced proceedings, with the Lead Action being case number HQ15 P 02152 between LG and 6 others v (1) Mr Paterson, (2) Spire and (3) HEFT ("Paterson Litigation"). The claims against Spire were by claimant patients who had either suffered negligently performed STMs or who had been the victims of unnecessary surgery as described by Jeremy Baker J and Hallett LJ or who have been the victim of both negligently performed STMs and unnecessary surgery. RSA accepts that Spire is entitled to an indemnity under Section 4 of the Policy in respect of its legal liabilities to the patient claimants and its defence costs. In total, Spire contends that its outlay on damages, costs and its own defence costs amount to £37,239,007.81. It maintains that it has incurred a combined outlay in excess of £10m in respect of each of the groups of cases which it maintains are to be aggregated. RSA does not accept that this is so and puts Spire to proof on that issue.

The Issues to be Determined

The Aggregation Issue

10. The Aggregation issue is the principal issue to be determined at this trial. It is the subject of issues 1-3 in the Agreed List of Issues. In summary, by clause 5(a) of the Policy, it was agreed between the parties that:

> "The total amount payable by the Company in respect of all damages costs and expenses arising out of all claims during any Period of Insurance consequent on or attributable to one source or original cause irrespective of the number of Persons Entitled to Indemnity having a claim under this Policy consequent on or

> attributable to that one source or original cause shall not exceed the Limit of Indemnity stated in the Schedule"

Spire maintains that there are two separate groups of claims being:

i) claims resulting from Mr Paterson negligently performing STMs where a mastectomy was clinically indicated, which Spire characterise as the "*Group 1*" claims; and

ii) claims resulting from the conduct summarised by Jeremy Baker J and Hallett LJ as quoted above – that is where Mr Paterson had deliberately misrepresented the contents of pathology, exaggerated the risk of cancer and advised and carried out unnecessary surgery including mastectomies, which Spire characterise as the "*Group 2*" claims

– see Issue 2 in the Agreed List of Issues. I refer to each of these groups of cases hereafter respectively as the Group 1 and Group 2 claims.

11. On this basis Spire maintains that it is entitled to at least two Limits of Indemnity of £10 million (subject always to the aggregate limit of indemnity of £20 million) being one in respect of each of the two separate groups of claims because, it maintains, each group of claims was consequent upon or attributable to a different source of original cause – Issue 1.1 in the Agreed List of Issues.

12. RSA maintains that the distinction that Spire draws between the two groups of cases is a false distinction and that on a proper construction of clause 5(a) of the Policy all the claims should be aggregated once because they are all consequent on or attributable to one source or original cause, namely Mr Paterson or Mr Paterson and his conduct. In relation to the alternative formulation, RSA's case as to what "*his conduct"* consisted of has varied. By the time this trial started the focus of attention was on an assertion that in both groups of cases the injuries and loss for which damage was claimed had been caused by Mr Paterson's negligence. This changed during the course of the trial to an assertion that the aggregating cause was that in both groups of cases the injuries and loss had resulted from deliberate misconduct on the part of Mr Paterson.

13. In relation to its case that the aggregating conduct in both groups was Mr Paterson's negligent and inappropriate clinical care, RSA relies on the fact that both types of claim were pleaded in the Paterson Litigation as having been caused by Mr Paterson's negligence and that Spire adopted a similar course when pleading its contribution claim against Mr Paterson. It also relies on the fact that the claimant patients who sent letters of claim relied exclusively on negligence, whether or not the claims were what Spire characterises as Group 1 or Group 2 claims. It relies on the fact that Mr Paterson conceded a breach of a duty of care in relation to the claims irrespective of whether they were Group 1 or Group 2 claims and that the duty by reference to which the claims were advanced in correspondence, pleaded in the Paterson Litigation and conceded by or on behalf of Mr Paterson was a duty to prevent harm whether caused "*accidentally or deliberately*" – see paragraph 25 of RSA's opening written submissions. In relation to RSA's alternative case that the single aggregating factor was Mr Paterson's deliberate misconduct, the focus changes to the fact that Mr Paterson continued to perform STM procedures notwithstanding his assurances to

HEFT's officials that he would not do so and so was deliberate just as was the performance of unnecessary surgery on patients within Group 2.

14. In either event, RSA argues that Spire's approach is impermissible disaggregation and in consequence, RSA maintains that Spire is entitled only to a single Limit of Indemnity of £10 million because all the Claims are consequent on or attributable to that one source or original cause being Mr Paterson and his conduct – see Issue 1.2 and Issue 3 in the Agreed List of Issues. Spire's response is that neither of RSA's approaches constitutes permissible aggregation either as a matter of construction of Clause 5(a) of the Policy or as a matter of general law because it does not identify properly why each category of loss occurred or how they were each caused.

