

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST (UHB, formerly UBHT)
HISTOPATHOLOGY INQUIRY INTO ALLEGATIONS OF MISDIAGNOSIS

What did they know?

When did they know about it?

What did they do about it?

The Cast

Mary Barnes Director, Avon, Somerset and Wiltshire Cancer Services Network (ASWCS)

Ruth Brunt Acting Chief Executive North Bristol NHS Trust (NBT), formerly Operations Director, NBT

Sir Ian Carruthers OBE, Chief Executive NHS South West

Murray Cochrane Associate Director of Strategic Services NHS South West

Mike Durkin Medical Director NHS South West

Deborah Evans Chief Executive NHS Bristol, **a witness at the Bristol Royal Infirmary Heart Inquiry.**

Deborah Lee UHB Director of Corporate Development (on secondment), formerly Co-Director of Commissioning, NHS Bristol, formerly a Governor of UHB, Acting Chief Executive NHS Bristol at the end of 2007

Rhona MacDonald Former Chief Executive NHS Bath & North East Somerset & former Chair of the Board, ASWCS

Lisa Manson Associate Director of Performance, NHS South West

Sonia Mills Former Chief Executive NBT, now Chief Executive NHS Oxfordshire

Andrew Millward Director of Communications and Corporate Services, NHS South West

Kieran Morgan Former Joint Director Public Health, NHS Bath & North East Somerset, **a witness at the Bristol Royal Infirmary Heart Inquiry**

Martin Morse Former Medical Director NBT

John Murdoch Lead Gynaecological Oncological Surgeon UHB

Geoff Pye Medical Director ASWCS

Graham Rich Former Chief Executive UHB

John Savage Chair of the Board UHB

Jonathan Sheffield Medical Director UHB

David Tappin Former Director of Strategic Development NBT, now performing the same role at NHS Bristol

Geoff Upton Strategic Service Change Manager NHS South West

Richard Weatherhead Chair of Bristol PCT

Statements in italics starting “*DL*” are taken from a response to a Freedom of Information Request that includes a timeline headed “UHB Pathology Issues” produced by Deborah Lee on 12th March 2009, covering the period 22nd July 2008 to 3rd March 2009 inclusive. Ms Lee's last entry of 3rd March 2009 says “ **DL admits defeat and escalates to Chief Executives**”.

<http://drphilhammond.com/blog/wp-content/uploads/2010/09/Deborah-Lees-timeline1.pdf>

31st August 2004

Letter sent by NBT Respiratory Physicians to a UBHT Consultant Thoracic Surgeon expressing serious concern about the quality of histopathology reporting of lung biopsy and resection specimens by UBHT Pathologists in respect of lung patients referred from NBT for surgical procedures at UBHT. The letter referred to a number of incorrect diagnoses and in 2 cases, serious adverse clinical effects.

Among the people copied on the letter were **Ruth Brunt, Martin Morse, Jonathan Sheffield.**

1st June 2007

A letter was sent to **Martin Morse** detailing 15 alleged errors in Histopathology at UBHT that had affected NBT lung, breast and skin patients. The allegations included malignancies incorrectly diagnosed as benign, and vice versa. **Jonathan Sheffield** received a similar letter in early **July 2007**.

15th October 2007

The Local Authority Joint Health Scrutiny Committee met to hear evidence from clinicians, NHS managers, patients and members of the public in respect of proposed changes to Bristol's breast care services. During the meeting, patients and members of the public heard from clinicians that **“the issue of the Pathology Services needs to be resolved”**

<http://www.bristol.gov.uk/item/committeecontent/?ref=wa&code=wa048&year=2007&month=10&day=15&hour=13&minute=00> - click on minutes, top left

and that some aspects of pathology services at UBHT are **“not up to standard”**.

