

A Response to the Bristol Histopathology Inquiry Report

by a member of the public

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10th January 2011

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1. PREFACE

The purpose of this response is:

- a. To comment on whether the Inquiry Panel has answered the questions I raised in my report on the Histopathology Inquiry published in November 2010. Details in the 9th December 2010 entry here:

<http://drphilhammond.com/blog/category/bristol-path-inquiry/>

The Panel has neither acknowledged nor responded to my report. Inquiry Panel Chair, Miss Mishcon, refused my request to provide a formal response to the Timelines contained within the report that I sent her separately on 6th September 2010.

- b. To comment on the contents of the Report issued on 8th December 2010 by the Inquiry Panel. The Panel's report refers to the Trust as "UHBT" and, for consistency, I shall do the same.
- c. to comment on the conduct of the Inquiry and the outcome of the reviews of 26 cases subject to concerns about misdiagnosis.
- d. To comment on whether the Inquiry has provided evidence that UHBT's breast, gynaecological, skin, lung and paediatric histopathology services are safe for the people of Bristol, North Somerset and South Gloucestershire.
- e. To comment on the implications of the Inquiry for the Bristol, North Somerset and South Gloucestershire Review of Pathology services, instigated in Summer 2010.

I have listed below the organisations of which I am a member. However I am the sole author of this response. It is not written on behalf of any of them and none of them have contributed to it.

Mrs Daphne Havercroft

10th January 2011

University Hospitals Bristol NHS Foundation Trust
The Patients Association
South Gloucestershire Local Involvement Network (LINK)
Independent Cancer Patients' Voice (ICPV)
Breakthrough Breast Cancer Campaigns and Advocacy Network
National Cancer Research Institute (NCRI) Breast Clinical Studies Group
NCRI Consumer Liaison Group
National Breast Cancer Coalition (United States)
BUST (Breast Cancer Unit Support Trust)
Lay Reference Group, Bristol, North Somerset, South Gloucestershire Review of Pathology Services

2. INTRODUCTION

- 2.1 The UHBT appointed Panel issued its final report on the Histopathology Inquiry on 8th December 2010.
- 2.2 On the same day I stated publicly that I regarded the report as a whitewash.
- 2.3 The Panel has not satisfactorily answered most of the questions raised in my November 2010 report.
- 2.4 The Panel has not provided satisfactory assurance that UHBT's breast, lung, gynaecological, skin and paediatric pathology services are safe. It is clear from its report that neither the Panel nor the Royal College of Pathologists (RCPATH.) have seen unequivocal, independent evidence to confirm that they are safe.
- 2.5 This not surprising because the Inquiry and the 3,500 and 26 case audits were not designed to provide this assurance.
- 2.6 The Panel says that its review of the findings of the RCPATH. assessment of 26 cases was **"not intended to establish the "correct" diagnosis**. In that case, what was the point of reviewing them?
- 2.7 Some clinicians believed and still believe that very serious misdiagnoses have occurred and may be still occurring and that the Panel has not taken them seriously.
- 2.8 The reviews of the 26 cases of disputed misdiagnosis were conducted in a secretive and unsatisfactory manner. It appears that some cases have been left out of the reviews and this raises the question as to whether cases were deliberately omitted from the review.
- 2.9 The arrogance of some aspects of the Panel's, UHBT's, NBT's and NHS Bristol's treatment of some doctors, patients and members of the public has been aptly described by a member of the public as **"treating us like serfs outside the castle walls"**
- 2.10 The Panel lost sight of patients. I believe the conduct of its inquiry has assisted powerful vested interests in the Strategic Authority (SHA), UHBT, NBT and NHS Bristol to try to cover up a health scandal. The inquiry outcome has delivered nothing for patients, other than what appears to be false reassurance, unsupported with convincing evidence, and therefore potentially dangerous to patients.
- 2.11 The Panel's report undermines the professional integrity of doctors who raised concerns for no reason other than concern for patient safety. It published speculative statements and hearsay about them, made by witnesses whose names are withheld.
- 2.12 The Panel's conduct of the Inquiry has made it far more difficult for clinicians to speak out about concerns. Therefore the Panel's actions have put patients at greater risk.
- 2.13 My November 2010 report on the Inquiry was unanimously endorsed by attendees at the South Gloucestershire Local Involvement Network (LINK) Core Management Group meeting held on 6th December 2010.
- 2.14 In this response I do not refer to the Panel as "Independent". It was appointed and paid for by UHBT, and I do not believe it has behaved independently. I provide evidence for that assertion in this response.

3. THE UHBT PANEL'S REPORT

- 3.1 Where I quote from the Panel's report, I refer to the paragraph and page numbers in brackets.
- 3.2 The report is too long (258 pages), repetitive, contains contradictions and draws many of its conclusions from hearsay and speculation, some of it not attributed to named people (and some of which appears defamatory to clinicians), rather than evidence.
- 3.3 An example of tittle-tattle presented by the Panel as evidence is this statement **"There were stories, which I can't substantiate, of pathologists from one laboratory going to the other laboratory late at night, taking slides out of the drawer and taking them back and reporting them and doing some things that you would not consider to be quite proper"** (3.159 page 113)
- 3.4 If the Panel was unable to substantiate this statement, it shouldn't be in its report. If it has been substantiated, it requires investigation by the GMC (General Medical Council). I suspect that it has been improperly used to pad out the report to detract attention from the real issues.
- 3.5 The report contains some misleading and inaccurate statements. This is unacceptable because the Panel knows from evidence that it possesses, but failed to publish, that some statements are inaccurate.
- 3.6 To read and understand the detail of the 258 page report requires time and stamina. It is disappointing that the report is not succinct and concise, as is the Oxford Paediatric Cardiac Inquiry Report. I think this is deliberate to encourage people to go straight to the Panel's recommendations and discourage them from reading the whole report to draw their conclusions about the quality of the Inquiry and the independence of the Panel.

4. THE CHANGING "HEART OF THE INQUIRY"

- 4.1 The Panel says it is 26 cases of misdiagnosis concerns that **"are at the heart of this Inquiry, rather than the 3,500 cases reviewed by Source BioScience"**.
- 4.2 This is surprising as the Panel's Terms of Reference do not mention the 26 cases and have never been publicly amended to focus on them. How can something be the **"Heart of the Inquiry"**, when it is not mentioned in the Terms of Reference?
- 4.3 The communications on UHBT's website relating to the Inquiry clearly show that it regarded the 3,500 case audit it commissioned from Source BioScience (formerly Medical Solutions) as the heart of the inquiry, not the 26 case audit.