The Quantum Issue

15. RSA puts in issue whether the damages interest and costs including defence costs paid out by Spire in respect of the Group 2 claims exceed £10 million. This issue has been formulated by agreement as being:

> "Did the quantum of the damages and interest paid to the Patients, the Patient's costs, and the Claimant's defence costs arising out of the second distinct group of Claims exceed £10 million? If not, what was the quantum of the damages, interest, costs and defence costs of Claims arising out of Mr Paterson's deliberate conduct?"

- see Issue 9 within the Agreed List of Issues. This issue was the only issue in respect of which oral evidence was adduced.

16. The only witnesses called were those called by Spire. The witnesses called were:

i) Ms Linda Millband, a partner in the firm of Thompsons and that firm's national practice lead for clinical negligence; and

ii) Ms Emma Doughty, Principal Lawyer and head of Clinical Negligence, London at Slater & Gordon.

Their evidence was relevant exclusively to the quantum issue.

17. Ms Millband was one of the Lead Solicitors in the Paterson Litigation, who acted for 5 of the claimants in the lead action referred to earlier. Slater & Gordon acted for the remainder. The lead action was a test case which was intended to resolve most of the common liability and causation issues that arose in respect of claims by patients falling into either or both of the groups identified by Spire against Mr Paterson, Spire and HEFT. Each firm acted in addition for a large number of non-lead claimants and for firms of solicitors acting for such claimants. The total number of clients for whom Thompson acted was 503. Slater & Gordon acted directly for 115 claimants including 2 of the lead claimants and in addition for various firms instructed by a further 169 non-lead claimants.

18. The claims in the Paterson Litigation were concluded by a confidential Settlement Agreement and a Consent Order which was approved by the High Court on 27th September 2017, both of which are prohibited from disclosure.

19. Each of these witnesses was asked to carry out an audit in order to help resolve Issue 9 in the Agreed List of Issues. Each was constrained as to the factual material that she could disclose both because of the prohibition on the publication of the agreements and orders made in the Paterson litigation and because neither solicitors' clients were prepared to waive privilege. I make clear at this stage that I accept the evidence of each of these witnesses in its entirety.

The Principles Applicable to the Aggregation Issue

20. It is common ground that construction of an aggregation clause should not be approached with a predisposition towards either a narrow or broad construction for the reason identified by Lord Hobhouse at paragraph 30 of his opinion in Lloyds TSB General Insurance Holdings v. Lloyds Bank Group Insurance Co Ltd [2003] UKHL 48; [2003] Lloyd's Rep IR 623 – that is because:

> "…aggregation clauses may favour the assured or the insurer and in some policies the same aggregation clause, because it qualities both a deductible clause and a limit clause, may at times work in favour of the assured and at other times in favour of the insurer. Aggregation clauses thus require a construction which is not influenced by any need to protect the one party or the other. They must be construed in a balanced fashion giving effect to the words used."

and see also AIG Europe Ltd v Woodman [2017] UKSC 18; [2017] 1 WLR 1168 *per* Lord Toulson JSC at paragraph 14 to similar effect.

21. Generally, a provision within a contract is to be construed by applying the well-known general principles of construction to the document in issue taking account of the commercial and factual context as well as the language used by the parties. However, where standard wording used in documents such as insurance policies is in issue it is appropriate to follow the construction of such or materially similar provisions in earlier cases unless there is a clear contextual distinction or other strong reason that suggests that would be inappropriate – see Hooley Hill Rubber & Chemical Company Limited v Royal Insurance Company [1920] 1 K.B. 257, per Scrutton LJ at 272. Neither party argues for such a departure in these proceedings.

22. The aggregation language used in clause 5(a) of the Policy is "… *all claims during any Period of Insurance consequent on or attributable to one source or original cause* …". This wording requires:

    i) The widest possible search for a unifying factor in the history of the losses it is sought to aggregate – see AXA Reinsurance (UK) Ltd v Field [1996] 1 WLR 1026; [1996] 2 Lloyd's Rep 233 *per* Lord Mustill at p.1035 and Municipal Mutual Insurance Limited v. Sea Insurance Company Limited and others [1998] Lloyds Rep I & R 421 *per* Hobhouse LJ as he then was at 434;

ii) That the doctrine of proximate cause should not apply and that losses should be traced back to wherever a common origin can reasonably be found – see ACE and Beazley Underwriting Limited v The Travelers Companies Incorporated [2011] EWHC 1520 (Comm) per Eder J at paragraph 127; but

iii) The words "… *original cause* …" must not be construed *"... at so generalised a level as not to be useful in the context of a search for an effective original cause. …"* – see The Cultural Foundation and another v. Beazeley Furlonge Limited and others [2018] EWHC 1083 (Comm); [2019] 1 Lloyds Rep 12 *per* Andrew Henshaw QC (as he then was) at paragraph 204(iii);