Among the NHS attendees at the meeting who heard clinicians express concerns about UHB's cancer pathology services were **Deborah Lee, David Tappin and Martin Morse**. **Deborah Lee** informed the meeting that **“all the issues raised could be resolved”**

According to a 2010 Freedom of Information Response from NHS Bristol **Deborah Lee** invited NBT to substantiate in writing and with detail the verbal allegations made at the Health Scrutiny Meeting. NBT did not provide any evidence in support of the allegations, despite **Martin Morse** having received details of 15 specific allegations over four months earlier, in **June 2007**.

It appears that **Deborah Lee** decided not follow up the concerns directly with the clinicians so that **“all the issues raised could be resolved”**.

Martin Morse knew that one of his former NBT colleagues, the late Jane Hopes, was one of the patients affected by misdiagnosis. It seems likely that **David Tappin**, also a former colleague of Mrs Hopes would have known that her case was one of the misdiagnoses. Yet it appears that neither provided **Deborah Lee** with details of the specific allegations that had been formally raised with **Martin Morse**. **David Tappin** moved to NHS Bristol in **August 2008**, as one of **Deborah Lee's** fellow NHS Bristol Board Members.

26th February 2008

The ASWCS Breast Site Specific Group met. The notes of the meeting record that one of the members **“raised the issue over the quality of UBHT Pathology Services. He felt that a clear statement should be issued by UBHT either acknowledging or refuting these claims. He wasn't aware that this had happened. The group felt the current situation was divisive”**

See item 13 – Any other business.

<http://89.234.34.107/avon/documents/website%5CSSGs%5CBreast%2FNotes%2026%20February%202008%2Epdf>

April 2008

Reporting of cervical histopathology for UBHT patients was transferred to NBT following a Quality

Assurance review in 2006 that identified that the correlation between cervical cytology reporting (all done at NBT) and subsequent biopsy reporting for UBHT patients (performed at UBHT), was significantly lower at UBHT than at NBT. It was stated to be the worst correlation in England. The Quality Assurance report concluded that, during the period studied, there was significant under grading of cervical cell changes in respect of loop biopsy specimens reported at UBHT. This would have increased the risk of gynaecological disease being under treated. The reviewers found no evidence that any patients were harmed. However, following the review, UBHT's cervical biopsy reporting was transferred to NBT. Other gynaecological histopathology reporting remained at UHBT, despite cervical biopsy reporting being regarded as one of the easier aspects of a gynaecological histopathology service.

15th June 2008

A letter was sent to **Graham Rich** for his urgent attention, copied to **John Savage** and **Sonia Mills**, referring to unresolved concerns about UBHT's histopathology services, including a range of diagnostic errors in reporting of gynaecological cases. It was stated that initially, the cases were drawn to the attention of the UHB Gynaecological Pathology lead and the UHB Lead in Gynaecological surgery, who is **John Murdoch**. Later cases were drawn to the attention of **Jonathan Sheffield** and **Martin Morse**. The letter also referred to allegations of substandard coroner's autopsies performed by UHB pathologists. The coroner's autopsies have not been included within the scope of the Inquiry for reasons which have never been publicly explained.

25th June 2008

A member of the public presented a paper to South Gloucestershire Health Scrutiny Select Committee containing questions relating to the clinical concerns about UBHT's histopathology services raised on **15th October 2007** and related this to public concerns about the ASWCS implementation of Cancer Surgery centralisation. **Mary Barnes** was asked by the Committee to respond to the letter.

22nd July 2008

***DL** – Correspondence sent to **Mary Barnes**, Cancer Network Director from Dr Charlie Thomson, Renal Physician and Safer Patient Initiative Lead raising concerns about the quality of pathology services and citing examples of pathology errors that had led to unnecessary treatment and missed diagnosis of serious conditions in the areas of lung, breast and gynaecological cancer.*

Dr Tomson's letter stated that he believed that **Mary Barnes** had been made aware of the concerns. However, in a Freedom of Information response dated **16th July 2010**, signed by **Mary Barnes**, it was stated that she was not aware of the concerns before **22nd July 2008**, despite them being raised at a Council meeting on **25th June 2008** in response to a paper she had produced.