<http://www.uhbristol.nhs.uk/who-we-are-and-what-we-do/histopathology-review/archive>

- 4.4 UHBT dismissed the 26 cases thus: **"Concerns about the original diagnosis in each case will have been dealt with at the time that they arose between 2000 and 2008, through established clinical procedures"**
- 4.5 As long ago as June 2009, Dr Phil Hammond summarised the fears of many members of the public in respect of the 3,500 case audit:

“Forced into action by the Eye, UHB has organised its own external review using a private company called Medical Solutions, which already does the trust’s breast cancer receptor testing, and so has a financial stake in one of the four areas of concern. Hardly independent. 3,500 slides across the entire pathology service are going to be chosen at random for one year (2007) to see if there is a significant error rate. If UHB had proper prospective audit, it would already know what its error rate is for subspecialties and pathologists. The random selection will not include any errors prior to 2007 and, according to one statistician, ‘is fraught with methodological problems and extremely unlikely to get to the heart of the problem.’”

(Private Eye: June 20, 2009 - Has Bristol learned from Bristol?)

4.6 Despite being obvious to Dr Hammond and many others, the fact that the methodology was unlikely to get to the heart of the problem seemed to elude the Panel when I met it several months later, in November 2009.

4.7 At the meeting Miss Mishcon made the following comments on the 3,500 audit:

“I think it is difficult for us to express a view on that, only because it something that we're not party to, even though we have to deal with it”.

“I don’t understand the mathematics completely, but presumably if one wanted – it would have been really quite an arduous task to have to do a much bigger sample.”

“It is certainly, I think it is safe to say, an acceptable review in the circumstances”.

Sir James Underwood concurred with this statement.

4.8 The Panel has not commented on the fact that UHBT misled the public when it said that the audit of 3,500 cases for only 2007 was based on it being the last year **“before the process changes in respiratory pathology agreed between the Trusts in August 2008”**. The changes were never implemented, therefore it appears that the Panel is implicated, along with UHBT and NBT (North Bristol NHS Trust) in withholding the facts from the public.

4.9 The Panel's final report says **“We were not satisfied with the way in which the 3,500 cases were selected for audit. In our opinion specimens should have been selected only from those specialties where concerns had been raised, namely respiratory, gynaecology, breast and skin.”**

4.10 The Panel spent public money on a review of the outcome of the 3,500 audit by RCPATH. December 2010 is too late for it to publicly acknowledge what people had been saying for eighteen months, that the audit was not fit for purpose.

5. THE 26 CASES

5.1 In my Open Letter (**Attachment 1**), I asked the Panel to demonstrate its independence by insisting on full transparency in the investigation of the 26 cases.

5.2 The Panel did not insist on full transparency and this has serious adverse consequences for its credibility, the fair treatment of doctors who raised concerns and patient confidence in Bristol’s Histopathology Services.

- 5.3 The President of RCPATH says “**in my opinion these 26 cases do not in isolation justify serious concern about the overall competence of the pathologists in the histopathology department at UHBT**” (*Annexe 4 (i), Page 210*). The key words are “**in isolation**”. Obviously 26 cases considered in isolation, without being part of an appropriately sized thorough, independent, systematic retrospective audit of specialist cases, is not sufficient to conclusively establish if there is a problem in a service that reports 20,000 cases per year.
- 5.4 The Panel says “**Although every single error should be taken extremely seriously, the review by the Royal College shows that there were in fact very few cases of misdiagnosis amongst the 26 which were of the kind which no reasonably competent histopathologist should make.**” In this response I shall demonstrate why the conduct of the review of 26 cases raises serious questions about the reliability of its findings.
- 5.5 A key question the Panel has not asked is whether the errors were those which consultant histopathologists (not merely “**reasonably competent histopathologists**”), performing pathology lead roles for respiratory, breast, gynaecology and skin histopathology at a major teaching hospital would be expected to make. (*75, page 12*).
- 5.6 The Panel appears to accept that UHBT is providing a sub standard service in comparison with many other major teaching hospitals: “**We acknowledge that there are not enough histopathologists at the BRI (Bristol Royal Infirmary) to develop genuine specialisation to the degree practised in many other teaching hospitals**”. The Panel confirms that UHBT Histopathologists did not participate in the lung pathology EQA (External Quality Assurance), yet, inexplicably appears to defend UHBT’s desire to cling on to lung pathology, while acknowledging that Dr Ibrahim at NBT is a national “**leader in the field of lung pathology**”. (*2.67, page 63*)
- 5.7 The Panel cannot confirm that the UHBT service is safe for Bristol patients because it did not conduct a proper Inquiry to find out if it is: “**The culture of “a Bristol disease which chips away at itself” and attitudes more suitable to the playground than to the NHS must change if there is to be a safe and effective histopathology service for the city’s patients**”. (*39, Page 7*). The Panel is saying that, currently, Bristol does not have a safe and effective histopathology service. It will doubtless deny or ignore this, but that is the meaning of the words it has used.
- 5.8 “**It should also be remembered that the UHBT histopathologists report about 20,000 cases between them each year. 26 cases have been identified at NBT over almost a decade of such reporting**”. (*76, Page 12*).
- 5.9 The Panel’s statement ignores a number of important facts:
- 5.9.1 It does not tell us how many of the 20,000 cases reported each year are UHBT patients, whose pathology reporting is managed entirely in a department whose culture the Panel describes as “**unwilling to acknowledge, let alone learn from, mistakes, and which is based on overconfidence bordering on arrogance**”. Therefore it is possible that serious mistakes that harmed UHBT patients may have never been acknowledged and dealt with.
- 5.9.2 The Panel describes the active tuberculosis missed in December 2009 as a “**serious misdiagnosis**”. Details on page 58 of the Panel’s Report. This error was identified by NBT. We do not know whether UHBT would have identified and corrected the error without external intervention. This example explains the fear that the 26 cases may be just the tip of the iceberg.

5.9.3 The Gynaecological cases covered the two year period 2006 to 2008, when a pathologist whom the Panel acknowledges as a “nationally acclaimed gynaecological histopathologist” identified them. Therefore it is incorrect to say that these cases cover “**almost a decade of such reporting**”.

5.9.4 The 26 case review does not cover all concerns, as explained below.

THE MANAGEMENT AND THE CONDUCT OF THE 26 CASE REVIEWS – INCOMPETENCE OR SOMETHING MORE SUSPICIOUS?