iv) There must be a causative link between what is contended to be the originating cause and the loss and there must also be some limit to the degree of remoteness that is acceptable: American Centennial Insurance Co. v. INSCO Ltd [1996] L.R.I.R 407, Moore-Bick J at p.414 LHC. In this connection there is no distinction to be drawn between an "original cause" on the one hand and an "originating cause" on the other – see Countrywide Assured Group plc & Others v Marshall and others [2002] EWHC 2082 (Comm); [2003] Lloyd's Rep I and R 195 *per* Morison J at paragraph 15 (LHC). The use of the alternative reference within the clause to "…*one source …"* does not impact the correctness of this proposition other than "*to emphasise yet further the intention that the doctrine of proximate cause should not apply and that losses should be traced back. ...*" - see ACE and Beazley Underwriting Limited v The Travelers Companies Incorporated (ibid.) at paragraph 259;

v) The search for a unifying factor in the Axa sense is a search for why something has happened - see Countrywide Assured Group v DJ Marshall (ibid.) at paragraph 15:

> "The word event, occurrence or claim describes what has happened; the word "cause" describes why something has happened. The words "one source or original cause" are, as Hobhouse LJ said, "wide". It is, I think, the force of the word "original", or "originating" in the Axa Reinsurance case. that entitles one to see if there is a unifying factor in the history of the claims with which the claimants were faced."

vi) An individual's reason for acting in a particular way is capable of being an originating cause if a mis-appreciation or deliberate decision leads that individual concerned to commit the negligent acts or omissions leading to the claims that an insurer seeks to aggregate – see Cox v Bankside Members Agency Ltd [1995] 2 Lloyds Rep 437 at 455 where Philips J (as he then was) distinguished between a culpable mis-appreciation by one individual on the one hand and similar mis-appreciations made by a number of different individuals on the other. This led him to hold:

> "A culpable mis-appreciation in an individual which leads him to commit a number of negligent acts can arguably be said to constitute the single event or originating cause

> responsible for all the negligent acts and their consequences. The same is not true when a number of individuals each act under an individual mis-appreciation, even if the nature of that mis-appreciation is the same.
>
> Each of the Gooda Walker underwriters formed his own policy, insofar as he had one, and took his own underwriting decisions for his Names, independently and from his own viewpoint. While their actions suffered from similar shortcomings, the individual approaches which resulted in these short-comings were by no means identical. In my judgment, if one applies the approach of Mr. Justice Clarke in Caudle v. Sharpe, the result is that the approach to underwriting of each underwriter was a separate originating cause, resulting in the losses suffered by the Names on whose behalf that under-writer was writing business."

23. Philips J's reasoning in Cox (ibid.) leads me to conclude that

    i) where a single individual acting under a particular mis-appreciation or decision results in that individual committing negligent acts or omissions leading to multiple claims, the mis-appreciation or decision can be an originating cause within the meaning of a clause such as the aggregation clause in the Policy; but

    ii) where similar mis-appreciations or decisions by multiple numbers of individuals acting independently result in negligent acts or omissions by those individuals each leading to multiple claims all insured under the same policy with an aggregation provision similar to that in the Policy, the mis-appreciation or decision of each individual is likely to be a separate originating cause; and

    iii) by parity of reasoning, where a single individual operates under two separate mis-appreciations or decisions, each resulting in negligent acts or omissions leading to multiple claims, there could be separate originating causes (being each of the separate mis-appreciations or decisions) even though only one individual was involved.

    I use the words "can" "is likely to be" and "could" deliberately because whether in fact the outcome is as summarised in (i) to (iii) is fact sensitive.

24. Although Mr Eklund QC on behalf of RSA does not accept the analysis in (iii) as correct, I think this is mistaken. If the result was not as I have summarised it, then there would be no effective causative link between what is contended to be the originating cause and the loss in each case that it was sought to aggregate nor would what is alleged to be the originating cause explain adequately or at all why the negligent act or omission leading to the claims had occurred. A hypothetical example may help to explain the point. An orthopaedic surgeon performs both knee replacement and hip replacement procedures. He operates under a mis-appreciation as to the manner in which hip replacements are to be carried out which constitutes negligence applying established principles resulting in multiple claims by patients on

whom he performed hip replacement surgery. At the same time in relation to his knee replacement practice he operates under another and different mis-appreciation relevant exclusively to knee replacement surgery which constitutes negligence applying established principles resulting in multiple claims by patients on whom he performed knee replacement surgery. In my judgment each mis-appreciation would constitute a separate originating cause unless for example it could be said that the existence of the mis-appreciations was for example the result of the Insured's failure properly to train the individual concerned.