<http://bristolbared.files.wordpress.com/2010/09/10.pdf>

Clinical members of **Mary Barnes'** Network had raised concerns publicly on **15th October 2007** and the concerns were referred to at the **26th February 2008** ASWCS Breast Site Specific Group Meeting.

It seems unlikely that **Mary Barnes**, ASWCS Director, and **Rhona MacDonald**, the ASWCS Board Chair, and whose Board Member colleague was **Deborah Lee**, would not have known that clinicians in their cancer network had expressed concerns about some aspects of UBHT's pathology safety long before **22nd July 2008**.

23rd July 2008

NBT's Medical Advisory Committee met. **Martin Morse** and **Sonia Mills** were attendance. The minutes record:

“Respiratory Histopathology

There continued to be serious cases of misdiagnosis by UHB histopathologists, despite there having been assurances that the problems had been overcome, and UHB continued to refuse to allow slides to be looked at by NBT histopathologists. Members discussed possible ways forward such as the consultant body reporting the matter to the Healthcare Commission”.

<http://bristolbared.files.wordpress.com/2010/09/nbt-mac-july-081.pdf>

8th August 2008

Letter from **Geoff Pye** to **Mike Durkin** informing him of Dr Tomson's letter regarding the pathology concerns and that Dr Tomson suggested that **“despite considerable efforts, these concerns have yet to be effectively addressed”**

<http://bristolbared.files.wordpress.com/2010/09/august-08-letter-g-pye-to-m-durkin.pdf>

22nd September 2008

DL – Geoff Pye and Mary Barnes notified Deborah Lee, Director of Commissioning of correspondence from Dr Tomson.

DL briefed (verbally) Deborah Evans and agreed action including letter to Network staff and Chair raising concerns over delay in reporting such a serious allegation to commissioners and brief to Strategic Health Authority.

Dr Tomson's letter referred to the same concerns in respiratory and breast pathology that were formally detailed in the letter to **Martin Morse** dated **June 2007** and alluded to by clinicians in public, in the presence of **Deborah Lee** on **15th October 2007**, and which **Deborah Lee** chose not to pursue after receiving no response from **Martin Morse** to the request for specific details.

23rd September 2008

DL – Detailed conversation with Dr Jonathon (sic) Sheffield who stated that he felt there was nothing in these allegations and that they were vexatious in nature. Discussion reached agreement that an external review of service would be undertaken to demonstrate to all that UHB services were safe and of appropriate quality and that the allegations were unfounded.

NHS BaNES hosted a stakeholder event to start a review process for centralisation of Gynaecological Cancer Services for Bristol and Bath at either UHB or the Royal United Hospital, Bath. None of the public and patient stakeholders were informed that serious allegations of misdiagnosis had been made in respect of the UHB Bristol Gynaecological pathology service. They only found out when the allegations were mentioned in the media, nine months later in **June 2009**.

24th September 2008

DL - Lisa Manson briefed and agreed to involve Mike Durkin and seek his confirmation on whether a Royal College Review was considered sufficiently robust for the purpose. MD confirmed he was happy with this approach.

2nd October 2008

DL - Deborah Lee met and briefed **Dr Graham Rich**, Chief Executive, UHB re Dr Tomson's correspondence and allegations.

It is unclear why **Graham Rich** needed to be briefed about any allegations since he and his Chair, **John Savage** had already been briefed in the letter of **15th June 2008** which stated that his Medical Director, **Jonathan Sheffield** had previously been informed of specific concerns, as had **John Murdoch**, his Lead Gynaecological Oncological Surgeon.

15th October 2008

DL – DL sent letter (in **Deborah Evans** name) to **Graham Rich** raising concerns that three weeks had elapsed with no sign of Terms of Reference.

16th October 2008

DL - Lisa Manson requested sight of Terms of Reference.

23rd October 2008

DL - Terms of Reference for external review of lung pathology services, to be undertaken by Royal College of Pathologists, received by PCT and copied to SHA.