- 5.10** On 20th July 2009, I attended a meeting with Ms Deborah Evans, NHS Bristol Chief Executive, and Dr Graham Rich, former Chief Executive of UHBT, during which they informed me that they believed there were 26 cases of possible misdiagnosis.
- 5.11** Dr Rich confirmed to me in writing on 9th September 2009 that NBT had notified his Trust of 26 specific cases of concern.
- 5.12** A Joint Freedom of Information (FOI) Response, received on 7th December 2009, from former UHBT Medical Director, Dr Sheffield and NBT Medical Director, Dr Burton (the Sheffield/Burton FOI response) said “**North Bristol Trust has found 26 individual cases in correspondence from clinicians relating to concerns about histopathology reporting at University Hospitals Bristol**”.
- 5.13** The two Medical Directors omitted to mention that of the 26 cases, UHBT admitted patient harm had occurred for 2 of them and the Trust had made financial settlement. Why were they subjected to further review when the differences of opinion had been resolved?
- 5.14** Pathologists who raised the concerns were not asked to verify that the slides, reports, existing external opinions and any other material that UHBT sent for review were **all** the ones relevant to the misdiagnosis cases.
- 5.15** The Sheffield/Burton FOI Response stated that many of the cases had already had an external review of the histopathology as part of the usual process for resolving cases where there is a difference of local opinion. The Panel has not commented on exactly how many of these cases had an external opinion and why this failed to resolve the local differences opinion.
- 5.16** The Panel quotes Dr Martin Morse (NBT’s former Medical Director) on 21st August 2008 “**my understanding is that, not all discrepancies have been sent for independent opinion, but where they have, in all cases this has confirmed the NBT opinion**”. (3.167, page 119) Dr Morse was very clear that it should be understood that in ALL cases where independent, external opinion had been sought, the NBT position had been upheld.
- 5.17** Clearly the independent opinions are crucial pieces of evidence to establishing the facts about the cases, but the Panel has disregarded them and, by so doing, undermines its independence.
- 5.18** *Annexe 4(ii), Page 229*, the Panel’s Overview of the 26 cases refers to 10 respiratory cases, and included the tuberculosis case that was not identified until 2010. In fact details of 11 respiratory cases, described as “**not all the cases of which we have been made aware**”, were provided to Dr Martin Morse in September 2008 to assist with a proposed RCPATH Review. Therefore the Panel should have reviewed 12 respiratory cases in total, not 10. The Panel has not explained why 2 of the cases were omitted from its Inquiry.
- 5.19** Page 231 of the Panel’s report says “**The Sheffield/Burton table does not include either case 11 or case 15, but histopathology reports labelled case 11 and case 15 are**

included in the bundle of 26 cases submitted to the Panel". The Panel hasn't explained this discrepancy.

- 5.20** As noted in 5.18, the Panel has not explained how, when Drs Sheffield and Burton had compiled the list of 26 cases by September 2009, a serious misdiagnosis of a missed tuberculosis, that was not misreported by UHBT until December 2009, and was not identified by NBT until January 2010, managed to become one of the 26 cases without the number increasing to 27.
- 5.21** RCPATH. notes that **"the original 26 cases included a lung biopsy taken at a private hospital in Bristol. Sections and reports from that case have not been supplied to the college"** *Annexe 4(i)*. The Panel has not explained why it allowed this apparent manipulation of identification of specific cases behind the backs of the clinicians who raised concerns.
- 5.22** The Panel fails to explain why the breast cancer grading error and misdiagnosed mesothelioma, brought to the Panel's attention in 2010, were not added to the 26 cases.
- 5.23** The Panel also fails to explain why three Nuffield cases (*81 page 10*) were not added to the 26 case review. It cannot be because they are cases from a private hospital because Case 24, reviewed by RCPATH, is a Nuffield Hospital case.
- 5.24** I believe that at least least 9 cases should have been added to the 26 to make 35 – the 2 missing respiratory cases, the two errors (in addition to the tuberculosis) drawn to the Panel's attention early in 2010, the three Nuffield cases, at least one gynaecological case that I understand was excluded and a recent gynaecological case raised with the Panel on 15th November 2010 (*84, page 13*)
- 5.25** How many more cases may have been raised with Medical Directors during 2009/2010 that should have been added to the 26 cases, but were not?
- 5.26** The reviews of the 3,500 cases and the 26 cases were performed by pathologists, whose names have been kept secret, working for Source BioSciences. We do not know whether they were appropriately experienced and knowledgeable about the specialist cases they were asked to review. This undermines public trust in the integrity of both the 3,500 and 26 case reviews.
- 5.27** From Annexes 4(i), page 210 and 4(ii), page 229, it is impossible to clearly determine for which cases NBT clinicians raised concerns and what specific concerns they raised.
- 5.28** Even the RCPATH Review of the 26 cases is shrouded in mystery. We know that there were 12 RCPATH Reviewers, but not their names, specialist interests, experience and whether they have any financial relationship with UHBT and/or Source BioScience.
- 5.29** We do not know whether the RCPATH. reviewers were provided with all the slides and reports to enable them to perform the reviews as there has been no external, independent quality assurance to ensure that all relevant material was validated by the NBT clinicians before being reviewed by Source BioScience reviewers, and subsequently by RCPATH reviewers.
- 5.30** We know that the RCPATH. reviewers were not provided with the UHBT reports for each case until they had submitted their opinions on each case. We do not know whether the same rules applied to Source BioScience reviewers.
- 5.31** We are not told whether the RCPATH. reviewers made their final assessment purely on the basis of UHBT's reports, or whether they also considered the NBT opinions and the many external opinions that the Sheffield/Burton FOI response claims were obtained for the 26 cases.

- 5.32 Nor are we told whether the RCPATH comments on each case were made after consideration of all the NBT, UHBT, External Reviewers and Source BioScience reviewers' reports, or a selection of them. Similar questions apply to the Source BioScience reviewers' conclusions.
- 5.33 Pathologists who raised concerns, acknowledged national leaders in some specialities, were not given a right of reply to the Panel's conclusions from the 26 case review.
- 5.34 On Page 230 of the report, the Panel says that **“the lung biopsies for the investigation of interstitial lung disease (cases 4,7,12,14,22 and 26) are complex and appear mostly to involve diagnoses and refinements of opinions that arguably could only be made and invariably were made eventually, after full discussion of each case by the MDT”**. Dr Ibrahim has confirmed that for all these cases, the diagnosis was made before, not at MDT. The Panel knows this, has not produced any evidence to contradict Dr Ibrahim, and, in the interests of fairness and accuracy, should have stated this in the report.
- 5.35 Public money was spent on reviews of 26 cases by Source BioSciences, yet its reviewers' findings have been withheld from the report. The Panel seems to have drawn its conclusions exclusively from the RCPATH review of the 26 cases and the comments of the RCPATH President.
- 5.36 What is the reason for this? It raises suspicions that the Panel does not wish the public to know the Source BioScience reviewers' findings.