25. Characterising the originating or original cause as "*... negligent and inappropriate clinical care ...*" or, alternatively, as deliberate misconduct does not assist because in the hypothetical example set out above, the cause of the negligent hip replacement surgery whilst causative of all the hip claims was not in any sense causative of the knee claims and vice versa. Submitting as Mr Eklund does that in this case it is a statement of the obvious that all the claims were the result of Mr Paterson and his conduct ignores the need to search for an effective original cause of all the losses it is sought to aggregate. As Mr Henshaw put it in The Cultural Foundation (ibid.):

> "To construe "original cause" so widely as to encompass any claims arising from bad design on a particular project by the insured architect would give too vague a meaning to those words"

26. This analysis is not merely the result of giving effect to the reasoning in the authorities referred to above but is the result of the language used by the parties in the Policy. The total amounts paid by Spire arising out of the relevant claims are required to have been "*... consequent on or attributable to ... one ... original cause...*". The words *"... consequent on or attributable..."* import a clear and express causal requirement. Thus if RSA is to be entitled to aggregate the claims against Spire resulting from Mr Paterson's practice at its hospitals, it must establish that they were all attributable to common origin with an effective causal link to the losses that it is sought to aggregate.

Application of the Aggregation Principles to the Aggregation Issue

27. Although there is a great deal of factual material that has been deployed in these proceedings in relation to what happened to particular patients, it is not necessary that I descend to that level of detail in this judgment because it is common ground that there were the two distinct aspects to Mr Paterson's conduct on which Spire relies. For similar reasons, it is unnecessary that I refer to the very lengthy and informative reports concerning Mr Paterson's conduct and its impact on the patients on whom he operated. The difference between the parties is that RSA submits this distinction is immaterial and Spire submits that it is.

28. It is thus common ground that Mr Paterson negligently performed STMs on Patients where a mastectomy was clinically indicated and/or justified and carried out unnecessary surgical procedures where there was no clinical indication for the surgical procedure undertaken – see paragraphs 4-5 of the Areas of Agreement set out in the Approved List of Issues. It is also common ground that where Mr Paterson carried out unnecessary surgical procedures, he deliberately misrepresented the

contents of pathology, falsely stated cancer was present or exaggerated the risk of cancer and advised and carried out surgery – see paragraph 6 of the Areas of Agreement. Finally, it is common ground between the parties that "*... it may be possible ...*" to categorise the claims against Spire into Group 1 and Group 2 claims – see paragraph 7 of the Areas of Agreement.

29. In my judgment there are clear causative differences between the two groups of case. In relation to the Group 1 cases, Mr Paterson performed STM surgery on both his NHS and Private patients. In each case the patient had a cancerous tumour that necessitated a mastectomy. That surgery was negligently performed for the reasons summarised above and exposed such patients to the risk of recurrence of breast cancer, the consequent risk that it would metastasise to form tumours elsewhere and to the risk that such patients would in consequence require further treatment that might otherwise have been avoided. Two explanations have been offered for this practice – either that it was simply rushed and careless surgery or that it was motivated by a desire to provide a better cosmetic outcome. There is no suggestion that such surgery was (or even could be) of any financial gain for Mr Paterson in carrying out STMs as opposed to correctly performed procedures.

30. In relation to Group 2 cases, most if not all the factors noted in relation to Group 1 cases are missing. The unnecessary surgery was in almost all cases performed on private rather than NHS patients; in none of the cases where unnecessary surgery was carried out did the patient have a cancerous tumour that required the unnecessary treatment and the unnecessary treatment did not expose them to the risk of recurring or metastasising disease and the only tenable explanation for why the unnecessary surgery was carried out using the dishonest and deceptive techniques described earlier was largely for financial gain.

31. It was submitted by Spire that it was of the essence of the Group 2 cases that they were all the result of dishonest conduct. The patients were lied to concerning the result of diagnostic tests and need for the surgery. RSA submitted that the Group 1 cases involved dishonesty as well. So it did but it was of entirely different nature. The dishonesty involved in failing to tell a patient in need of a mastectomy that the surgeon intended to perform STM surgery or of the risks inherent in such surgery and of performing such surgery having previously agreed with the HEFT managers that he would not do so is different from the dishonesty involved in the Group 2 cases. Analysed in causal terms, a propensity to dishonestly misrepresent the outcome of diagnostic tests and thereby obtain consent for surgery that was in truth entirely unnecessary was not causative of any of Group 1 cases but was of the Group 2 cases whereas the propensity to carry out STM procedures without first obtaining the informed consent of patients and ignoring the assurances given to the HEFT managers was not causative of any of the Group 2 cases but was of the Group 1 cases. Thus, while in each case dishonesty was at least strongly arguably involved, the dishonesty of Mr Paterson in relation the Group 1 cases was different from the dishonesty that occurred in the Group 2 cases.