24th October 2008

DL – Email to Jonathan Sheffield (copied to Dr **Martin Morse**) from **DL** raising concerns about the limited scope of the review and advising that NBT would be required to confirm they no longer had concerns about breast and gynaecological pathology for PCT to sign off Terms of Reference which limited review to lung only.

Email from **Martin Morse** expressing his concerns that the Terms of reference were developed without collaboration with NBT despite this having been the agreement.

No response to **DL** re scope of Terms of Reference.

4th November 2008

DL – Email from DL to **Jonathan Sheffield** enquiring about outcomes from review.

5th February 2009

DL - Email from Jonathan Sheffield advising that they are still awaiting NBT's agreement on whether review should include breast and/or gynaecology and whether lung review should extend to both Trusts or solely focus on UHB. This email however noted that **The Royal College felt that the cases originally reflected difference of opinion which are in keeping with the accepted variations of pathology reporting**. It is not clear how this view was reached as it appears the review has still not taken place.

DL emailed **Martin Morse** asking him what was holding up clarification of Terms of Reference for the review. No reply received.

3rd March 2009

DL – DL admits defeat and escalates to Chief Executives.

26th March 2009

Deborah Evans informed the Board of NHS Bristol about concerns about quality of histopathology at UHB, **six months** after being informed by **Deborah Lee** about them. **Deborah Lee**, an Executive Member of the NHS Bristol Board, had known about concerns since October 2007, **seventeen months** earlier.

See Chief Executive's Report, Page 5

<http://www.bristol.nhs.uk/thetrust/board/2009/July/default.asp>

27th March 2009

Deborah Lee email to **Lisa Manson** with timeline of actions taken between 22nd July 2008 and 3rd March 2009. “**Lisa – my records of attempts to get UHB to take this seriously, now with Deborah E**”

12th May 2009

In response to concerns raised by a member of the public, **Dr Kieran Morgan**, Chair of the Gynaecological Cancer Service Review advised that **Rhona MacDonald**, Chief Executive of NHS BaNES and Chair of the ASWCS Board had sought assurance that the quality of pathology at UHB was “appropriate”.

This was **two months** after **Deborah Lee** had “**admitted defeat**” and apparently failed to “**get UHB to take this seriously**”.

22nd May 2009

A external clinical panel, commissioned by **Mary Barnes** and **Rhona MacDonald** met in Bristol to review UHB's and the RUH's cases to be the centre for Gynaecological Cancer Surgery. Their report noted that “**The pathology services appear to operate well across the network and did not concern the panel**”. There was no specialist pathologist on the Panel. A few weeks later, Private Eye and the BBC reported on the misdiagnosis allegations, including Gynaecological errors. There is no evidence that **Ms Barnes** and **Ms MacDonald** informed the external panel that there were serious gynaecological histopathology concerns, despite **Ms Barnes** having known of them at least **ten months** earlier, in **July 2008**.

1st June 2009

Monitor was informed of the histopathology allegations by **John Savage** during a routine telephone call.

<http://bristolbared.files.wordpress.com/2010/09/john-savage-notification-to-monitor1.pdf>

John Savage had known about them for at least a year as he was copied on the **15th June 2008** letter to **Graham Rich**. Yet neither thought it necessary to inform Monitor as a Foundation Trust regulator. UBHT became a Foundation Trust on 1st June 2008 and was thereafter known as UHB.

Clearly this rankled with **Sonia Mills** and **Martin Morse**. The Minutes of the 3rd June 2008 NBT Medical Advisory Committee meeting record under the Chief Executive's and Medical Director's report that:

“UBHT had been given Foundation Trust status and would henceforth be known as University Hospitals Bristol NHS Foundation Trust. This was thought by NBT to not only be inaccurate but also contentious”

<http://bristolbared.files.wordpress.com/2010/09/nbt-mac-june-08.pdf>

As Chair of the Board of UHB, and therefore a non-executive member, **John Savage** has a **“responsibility to ensure the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses”** (*Department of Health, Delivering Quality and Value: A briefing for NHS Chairs and Non-Executive Directors.*)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123285

2nd June 2009

Kieran Morgan advised a member of the public that he was **“assured that UHB meet pathology standards as assessed against national standards”**. But did not provide any data to support that view. This was **three months** after **Deborah Lee's** admission to Chief Executives of defeat and apparent failure to **“get UHB to take this seriously”**

9th June 2009

Sir Ian Carruthers OBE was verbally briefed about the allegations by **Andrew Millward**, his Communications Director, the day before the they were reported by Private Eye.