DISREGARD FOR PATIENTS

- 5.37 The Panel describes Case 24 as a **“serious error”** and casually comments that it may be an error of diligence by the pathologist examining the wrong slide, rather than a diagnostic error, which would indicate that another patient who had malignant melanoma was misdiagnosed. There is no indication that the Panel ensured this was followed up to establish the truth, in the best interests of the patients concerned. This is reprehensible.
- 5.38 Further lack of consideration for patients, (or in this case their relatives, as the patient is deceased), is demonstrated in the review of Case 10, BH01/06137, page 233. This is agreed by RCPATH to be a diagnostic error, yet, despite the patient's death, is not considered to be one of the four serious errors that the Panel accepts have been made. It is dismissed as an error that **“a small proportion of histopathologists might make”**. No account is taken of the fact that it was made by a consultant histopathologist who performs the lead role in UHBT's breast histopathology reporting, including the work of the Avon Breast Screening Service. It is reported that the slides were faded. Why were they not re-stained?

Dr Chris Burton, NBT's Medical Director stated that **“Dr Sheffield and I took the view that this report (from the Source BioScience reviewer) neither supported the original benign diagnosis, nor fully supported the subsequent MDT diagnosis of DCIS”**. Dr Ibrahim confirms that the DCIS diagnosis was made by three NBT histopathologists, with specialist interest in breast disease, BEFORE the MDT. Why did Dr Burton make a statement to the Panel about the circumstances of this diagnosis without apparently checking the facts with his Lead Breast Histopathologist? We do not know whether ALL the slides were provided to the Source BioScience reviewer to enable him/her to form an opinion based on the same material reviewed by NBT.

- 5.39 The absurd conduct of the 26 case review is further illustrated by Case 17, Bristol Case Number BH06-15770 and BH06-16908.
- a. **“The salient biopsy from case 17 was reported as a “grade 1 tubulo-lobular**

carcinoma” at UHBT. The patient was referred to NBT for surgery, but apparently only the report, not the slides, was considered at the MDT prior to wide local excision of the lesion and lymph node sampling. No malignancy was found in the excised tissue. According to the Sheffield/Burton table, this case was settled in litigation, implying that a misdiagnosis of the biopsy at UHBT was conceded. However, one of the College’s expert reviewers regarded the biopsy as “invasive carcinoma of no special type” and thus agreed that carcinoma was present as stated in the UHBT report; consequently, the College “cannot conclude that this case represents a proven diagnostic error”.

b RCPATH. has applied the rule that unless two independent reviewers confirm a discrepancy, it is not considered an error. However, it seems that it has drawn this conclusion without considering the opinions of the Source BioScience reviewers and any independent external opinions that are likely to have been obtained prior to UBHT admitting misdiagnosis and compensating the patient.

c. The patient has been paid compensation for surgery to remove a cancer she did not have, yet, an anonymous person described as one of the College's “expert reviewers” now concludes she had cancer. The other RCPATH reviewer doesn't, but notes that the slides were faded. Why were they not re-stained prior to review?

d. It is of concern that an “expert reviewer for the college” made a diagnosis of malignancy
1. Was he/she expert in reporting breast pathology? 2. Did he/she examine ALL the slides belonging to this patient?

e. Not only did all breast histopathologists at NBT diagnose the patient's core biopsy as benign, the UHBT histopathologist reviewed the slides, admitted she had made an error and agreed with the NBT diagnosis. One of the College's other “expert reviewers” also regarded the biopsy as benign. We do not know the Source BioScience reviewers' findings as the Panel has withheld them.

f. The Panel has demonstrated no consideration for the patient and seems to have neglected a duty of care to ensure that all opinions relating to her case were taken into consideration before putting information into the public domain that demonstrates that the RCPATH. reviewers did not agree with each other that she was misdiagnosed, despite the NBT and UHBT pathologists agreeing that she was.

g. Miss Mishcon, whose principal area of practice for Hailsham Chambers is clinical negligence, has allowed a case that was settled by legal proceedings to be undermined by the opinion of one anonymous reviewer.

h. The reason for the UHBT error is claimed to be lack of double reporting due to the pathologists' colleague being on holiday. The Panel has not asked the obvious question, why did the histopathologist not ask NBT to double report the biopsy? I ask the same question in section 8 in the discussion on a more recent error in breast cancer grading. It appears that UHBT did not apply lessons learned from case 17.

5.40 Another absurdity. On Page 232, Case 19:

a. The Panel reports that more than one NBT histopathologist was convinced that the lesion was squamous cell carcinoma, and that if any diagnostic error was committed in this case, it is attributable to the NBT pathologists. The Panel omits to comment on the information provided to Dr Martin Morse about the case in the June 2007 letter, which the Panel has seen:

“Vulval skin lesion. Diagnosed at Frenchay as squamous carcinoma. Referred to BRI for Definitive surgery. BRI Pathologist reviewed the sections and reported this

(without any discussion with the reporting pathologist at Frenchay) as keratoacanthoma (benign lesion), a lesion which affects mainly sun-exposed skin. All pathologists at Frenchay and Southmead who have seen this lesion independently came to the diagnosis of squamous carcinoma. Sections were also sent to an international expert in skin pathology who confirmed the diagnosis of squamous carcinoma”.

b. The Panel withholds the important information that this case was reviewed by least 5 histopathologists including a national expert in skin pathology and a national expert in gynaecological pathology. As the Source BioSciences and RCPATH reviewers' findings are so inconsistent with those of national experts, it suggests that they may not have seen all the slides from this case and/or did not have the appropriate specialist skills and experience to review the case. Their identity and qualifications have been kept secret.

c. The Panel omits to mention whether it has contacted the international expert in skin pathology to advise him that it regards him as guilty of diagnostic error, and whether it has discussed with him the considerable odds against a patient developing a lesion associated with sun exposure on her vulva.

OTHER CONCERNS

- 5.41 The Panel's report has been made public and should be readable and accessible to lay people as well as experts. Annexe 4(i) and 4(ii) covering review of the 26 cases is difficult to read, perhaps deliberately so. The case numbers in Annexe 4(ii) have not been cross-referenced to the Bristol case numbers in Annexe 4(i).
- 5.42 The Panel denied affected patients and their families the opportunity to give evidence by not insisting that they were informed of the Inquiry by UHBT and NBT. This is deplorable.
- 5.43 The Panel says in Annexe 4(ii) that its analysis of the 26 cases is “**not intended to establish the “correct” diagnosis, but to consider what conclusions the Panel can draw from them within its remit under the terms of reference**”. This illustrates how the Panel is seriously out of touch with what patients and the public wanted from the review – independent evidence as to whether UHBT's breast, lung, gynaecological and skin histopathology services are safe, which the Panel has failed to deliver.
- 5.44 Miss Mishcon told me that “**The fact that we are paid by the Trust in no way constrains our judgement. Our only intention is to tell the truth as we see it in the best interests of patients.**” I disagree. The Panel has made the Heart of its Inquiry a flawed review of 26 cases, as evidenced above. Patients' best interests appear to have been the Panel's lowest priority.