32. The management issues within Spire that led to the continuation of these two strands of misconduct by Mr Paterson were entirely different in nature. In relation to Group 1 cases, the failure was a failure by applying various controls to prevent the development or continuation of Mr Paterson's practice of performing STM

procedures. This was largely the result of a failure by other clinicians to notice or comment on the practice even though Mr Paterson had been asked to give an assurance to HEFT that he would cease performing such procedures and even though the fact of such procedures were or should have been obvious from follow up procedures. The management failure that contributed to the Group 2 cases was entirely different. It consisted in the failure to challenge the need for the unnecessary surgery before it was carried out by reference to the diagnostic information that on proper analysis would have shown that the surgery was unnecessary.

33. The distinction between Group 1 and Group 2 claims was apparent in the master Particulars of Claim served in the Paterson litigation. Whilst it is true to say that the pleading did not distinguish formally between Group 1 and Group 2 claimants it distinguished between the two types of conduct as is apparent for example from paragraph 84 where under the heading "*THE ALLEGATIONS AGAINST MR PATERSON"*, it was alleged that that claimants had undergone "*... inappropriate and entirely unnecessary operations ..."* on the one hand and "*... a cleavage sparing mastectomy which was not a recognised procedure and which left patients at risk of recurrence of breast cancer"* on the other. This distinction is reflected in the particular allegations of the lead claimants in the Paterson Litigation. In the case of patient LF, all the allegations made are of unnecessary surgery – see Appendix 2 to the master Particulars of Claim, where the nature of LF's claim is described in these terms:

> "Mr Paterson performed surgery or diagnostic treatment on LF on 25 October 2000,24 April 2002,7 January 2004, 2 February 2005,12 July 2006 and 2 May 2007 that was unnecessary and carried out without informed consent. Had LF been advised, as she should have been, that the procedures were unnecessary she clearly would not have consented to them.
>
> b. Mr Paterson failed to carry out a standard triple assessment to diagnose LF's condition in April 2002, December 2003, January 2005, July 2006 and April 2007. Had he done so, he would and should have ascertained that surgery was unnecessary.
>
> c. On 5 occasions Mr Paterson performed a lumpectomy that was unnecessary. This was an invasive procedure carried out under general anaesthetic that had no benefit for LF and which caused her the anxiety of believing she had needed treatment for breast cancer when with competent care it ought to have been ascertained that she never had breast cancer."

By contrast, it was alleged on behalf of Patient AO, that:

> "On 12 November 2008, [Mr Paterson] performed a "cleavage sparing mastectomy" whereby a mastectomy was purportedly performed upon the Claimant but a significant proportion of the tissue in her left breast was left behind. This was not a procedure recognised by a responsible body of surgeons and

> the Claimant did not give informed consent for it. As a result of this negligently performed procedure the Claimant was exposed to an unnecessary risk of recurrence of her breast cancer. The residual tissue was not discovered until 2012, when it was discovered as part of the [Spire's] review of [Mr Paterson's] private patients. As a result of the discovery, the Claimant was required to undergo two further operations to remove residual breast tissue in February 2012 and January 2013."

34. Occasionally, a private patient would suffer both a Group 1 and a Group 2 type procedure at the hands of Mr Paterson. An example is another of the lead claimants, LB, by whom it was alleged in Appendix 6 to the Master Particulars of Claim that (a) Mr Paterson performed an STM procedure when a mastectomy was required by reason of the presence of a tumour and (b) the performance of a mastectomy on LB's other breast just over a year later for which there was no medical justification.

35. I do not accept that the occurrences of cases such as that of LB either supports RSA's case on aggregation or defeats Spire's case on this issue since LB would have two separate causes of action – one falling within Group 1 and the other within Group 2. The same procedure cannot be both wholly unnecessary and needed but incompletely carried out even if one procedure was unnecessary and the other was incompletely carried out.

36. Mr Eklund relied very strongly in support of Mr Paterson's negligence being the original cause on the way in which the case had been pleaded in the Paterson Litigation both by the patient claimants and by Spire – see the summary earlier in this judgment. However, in my judgment that misses the point. The focus of attention is not on legal classification but on the factual cause that is said to be the same original cause of each claim that it is sought to aggregate. This is unaffected by the use of the word "*claims"* in the aggregation clause in issue in this case. Whilst I accept that an event giving rise to loss that is actionable by two or more legally different causes of action – for example fraud, negligence or unjust enrichment – is a single claim – see for example West Wake Price & Co v Ching [1957] 1 WLR 45 per Devlin J at 55 to 57 – in LB's case there are two different events each of which gives rise to a separate loss actionable in either negligence or assault. Whether each is to be aggregated turns on whether each of the claims is, to use the language of the aggregation clause in this case, "*…consequent on or attributable to one source or original cause…"* not on whether one is classified legally as negligence and another as assault or whether both have been classified as negligence. Legal classification is simply not the issue.