Deborah Evans informed the Care Quality Commission (CQC) of the allegations, the day before they were reported in Private Eye. In a Freedom of Information response dated 13th September 2010, CQC says:

“Concerns about poor performance in pathology services had been raised in July 2008. The PCT had been attempting to get University Hospitals Bristol NHS Trust (UHB) and North Bristol NHS Trust (NBT) to resolve the concerns but it was felt little progress was being made the PCT escalated the issue to CQC and Monitor.”

CQC also notes that:

“CQCs investigation team undertook preliminary enquiries. In August 2009 the independent panel review was announced; it was therefore decided that CQC would take appropriate action following publication of the review.

CQC (nor the HC before it) were not aware of any previous concerns or investigations. However after the concerns were raised, papers from a local Links meeting were shared with us which identified the concerns of management and clinicians from 2 years previously”.

10th June 2009

Private Eye Magazine broke the story of the 15 alleged misdiagnoses detailed in the **1st June 2007** letter to **Martin Morse**.

Shortly afterwards, UHB announced an inquiry into the 15 cases of misdiagnosis. Gynaecological allegations were not included in the 15.

<http://www.uhbristol.nhs.uk/university-hospitals-bristol-nhs-foundation-trust-launch-independent-pathology-review>

19th June 2009

BBC Points West broadcast the pathology allegations, mentioning that there were gynaecological cases identified over a two year period.

<http://news.bbc.co.uk/1/hi/england/bristol/8109011.stm>

24th June 2009

Murray Cochrane became aware of the allegations when he was asked to draft a letter for **Sir Ian Carruthers** OBE in response to a letter from a member of the public which contained references to them.

26th June 2009

Deborah Evans said this in response to a letter from a public member or UHB:

“In your letter of 22 June 2009 to Jonathan Sheffield, you talk about gynaecological cases which were misdiagnosed and you ask for a review of these individual cases. I have been unable to establish what you refer to in this instance”.

<http://bristolbared.files.wordpress.com/2010/09/deborah-evans-letter-26-june-091.pdf>

The member of the public pointed out that the cases referred to were the ones the BBC had mentioned a week earlier.

Graham Rich, UHB's Chief Executive and **John Savage**, the UHB Chairman had formally been notified of the gynaecological allegations a year earlier, on **15th June 2008**. **Jonathan Sheffield**, UHB's Medical Director had known about them before then and **John Murdoch**, UHB's Lead Gynaecological Oncological Surgeon had known about them at least since **June 2008**.

Therefore it is strange that UHB publicly announced an inquiry into the 15 cases without including the Gynaecological cases and apparently only did so when prompted by one of its Foundation Trust Members.

By the end of August 2008, the number of specific allegations was 26 cases, not 15. The increase was presumably due to inclusion of the gynaecological cases, although this was never publicly confirmed.

Until August 2010, NHS Bristol appeared reluctant to explain when its Chief Executive, **Deborah Evans** first knew about the Gynaecological allegations of misdiagnosis, by whom and by what means.

However, Freedom of Information responses from another organisation show that, on **22nd September 2008**, **Ms Evans** was verbally briefed by her Director of Commissioning, **Deborah Lee** on Dr Tomson's letter to **Mary Barnes** of **22nd July 2008**. Dr Tomson's letter referred to Gynaecological allegations.