CONCLUSIONS ABOUT THE 26 CASE REVIEWS

- 5.45 The Panel says “**26 cases had been identified by clinicians at NBT as being a cause of concern**” There is no evidence that past and present NBT clinicians were formally asked to identify the cases.
- 5.46 The Panel's failure to ensure that the reviews were conducted transparently, and the obvious flaws in the process, raise suspicions of incompetence and even dishonesty in the process. Therefore I do not accept the Panel's conclusions on the 26 cases.

6. THE 3,500 AUDIT

- 6.1 I have discussed this in my November 2010 report and Section 4 of this response. However there are other points I wish to make.
- 6.2 Annexe 6, page 240. It is noted that because the audit was not selective, the number of cases reported by each pathologist in each organ system is relatively small. It is a pity that the RCPATH Professional Standards Unit appears not to have pointed out the obvious shortcomings of that approach (funded by the public) to UHBT when it was assisting in developing the audit methodology.
- 6.3 It is stated that **“It must also be borne in mind that a specialist reviewer, whose routine work is limited to one organ system, may have a different concept of what is an “understandable” mistake to that of a generalist whose work covers all human disease”.** (*Annexe 6, 3.3*)
- 6.4 Missing from this discussion is consideration for patients and what they would regard as “understandable” mistakes. For a patient, a misdiagnosis that has an adverse effect on their physical and psychological health, or has the potential to do so, is a mistake. It doesn’t matter whether it was made by a specialist or generalist. Unfortunately this is just one of many examples in the report that demonstrates that the Inquiry lost sight of patients.
- 6.5 Annexe 6 describes a “prima facie” unacceptable rate of B1 discrepancies in gynaecological discrepancies. B1 is a discrepancy in microscopy **“which one is surprised to see from any pathologist (e.g. an obvious cancer reported as benign)”**
- 6.6 It is suggested that a reason for the high levels of B1 discrepancies could be a problem with the work of one of the Source BioScience reviewers. The President of RCPATH suggests some actions that should be taken to establish whether this is the case, including further review of all the B2 cases.
- 6.7 Instead of following the advice of RCPATH to establish for sure whether there was a high rate of B1 gynaecological discrepancies, the Panel decided that the Source BioScience reviewer was unreliable, without apparently testing the assumption suggested by RCPATH.

“The high rate of gynaecological B1 discrepancies would obviously skew the overall figure for B1 discrepancies. We were therefore of the opinion that the B1 discrepancy rate could not necessarily be relied on, particularly insofar as it relates to gynaecological pathology.” (*4.23, Page 160/1.*)

This is another example of the Panel losing sight of patient interests. In this case, it failed to establish the truth about the rate of B1 discrepancies. This is evidence of a lack of independence.

7. CANCER SCREENING SERVICES

- 7.1 **“Some diagnoses in histopathology are known to be difficult where there is large inter-observer variability, including melanocytic skin lesions, breast pathology and gynaecological pathology.** (*Dr Ray McMahon, Annexe 3, Page 207*)
- 7.2 Bristol is a regional centre for women’s cancer screening, yet the Panel has not considered the histopathology concerns in relation to safe delivery of these services.

BREAST SCREENING

- 7.3 UHBT manages the Avon Breast Screening Service. Each year the service screens over 40,000 women. With the national policy of age extension from 47 to 73, this number will increase.
- 7.4 A few of those 40,000 women a year will be recalled for breast biopsies, many of which will be performed by UHBT's histopathology department that the Panel describes as having a culture **"which is at times defensive, responds aggressively to criticism, is sometimes unwilling to acknowledge, let alone learn from, mistakes, and which is based on overconfidence bordering on arrogance."**
- 7.5 The Panel should have recommended a thorough review of UHBT's breast screening pathology to establish whether the service provided to its local female population is of a standard which should be expected of a major provider of breast screening services, under pressure to expand its services to a wider age range.
- 7.6 Dr Ray McMahon, who is of the opinion that there is large inter-observer variability in breast pathology, also says that **"in this situation, pathologists should develop alternative strategies including consultation with other colleagues"**. In Section 8, I describe a relatively recent case which illustrates that these strategies are not in place for breast pathology. With the recent resignations of NBT's entire team of Breast Pathologists, these strategies cannot currently be implemented in Bristol and this raises serious, ongoing concerns about the safety of all Bristol's Breast pathology, not just UHBT's.

CERVICAL SCREENING

- 7.7 **"Dr Karin Denton, Head of the Histopathology Department at NBT told us: *"I've had roles outside North Bristol Trust and I continue to have some – I'm the Quality Assurance Director for cervical screening for the South West region, I have held the same role for breast screening for South West, I've been on various College committees, I have been a CPA inspector. I have a lot of experience of what goes on in other pathology departments and I would have to say that I don't think that the BRI lies outside the spectrum of what is considered acceptable nationally."* (2.75, Page 65).**
- 7.8 The Panel has failed to evaluate and comment on evidence it has seen that calls Dr Denton's remarks into question. In 2006/7, Dr Denton was involved in a Quality Assurance review of UHBT's Cervical Cytology Quality that revealed that UHBT's correlation between cervical cytology (reporting on cervical smears) and subsequent cervical histology (reporting on cervical tissue biopsies), was the worst of any centre in England. Consequently, in 2008, all UHBT's cervical histology reporting was transferred to Dr Denton's own department at NBT, leaving other gynaecological cancer histology reporting at UHBT.
- 7.9 It should be noted that, in respect of the B1 discrepancies discussed in points 6.5 to 6.7 above, the Source BioScience reviewer **"repeatedly reported B1 discrepancies on the basis of disagreement with the tumour grade, notably in cervical biopsies"**. The Cervical Screening Quality Assurance Report commented that, during the period reviewed, which was 2006, the year before UHBT's 2007 review of 3,500 cases that exposed the B1 discrepancies, there was significant under grading of cervical cell changes in respect of cervical loop biopsy specimens reported at UHBT.