37. Against that factual background, it is necessary now to turn to the aggregation issue applying the general principles identified earlier. To be capable of being aggregated, all the claims it is asserted should be aggregated must be "*…consequent on or attributable to one source or original cause…"*. The effect of the words "*…consequent on or attributable to…"* when read together with the word "*cause"* is to import a requirement that the claims that it is sought to aggregate must be caused by the same "*… one source or original cause …"* This not merely follows as a matter of construction of the words used by the parties but also as a matter of general principle – see Cox v Bankside Members Agency Ltd (ibid.), where Philips J identified the task in an aggregation dispute as being a search for " … *the single event*

or originating cause responsible for all the negligent acts and their consequences …"; American Centennial Insurance Co. v. INSCO Ltd (ibid.) where Moore-Bick J emphasised the need for a causative link between what is contended to be the originating cause and the loss and The Cultural Foundation and another v. Beazeley Furlonge Limited and others (ibid.) where Mr Henshaw QC emphasised that the search was for " … *an effective original cause* …" and the need to avoid construing the words "*original cause"* at such a generalised level as to defeat that exercise.

38. The requirement for a causative link between what is contended to be the originating cause and the losses it is being sought to aggregate was in issue on the pleadings – see paragraph 43.2.2 of the re-amended Defence. In my judgment this was mistaken as a matter of construction of the aggregation clause when read as a whole for the reasons already explained and is contrary to the principles identified in the authorities referred to earlier.

39. RSA pleads in the same paragraph of its re-amended Defence that "…*if, contrary to the denial in this sub-paragraph, the one source or original cause has to be causative, Mr Paterson and his conduct was causative of the losses and subsequent Claims*." The difficulty with this formulation (whether the conduct is characterised as negligence or deliberate misconduct) assumes what it must prove namely that the same conduct was causative of all the losses in each of the claims. For the reasons that I have explained already, once it is accepted that where a single individual operates under two separate mis-appreciations decisions or motivations, each resulting in multiple claims, there would be separate originating causes (being each of the separate mis-appreciations decisions or motivations) even though only one individual was involved. To attempt in those circumstances to attribute all the losses to the conduct of an individual simply ignores the requirement for a causal link.

40. I find that Mr Paterson's motivations in respect of his decision to carry out STM procedures to patients with breast cancer were different from his motivations in respect of his decisions to carry out wholly unnecessary procedures either on patients who were not ill at all or who were ill in ways that did not necessitate such procedures.

41. I have already set out the cardinal differences. In substance however, the fundamental difference was that in the Group 1 cases the procedures were carried out on patients that required mastectomies in order to remove the breast tissue from a breast that had cancerous tumours within it whereas in the Group 2 cases the patients concerned were not suffering from any medical condition that necessitated the treatment undertaken. Whether the cause of action available to patients in each group is legally characterised as negligence or assault is immaterial. What matters is essentially a factual question – what factually was the original cause of each of the claims? As I have said, when analysed at that level, the original cause of the group 1 cases was not the original cause of the Group 2 cases.

42. If legal characterisation matters at all, I consider how in fact the claims were set up is immaterial. That the Group 2 cases should be characterised for these purposes as assaults is both obvious and apparent from the verdicts in the criminal proceedings against Mr Paterson referred to earlier. The cases considered in those proceedings were exclusively cases concerning unnecessary procedures on patients who were not

ill in any relevant sense. As Jeremy Baker J observed in paragraph 64 of his sentencing remarks:

> "In order to gain a proper understanding of this case, it is important to appreciate that the offences of which you have been convicted by the jury are not ones involving either negligence or even recklessness, where someone causes harm either by oversight, or knowingly or otherwise is working beyond their capabilities. On the contrary, as the jury found, these offences represent the intentional application of permanent harm by you upon patients who were in your care, for your own selfish purposes, rather than because they were necessary to maintain their health. In these circumstances, they represent the antithesis of the Hippocratic oath."

The Group 1 cases were either the result of a mis-appreciation by Mr Paterson that an effective mastectomy could be carried out leaving some tissue behind for cosmetic reasons or because some breast tissue was left behind as a result of the procedure being carried out too hurriedly.