Furthermore, the Minutes of the Performance Review Meeting for Bristol Primary Care Trust (now NHS Bristol) held Tuesday **4th November 2008** record this:

“Pathology

Deborah Lee explained that the report to the Royal College regarding pathology at University Hospitals Bristol NHS Foundation Trust covered only lungs, whereas gynaecology and breast were also raised as concerns, these issues have not been addressed as yet”

Ms Evans was present at that meeting, yet, **seven months** later, according to the wording of her letter of **26th June 2009** to a public member of UHB, she appeared to deny knowledge of any gynaecological allegations.

One of NHS Bristol's Key Values is Achieving High Performance, **“The safety of patients and users of the service will remain at the top of our agenda”**.

<http://www.bristol.nhs.uk/thetrust/values.asp>

30th June 2009

Geoff Upton was informed of the allegations by an email.

1st July 2009

Email from **Deborah Evans** to the Care Quality Commission:

“We have been very keen to establish what action has been taken about the 15 cases that Private Eye brought to our attention.....we would like to get everything on the table at this stage, if possible.

We are prioritising the communication and reputation management aspects of this issue”.

Not prioritising protection of patients?

<http://bristolbared.files.wordpress.com/2010/09/deborah-evans-email-to-cqc.pdf>

If, in **October 2007**, **Deborah Lee** had insisted that **Martin Morse** and **David Tappin** substantiated the pathology issues mentioned in public by clinicians, she would have received the details of the 15 cases. They are all contained within the letter sent to **Martin Morse** on **1st June 2007**.

Nearly two years was wasted because NHS Bristol did not pursue NBT to reply to its requests for specific information and produce the information its Medical Director possessed about the 15 specific cases.

20th July 2009

Meeting between three members of the public, **Deborah Evans & Graham Rich**. **Ms Evans** and

Dr Rich said they believed that there were approximately 26 cases of possible misdiagnosis and that it was proving quite difficult to get all the details together.

Dr Rich had known about concerns since at least **June 2008**, eleven months earlier, and **Ms Evans** had known about them since at least **September 2008**, nine months earlier.

It has been alleged that at least one person died as a result of a misdiagnosis and some others were seriously harmed. Yet it has never been explained exactly why the two Chief Executives were finding it difficult to get details together five years after serious allegations were raised with UHB in NBT's **August 2004** letter and a year after they were escalated to NBT's Medical Advisory Committee in **July 2008** and formally raised with **Mary Barnes** and **Geoff Pye**, also in **July 2008**, by a Clinical Lead in Patient Safety.

23rd July 2009

NHS Bristol, Chief Executive's report to Trust Board:

“The Private Eye article identified 15 specific individual cases where over or under diagnosis is alleged. NHS Bristol was not previously aware of these cases and North Bristol Trust is currently checking that each of these individual cases has been identified and followed up”.

Chief Executive's Report, page 5

<http://www.bristol.nhs.uk/theTrust/board/2009/July/default.asp>

Deborah Evans, Chief Executive of NHS Bristol knew about concerns in **September 2008**, ten months before Private Eye's article. Her Director of Commissioning, **Deborah Lee** knew about concerns **twenty one** months earlier, in **October 2007**.

Yet NHS Bristol claims not to have been aware of the 15 cases that were subject to the concerns, despite them being listed in letters to **Martin Morse** and **Jonathan Sheffield** in **June/July 2007**, despite Deborah Lee's “detailed” discussion about them with Jonathan Sheffield on the **23rd September 2008** and despite discussion of the pathology concerns in NHS Bristol's regular performance reviews with **Lisa Manson**, Associate Director of Performance, NHS South West, during the eight months prior to the Private Eye article.

Do NHS South West and NHS Bristol expect the public to accept that they could effectively discuss the performance of the internal review of pathology without having the most basic information – namely the specific details of very serious allegations of misdiagnosis?

29th July 2009

Meeting of the Joint Meeting of UHB Trust Board and Membership Council. The minutes record that:

“concerns were expressed about the reports of misdiagnosis from the histopathology service and sought reassurance that the Governors had been notified as soon as these problems surfaced. Graham Rich reported that there was no evidence that this was a particular risk and the article in the press had been unexpected. It was acknowledged that Governors should be receive (sic) briefings that were circulated to Non-Executive Directors on key issues as required”.