- 7.10 The Panel should have ordered a further review of the B1 discrepancies, as described in 6.7 above.
- 7.11 The Panel appears not to have asked Dr Denton to explain the contradiction between her support for the cervical histology transfer to NBT, prompted by the documented quality assurance concerns, and her assertion to the Panel that UHBT is not an outlier nationally.
- 7.12 A possible explanation for Dr Denton's contradictory behaviour is that NBT has a large, new pathology laboratory at its Southmead site, in which it would very much like to integrate NBT's and UHBT's histopathology Departments. For Dr Denton and other NBT managers to openly acknowledge the evidence that, at least in cervical histology reporting, UHBT was providing a sub-standard service in comparison to other centres in England, would not be conducive to encouraging the UHBT histopathologists to come to Southmead to perform some of their work.
- 7.13 The Panel notes that **"One of the NBT Histopathologists who worked with Dr Hirschowitz described Dr Pawade as "perfectly competent" in reporting gynaecological pathology"**. This is not consistent with Dr Denton's approval of the plan to transfer Dr Pawade's cervical histology work to NBT following Quality Assurance concerns.
- 7.14 The Panel quotes Mr John Murdoch as saying on 4th April 2008 that Dr Pawade does **"not engage in formal review of her Gynae. Pathology with any other Gynae. Pathologists"** (3.110, page 96). Therefore it seems unlikely that an NBT pathologist would have seen sufficient evidence to confirm whether Dr Pawade was **"perfectly competent"** in Gynaecological pathology.
- 7.15 Evidence indicates that NBT puts its corporate ambitions to achieve histopathology integration at Southmead ahead of its obligation to its patients and clinicians to find out the truth about the safety of the UHBT histopathologists. This is trying to paper over the cracks, may put patients at serious risk of harm and contravenes the General Medical Council Guideline **"Make the care of your patient your first concern"**

8. THE BREAST CANCER GRADING ERROR

- 8.1 One of the three cases reported to the Panel during the course of the Inquiry was a breast cancer core biopsy diagnosed by UHBT as a grade 1 breast cancer and by three NBT histopathologists with a specialist interest in breast cancer as a grade 3 cancer. This occurred late in 2009.
- 8.2 The Panel dismissed the misdiagnosis with this brief comment:
- "The second case concerned a difference of grading of a breast core biopsy. Although we are aware that some people consider such a difference of grading to be a concerning error, such differences in grading are common - even sometimes by the same pathologist reviewing the same biopsy on a different occasion."** (4.9, page 157)
- 8.3 I notified UHBT Governors of this case in Spring 2010 and received a response from Mr Woolley, then the Acting Chief Executive of UHBT, in respect of investigation of the case. I have listed my questions and Mr Woolley's answers.
- 8.4 **Q - did the investigation corroborate the findings of the NBT pathologists or the UH Bristol Pathologist – or none of them?**

A - Our investigation showed that the case referred to was dealt with appropriately and in line with clear guidance regarding the grading of core biopsies from both the Royal College of Pathologists and the Avon, Somerset and Wiltshire Cancer Services Network Breast Group. This guidance allows for the fact that there is a high level of intra- and inter-observer

variability in such cases. Tumour heterogeneity also determines that grading should be formalised on the excised lumpectomy, as happened in this case.

8.5 Mr Woolley is incorrect. The grade 3 was confirmed by three NBT histopathologists on the **same core biopsy specimen** that the UHBT histopathologist reported as grade 1, not the excised lumpectomy.

8.6 **Q - Have the NBT Pathologists, the UH Bristol Pathologist and the NBT Breast Multidisciplinary Team been formally informed of the outcome of the investigation?**

A - The UH Bristol Pathologist is fully aware of the investigation and its outcome. A formal response was sent to North Bristol NHS Trust, which is responsible for further dissemination.

8.7 **Q - If the UH Bristol interpretation (I understand grade 1 cancer) was confirmed by the investigation, have the NBT Breast Team accepted that that they may have over treated a breast patient by giving them treatment that was not required which could cause long term side effects?**

A - Please see my answer to your first question.

8.8 **Q - If the NBT interpretation (I understand grade 3 cancer) was confirmed by the investigation, have the UH Bristol Breast Team accepted that it is possible that, if the patient's slides had not been reviewed at NBT, they would have been under treated, with serious implications for optimal survival?**

A - The high grade differentiation is based on the lumpectomy specimen produced at North Bristol. All core biopsies should be reviewed at the Breast multi-disciplinary team meeting at the institution where definitive surgery is planned to occur. The reporting Pathologist appropriately sent this case for full clinical discussion at the multi-disciplinary team meeting.

The implication of potential patient harm behind your question appears to be based on a misunderstanding of the clinical process.

8.9 Again it is stated that the difference of opinion was based on the lumpectomy specimen. This is not true.

8.10 As a patient who had a breast core biopsy in 2003, followed by two surgical resections, it is strange to be told that I appear to misunderstand the clinical process.

8.11 **Q - If UH Bristol accepts the NBT interpretation, would the UH Bristol interpretation ever have been identified and corrected if the patient's care had remained entirely at UH Bristol?**

A - The UH Bristol breast pathologists follow the Guidance of the Royal College of Pathologists and the Avon, Somerset and Wiltshire Cancer Services Network Breast Group and grade tumour differentiation on the excision sample. All cases are routinely discussed prior to surgery. Therefore the high grade differentiation would have taken place had the patient been under the care of the UH Bristol Breast Surgery team.

8.12 **Attachment 2** is a relevant extract of the transcript of my 3rd June 2010 interview with the Inquiry Panel, updated with comments made after the meeting and sent to it.

8.13 In Annexe 3(i), page 204, Sir James Underwood says that **“for many diseases, notably cancer, the final decision about diagnosis and treatment will be made at a meeting of the multidisciplinary team where all relevant information (surgical, radiological, histopathological etc) about the patient can be reviewed and discussed”**.

- 8.14 This statement appears to assert that it is not possible to reliably assess a cancer grade before surgical resection and appears to contradict the BASO (British Association of Surgical Oncologists) guidelines for the management of breast cancer which say that **“A non-operative diagnosis should be possible in the vast majority of invasive breast cancers, with a minimum standard of achieving this in at least 90% of cases and a target of more than 95%. The majority of non-invasive breast cancers will be screen detected and impalpable, making a non-operative diagnosis potentially more difficult. The minimum standard for non-operative diagnosis is at least 85% of cases for non-invasive cancers with a target of more than 90%.**
- 8.15 This means that it should be possible to make a reliable diagnosis in most cases before surgical resection and that resections are primarily therapeutic, not diagnostic. I made this point twice to the Panel during the course of the Inquiry, yet received no response.
- 8.16 The BASO guidelines do not explicitly say that grading a breast cancer as well as diagnosing it should be possible in the majority of cases before surgical resection. However, the NHS Breast Screening Programme (NHSBSP) document, Guidelines for Non-Operative Diagnostic Procedures and Reporting in Breast Cancer Screening dated 2001 says **“Grading on core biopsy can be performed and is reasonably accurate. Current evidence suggests that concordance between grade on core biopsy and that in the definitive excision specimen can be achieved in approximately 75% of cases”**. It should, however, be made clear to the clinicians that the grade may differ (**almost invariably by only one level**) from that in the subsequent resection specimen. Mitotic count in particular may be lower in the core biopsy than in the excision specimen, therefore leading to underscore on the core”
- 8.17 The important points to note are that the Panel dismisses the seriousness of the UHBT error of grading the core biopsy as 1 when three pathologists in another Trust graded the **same specimen** as 3. Given that as long ago as 2001, NHSBSP stated that concordance between the core biopsy grade and subsequent excision should be achieved in 75% of cases, the Panel is incorrect to say that **“such differences in grading are common”**. It has not provided any evidence to support this assertion.
- 8.18 In some ways, whether or not the NBT pathologists diagnosed grade 3 cancer on the core biopsy specimen or lumpectomy specimen is a red herring. It is undeniable that the UHBT pathologist seriously misdiagnosed the grade of the core biopsy. Most patients would regard a core biopsy difference of one level as understandable, especially if they were informed of the possibility.
- 8.19 However a difference of two levels, from a pathologist supporting a large regional breast screening service, is a serious concern for patients.