43. At a factual level the original cause of each group of cases was different. I find on the balance of probability that the Group 2 cases were motivated at least primarily and predominantly by financial greed. I infer that to be most likely to be the dominant motivation because the vast majority of the patients on whom unnecessary surgery was performed were private not NHS patients and from the fact that in a number of cases, procedures were misdescribed when Mr Paterson claimed payment so as to enhance further the payment he received for the unnecessary procedures. It is conceivable that a subsidiary motivation for carrying out the unnecessary procedures was psychological. There is some evidence for that to be derived from the fact that Mr Paterson carried out some albeit very few wholly unnecessary procedures on NHS patients. Jeremy Baker J alluded to this in paragraph 62 of his sentencing remarks when he observed that he was satisfied that Mr Paterson was motivated in relation to the cases that were the subject of the prosecution (all Group 2 cases as I have noted) by "*… your own self-aggrandisement and the material rewards which it brought from your private practice…"* However that is immaterial to the issue I am concerned with because there is no evidence either direct or inferential that suggests either of these factors played any part in his decision to carry out STM procedures on patients who required Mastectomies because they had breast cancer in the affected breast.

44. Returning to the analysis necessary to determine the aggregation issue, the terms of the aggregation clause agreed between the parties when construed correctly and in accordance with the authorities referred to earlier require that what has to be identified is the single source or originating cause of all the negligent acts and their consequences. It is obvious but in any event I find that Mr Paterson's motivations for carrying out unnecessary procedures were entirely different from his motivations for carrying out STM procedures on patients with cancer when he should have been carrying out conventional mastectomies. It follows from this that his motivations for carrying out unnecessary procedures could not and I find did not cause him to carry out any of the STM procedures on patients with a medically identifiable need for

mastectomy procedures and likewise his motivation for carrying out STM procedures to such patients did not cause him to carry out any of the unnecessary procedures.

45. In my judgment two consequences follow from this. First RSA's pleaded case that "… *Mr Paterson and his conduct was causative of the losses and subsequent Claims*" must be rejected. RSA asserts that the true originating cause of all the losses for which an indemnity is claimed by Spire was Mr Paterson and his conduct. However this ignores the fact it was different conduct that caused each group of cases. This approach to aggregation is precisely what Mr Henshaw warned against in The Cultural Foundation and another v. Beazeley Furlonge Limited and others (ibid.) because it defeats "… *a search for an effective original cause.* …" of the losses it is sought to aggregate. By focussing on "*... Mr Paterson and his conduct ...*" RSA focus on the role of the individual not the cause of his actions and so simply ignore the reasons for such conduct entirely and that Mr Paterson's was motivated entirely differently for each group of cases.

46. The single effective source or cause of Mr Paterson performing STM procedures on patient whose medical requirement was for a mastectomy was either a desire to preserve some cosmetic advantage or perhaps because the procedure was carried out so hurriedly that he failed to appreciate that he had failed to remove all the tissue that should have been removed had the mastectomy been carried out competently. Mr Paterson's motivation for carrying out unnecessary procedures was not a cause and, much less, an effective cause, of him carrying out STMs to patients with a medical need for a competently executed mastectomy. Similarly, Mr Paterson's motivation for carrying out STMs rather than conventional mastectomies was not a cause and, much less, an effective cause, of him carrying out unnecessary procedures on patient without any medical need for the procedures carried out. That being so it would be wrong in principle to aggregate claims for losses resulting from Group1 cases with losses resulting from Group 2 cases or *vice versa*.

47. Mr Eklund submits that all this is wrong and ignores common sense. He maintains that it is obvious that the one source and original cause of all the claims was that each of the patients was operated on by Mr Paterson, that the relevant conduct was a breach of duty by Mr Paterson and thus his conduct was the single source of all the patients' injuries. However, as I have said this ignores the need to identify a common effective cause of all the claims. The effective cause of the Group 2 claims was wholly different from the effective cause of the Group 1 claims. Mr Eklund places particular reliance of Eder J's formulation in Ace (ibid.) that the search is not for a proximate cause but that "… *losses should be traced back to wherever a common origin can reasonably be found …"* I do not dispute that, although this formulation must be read together with the alterative formulations to which I referred earlier. The search is for the single originating cause responsible for all the negligent acts and their consequences. The effective originating cause for the Group 1 cases was different from that of the Group 2 cases. The effective originating cause of the Group 1 cases was not the effective originating cause of the Group 2 claims and vice versa. To suggest that Mr Paterson and his conduct was the effective cause of all the claims ignores both the need to demonstrate an effective original causal link applicable to all the cases that it is sought to aggregate and the fact that his conduct in relation to the Group 1 claims did not cause the losses the subject of the Group 2 claims and vice versa.

48. Mr Eklund submits that the fallacy in all this is demonstrated by reference to patients who suffered both treatment falling within Group 1 and Group 2. I do not accept that for the reasons already given. If a claimant is operated on when there was no cause to do so, how the operation was performed is not to the point. The claim is a Group 2 claim. Similarly, a patient who is initially operated on unnecessarily, then subsequently develops breast cancer and undergoes an STM has two distinct claims one in each group. That a particular patient is capable of falling into different groups by reason of having undergone different procedures does not lead to the conclusion that what caused the first procedure also caused the second.