See item 14.

<http://www.uhbristol.nhs.uk/files/nhs-ubht/03a%20Joint%20Trust%20Board%20and%20Membership%20Council%20minutes%2009%20JUL29.pdf>

As the problems had surfaced long before UHB achieved Foundation status on **1st June 2008**, the Governors should have been informed of the problems when they were appointed to the Trust. **Deborah Lee**, the UHB Governor representing NHS Bristol had known about pathology issues since at least **October 2007**. It seems that the other Governors were kept in the dark until the Trust informed them of the serious allegations of misdiagnosis shortly before Private Eye exposed them in **June 2009**.

26th October 2009

John Savage wrote to a public member of UHB:

“You wrote to NHS Bath and North East Somerset on 12th May 2009 about the gynaecological cancer services review. They forwarded it to Graham Rich. Please accept my profound apologies that you did not get a response to that specific email. I can assure you that your concerns were noted and that, in part, this led to the review of pathology services that is now being conducted”.

Strange then that the gynaecological cases were not included in the review when it was announced by UHB the following month, on **19th June 2009**.

5th November 2009

In response to public questions, **Kieran Morgan** claimed that NHS BaNES had not withheld information about pathology during the course of the gynaecology review and that concern about the pathology service in UHB surfaced in the early part of 2009. In fact four members of his Gynaecological Review Steering Group knew that concerns had surfaced much earlier. **Deborah Lee** and **David Tappin** had known since at least **October 2007**, **Jonathan Sheffield** since **August 2004** and **John Murdoch** since at least **June 2008**.

None of these five senior NHS staff, three of them doctors, and subject to the GMC codes of conduct, thought it necessary to tell the patient and public members of the Gynaecological Cancer Services Review that serious allegations of gynaecological misdiagnosis against UHB had been the subject of an NHS internal review involving NHS South West, NHS Bristol and UHB since **September 2008**, **fourteen months** earlier.

Nor did **Rhona MacDonald**, Chief Executive of NHS BaNES, the lead PCT for the Gynaecological Cancer Services Review, and Chair of the ASWCS Board think it necessary to inform patient and public members of the review of the allegations, despite **Mary Barnes**, her Network Director, knowing about them since at least **July 2008**.

25th March 2010

UHB's Lead Governor was informed of at least two further misdiagnoses that had allegedly occurred since the UHB Histopathology Inquiry was instigated. In fact there were three cases:

1. A breast cancer diagnosed as grade 1 by UHB, and grade 3 by three NBT specialist pathologists.
2. A tuberculosis missed by UHB.
3. A patient diagnosed with malignant mesothelioma by UHB. NBT reviewed the case shortly before the patient was scheduled for chemotherapy and diagnosed a benign condition. Consequently the patient was saved from having unnecessary chemotherapy.

27th August 2010

Freedom of Information Response from **Richard Weatherhead** to a member of the public stating:

“On **23rd September 2008**, following her conversation with **Mr Pye** and **Mary Barnes Deborah Lee** orally advised **Deborah Evans** that concerns had been raised including concerns around breast, lung and gynaecological, however there was no supporting evidence or specific cases”

<http://bristolbared.files.wordpress.com/2010/09/nhs-bristol-august-2010-foi-request.pdf>

On the contrary, the 15 specific cases of lung, breast and skin were detailed in the letters sent to Martin Morse and Jonathan Sheffield over a year before, in **Summer 2007**. The details of the Gynaecological cases had been provided to John Murdoch, Jonathan Sheffield and Martin Morse during the two years to **June 2008**.

All the details were in documents possessed by the UHB and NBT Medical Directors. For some reason, it appears that NHS Bristol, on behalf of the communities whose safety is at the “**top of its agenda**” was unwilling or unable to extract this information from the two Trusts in order to conduct a proper investigation into serious allegations of misdiagnosis that have festered unresolved for far too long and are still occurring in 2009/2010.

Daphne Havercroft

September 2010