9. PANEL’S INDEPENDENCE & TERMS OF REFERENCE

- 9.1 The Panel's impression of the UHBT Histopathology Department is that it **“does not reflect uniformly what one would normally expect in a prestigious teaching hospital”** (29, page 5). Yet the Panel does not investigate or comment as to why NHS Bristol, the lead Commissioner for UHBT, failed to acknowledge and deal with that.
- 9.2 The Panel knows that NHS Bristol (formerly Bristol PCT), has known about the allegations since at least 2007, and failed to take effective action. Yet the Panel has ignored this. The evidence relating to NHS Bristol is one of many examples of important evidence that the Panel has ignored.
- 9.3 On 6th September 2010, I sent the letter in **Attachment 3** to the Panel, with the Timeline that now forms part of my November 2010 report on the Inquiry. I asked the Panel for a

formal response to the letter and to the Timeline. Miss Mishcon refused to provide one.

- 9.4** I was required to sign the confidentiality agreement referred to in the last paragraph of the letter in order to see the Panel's draft report. Witnesses whom the Panel was minded to criticise were given the opportunity to see the proposed comments in the context of the whole report, subject to signing a confidentiality agreement.
- 9.5** One of the most serious examples of the Panel's failure to present evidence in a fair, accurate and balanced way is the false impression given in its report that Deborah Lee, UHBT's Lead Commissioner, NHS Bristol, was not aware of NBT clinicians' concerns about some specialist areas of UHBT's histopathology until 2008. NHS Bristol has known about them since at least October 2007. The Panel knows this from verbal and documentary evidence I provided in 2009 and subsequently.
- 9.6** The Panel reports that in August 2008 "**Mr Pye (the ASWCS Medical Director) therefore went to see Deborah Lee, Director of Commissioning at NHS Bristol, and discovered that this was the first that she knew about any concerns about the histopathology department at UHBT**" (3.160, Page 113). The Panel has ignored my evidence that proves this is untrue.
- 9.7** The Panel says: "**In October 2007 Dr Ibrahim was quoted in an article about the proposed centralisation of breast surgery at St Michael's Hospital reported in the Bristol Evening Post as saying that —some aspects of pathology services at St Michael's are not up to standard**". Six days later a press statement issued by UHBT responding to that article said that the consultant was misquoted and that UHBT's breast pathology service met national cancer standards" (1.21, Page 40)
- 9.8** Dr Ibrahim was not misquoted. He made the statement at a meeting of the Joint Health Scrutiny Committee on 15th October 2007, in the presence of Deborah Lee (then Acting Chief Executive, Bristol PCT), David Tappin (then Director of Strategic Development, NBT, now holding the same position at NHS Bristol), and Dr Martin Morse. Public witnesses who attended that meeting can testify that the Bristol Evening Post reported Dr Ibrahim correctly, except for a minor inaccuracy. He actually said "UBHT" and not "St Michael's".
- 9.9** If Ms Lee told Mr Pye she did not know about the concerns about the Histopathology Department at UHBT until August 2008, it is untrue. She has known about them since at least October 2007. The Panel knows this, yet fails to state this in its report.
- 9.10** I can appreciate that it would have been embarrassing for Ms Lee and Mr Tappin if the Panel's report had stated that Dr Ibrahim had been quoted correctly by the Bristol Evening Post, particularly as I understand that Mr Tappin approached Dr Ibrahim within a couple of days of the meeting to try to persuade him to retract his statement as reported by the Bristol Evening Post, and Dr Ibrahim declined to do so.
- 9.11** I also understand that, following the 15th October meeting, Dr Martin Morse planned to discuss the issues raised at the Joint Health Scrutiny Meeting with Deborah Lee and Dr Jonathan Sheffield.
- 9.12** As Dr Morse possessed Dr Ibrahim's June 2007 letter listing specific cases of concern, it is inconceivable that Ms Lee and Mr Tappin did not know about the allegations of misdiagnosis in October 2007, and probably earlier.
- 9.13** The Panel knows from my evidence that Ms Lee told the Joint Health Scrutiny Committee that she had met with clinicians and heard their views and concerns. This is recorded in the minutes of the meeting. Therefore it seems clear that Ms Lee must have known that Dr

Ibrahim was referring to diagnostic standards on 15th October 2007. If she wanted to clarify the specific details of his diagnostic concerns, she only had to ask him.

- 9.14 Attachment 4** is an extract from an NHS Bristol (formerly Bristol PCT) Freedom of Information Response. It is further evidence that that Ms Lee was aware of the concerns about UHBT's histopathology in October 2007.
- 9.15** The Panel also knows from the Timeline I sent it on 6th September 2010 that Deborah Evans, Chief Executive of NHS Bristol, denied knowing about the gynaecological misdiagnosis allegations in a letter to me dated 26nd June 2009, yet I have proved that she was briefed about them by Deborah Lee, 10 months earlier, on 22nd September 2010.
- 9.16** It appears that Dr Graham Rich, UHBT's former Chief Executive and Ms Evans would not have included the Gynaecological allegations in the Inquiry unless forced to do so by their publication in the media.
- 9.17** Similarly the serious paediatric misdiagnoses were only included in the Inquiry after Dr Hammond reported them in Private Eye.
- 9.18** The Panel knows that Dr John Savage, UHBT's Board Chair, has known about allegations of misdiagnosis since at least June 2008, yet has failed to investigate why he appears to have taken no action to ensure that they were investigated and resolved. Inquiring into Dr Savage's actions is certainly within the Panel's Terms of Reference. One of his duties as a non-executive board member is to hold the executive board members to account on behalf of the local community. I believe if the Panel was truly independent, it would have investigated Dr Savage's apparent failure to discharge this duty.
- 9.19** Panel member Mr Ken Jarrold chaired the working group that developed the Code of Conduct for NHS Managers . Therefore it is particularly worrying that the Panel has not commented on why the Senior NHS managers named above appear not to have adhered to it, particularly in respect of these requirements:

make the care and safety of patients my first concern and act to protect them from risk

be honest and act with integrity;