49. In those circumstances and for those reasons, I conclude that there was a different source and originating cause for each of the groups of cases identified by Spire.

The Quantum Issue

50. Issue 9 in the Approved List of Issues identifies the issue to be resolved as being:

> "Did the quantum of the damages and interest paid to the Patients, the Patient's costs, and the Claimant's defence costs arising out of the second distinct group of Claims exceed £10 million? If not, what was the quantum of the damages, interest, costs and defence costs of Claims arising out of Mr Paterson's deliberate conduct?"

RSA does not advance any positive case in relation to this issue but merely puts Spire to proof – see paragraph 83 of the amended particulars of Claim and paragraph 46 of the re-amended Defence. In order to address this issue Spire's solicitors instructed Ms Millband and Ms Doughty in similar terms namely:

> "… to audit and analyse the underlying claims, to establish whether a claim falls into the second group and, where it does, to identify the quantum (damages, the Patients' individual costs, and the appropriate share of Patients' common costs) of such a claim. We request that in your analysis you break down the quantum figures so that it is clear how much is attributed individually to damages, the Patients' individual costs, and the appropriate share of Patients' common costs. It is only necessary to continue this task up to and until it is established that the quantum of the second group of claims exceeds £10 million. After that value is reached, it is unnecessary to continue the task."

Each produced witness statements in compliance with these instructions. As I have indicated I accept the evidence of each witness. To the extent that they were criticised on behalf of RSA for not producing relevant documents or not being willing to discuss the details of particular cases, I reject that criticism first because they had not been asked to give evidence other than by reference to the issue referred to in the letter of instruction quoted above and in any event because each considered to do so would involve a breach of legal professional litigation privilege. I agree with the

stance that each solicitor took. The privilege is not theirs to waive but that of their clients and each had made clear that privilege had not been waived by their clients both in their witness statements and orally in the course of their cross examination.

51. Ms Millband's evidence was summarised in paragraph 19 of her statement as being:

> "Accordingly, from my involvement in these claims and my work on the audit, whilst I am unable to disclose the total figure for reasons of confidentiality, I can be (and have always been) confident that the value of the Category 2 claims, including damages, VAT and costs (including disbursements), is well in excess of £10 million."

Ms Doughty's evidence was summarised in paragraphs 23-24 and 26 of her statement as being:

> "23) In terms of Slater and Gordon's cases, these have all now been assessed to see whether they fell into category 1 or category 2. The claims which fell within into each category were then entered onto an Excel Spreadsheet. That Spreadsheet is privileged and confidential. I do not waive any privilege or confidentiality by referring to it. My clients are not willing to waive privilege or provide that Spreadsheet. The damages received by each client and costs were added in separate columns and totalised.
>
> 24) The audit shows that out of 115 cases, 84 fall within the Second Group. These claims are consequent on, or attributable to, Mr Paterson deliberately or dishonestly performing surgery
>
> …
>
> 28) The audit and analysis confirmed that the amount of damages and costs awarded to the 84 Claimants in the Second Group came to a total of £2,267.693.00. For the avoidance of doubt, that total necessarily does not include the amount of any defence costs incurred for and on behalf of Spire and which may be allocated to the Second Group.
>
> 29) I have spoken with Thompsons and understand they have undertaken a similar audit and the amount of damages and costs awarded to their Group 2 cases is in itself over £10 million"

52. Mr Eklund did not challenge how the audit was carried out and no attempt was made by RSA's solicitors to seek any more detailed data than was available in the witness statements. As Mr Shapiro put it in his closing submissions:

> "Quite remarkably, my learned friend asked no question whatsoever about the way in which the audit had been carried

> out, nor did he check how it had been added up, nor did he check the margin with which they are able to be confident that these claims exceed 10 million. In short, everything points to the fact that the group 2 claim exceeds 10 million."

53. In those circumstances, Mr Eklund's closing submissions on this issue to the effect that:

> "There's never been any real visibility about the value of the claims that apparently fall into category 2. It's very difficult for RSA to deal with those when we've not been provided ourselves with any of the underlying material and information to provide or to test the evidence as to the value of those claims. It became impossible yesterday when I was cross−examining Ms Doughty because of her insistence that all the information was confidential. None of the information has been provided to us, even in an anonymised way."

lack any material force. His later complaint that there could have been a breakdown provided that anonymised the patients' identities but set out what each received lacks force simply because RSA did not seek such information ahead of the trial. I remain of the view that client consent would have to be obtained by the solicitors before even anonymised information could be provided. As I have said I accept this evidence and in those circumstances find this element of Spire's case proved.

Conclusion

54. Spire's claim succeeds and I will hear counsel as to the terms of the order at the handown of this judgment.