- 9.20** The Panel reports that, on 28th July 2008, eight thoracic surgeons and physicians wrote to Dr Sheffield and said of the plans to move lung pathology reporting to NBT **“we believe this undermines the status of UHB FT (Foundation Trust) as a regional centre for thoracic services and as a cancer centre.”**
- 9.21** The Panel has failed to investigate to what extent UHBT's Foundation Trust ambitions influenced the apparent failure of Dr Rich, Dr Savage and, latterly, Mr Woolley, as well as the Trust Board, to deal responsibly with the concerns, and why they allowed Dr Sheffield the freedom to control the now discredited 3,500 and 26 case reviews.
- 9.22** The Panel has also failed to investigate the relationship between the UHBT Board and the UHBT Governors to establish why the Governors were not informed of the pathology concerns until June 2009, just before Dr Hammond exposed them.
- 9.23** The Strategic Health Authority, NHS South West, certainly knew about the allegations in 2008, as evidenced by my Timeline. However, the Panel has seen documentary evidence that shows the SHA knew about them much earlier, in 2007 – and apparently took no

effective action.

- 9.24** It is also clear from the Panel's report that the SHA knew about the allegations long before Summer 2008 and appears to have taken no action. It notes that Dr Martin Morse said on 14th July 2008, that **"Sonia (Mills: Chief Executive of NBT) and Mr Mike Durkin (MD of the SHA) have been aware of my concerns for some time".** (3.226, page 138)
- 9.25** As Dr Durkin is a member of the Board of NHS South West, it is inconceivable that he would not have informed the whole Board of Directors, including Chief Executive, Sir Ian Carruthers, OBE, of concerns that included a patient's death, when he knew about them.
- 9.26** In sections 7.7 and 7.8, I mention the contradiction between what Dr Karin Denton of NBT told the Panel and her support for the transfer of cervical histology from UHBT to NBT due to quality issues.
- 9.27** There are similar contradictions from Dr Rooney. He told the Panel that **"I do not share concerns about the individuals"** yet **"they are trying to be an expert in too many different areas"** (2.74, Page 65)
- 9.28** On 4th February 2009, Dr Rooney said in a letter to the UHBT and NBT Medical Directors **"we have already supplied a list of cases where we think there is a cause for concern"** (3.206, page 132). This raises two questions, 1. Did Dr Rooney consult Drs Hirschowitz and Dr Ibrahim to confirm the list was complete? 2. Since Dr Rooney agreed there was cause for concern about the work of some individuals, why did he tell the Panel that **"I do not share concerns about the individuals"**?
- 9.29** Drs Denton and Rooney's comments to the Panel seem to contradict the evidence provided by their former Medical Director, Dr Morse who said this in an email concerning a letter UHBT had drafted to RCPATH. **"The letter also gives the impression that the complaints have come from NBT clinicians via the MDT – whilst this is correct I must insist that it is stated that there is a formal complaint made by me on behalf of NBT, and this should be reflected both in the letter and the form itself, with clarity as to my joint involvement in the request for review"** (3.167 page 119). It is strange that if Drs Denton and Rooney thought there was nothing to worry about, their former Medical Director was sufficiently concerned to raise a formal complaint.
- 9.30** The Panel reports Dr Martin Morse saying on 14th July 2008, that **"Sonia (Mills: Chief Executive of NBT) and Mr Mike Durkin (MD of the SHA) have been aware of my concerns for some time"**. (3.226, page 138). Further evidence that the SHA knew about the allegations long before Summer 2008, and apparently failed to ensure that they were investigated.
- 9.31** NHS Bristol knew about the allegations of misdiagnosis in 2007. NHS South West, responsible for Performance Managing NHS Bristol, knew about them in 2007 too. The Panel should have investigated why the PCT and SHA did not follow the Code of Conduct for NHS Managers to make the care and safety of patients their first concern and act to protect them from risk.
- 9.32** Although the actions of the SHA and NHS Bristol are not within the Terms of Reference of the Panel, Mr Woolley stated that the Panel had the latitude to inquire into all matters it deemed relevant. Clearly the failure of NHS Bristol and the SHA to take the allegations seriously is relevant, yet ignored by the Panel
- 9.33** NHS Bristol failed to hold UHBT and NBT to account to properly investigate the concerns. Its managers must have realised that patients were being put at risk, but, eighteen months after knowing about the concerns, NHS Bristol's Co-Director of Commissioning gave up, for the second time. She had already failed to ensure that the concerns were properly dealt

with in 2007 (Attachment 4). **“On 3 March 2009 Ms Lee e-mailed Dr Sheffield with copies to Dr Rich, Ms Mills, Ms Evans and Dr Morse: *“Rather than send another of my monthly e-mails chasing you and Martin, to little avail – I now surrender to professional failure in this regard and escalate to Chief Executives for resolution”*** (3.215, page 135). The Panel fails to comment on this extraordinary behaviour from UHBT's Lead Commissioner. Ms Lee worked less than 200 metres from Dr Sheffield's office. Why did she not go there in person and insist on urgent and effective action?

- 9.34** Ms Lee's 3rd March 2009 email also says **“sorry to take recourse to this, but given it is over 6 months since I began to try to make progress on this, I am concerned that patients may be being put at risk due to my inability to galvanise you and Martin into action”**
- 9.35** It seems that Ms Lee failed to galvanise herself into action in October 2007 when she knew that NBT clinicians had concerns about UHBT Histopathology. There is no evidence that she took any effective action during the 11 months between then and September 2008 and she appears to have shown no concern that patients may have been put at risk.
- 9.36** I believe NHS South West and NHS Bristol put reconfiguration of Bristol's clinical services to meet deadlines (no doubt to cut costs and meet financial targets), before patient safety. When the two organisations discovered the pathology concerns, they could and should have stopped clinical reconfigurations while they investigated them. But they just carried on regardless and by doing so, may have caused patients serious and avoidable harm.
- 9.37** The Panel's report speaks of rivalry damaging the sane and rational distribution of services. It omits to mention the **insane and irrational** attempts by local NHS organisations to reconfigure services without ensuring that pathology quality and standards between the Trusts were consistent, safe and high quality. This is the root cause of the Bristol Pathology Problem and one that the Panel had no appetite to investigate.
- 9.38** The Panel has seized on **“playground behaviour”** and blown it out of proportion to divert attention from the real management issues. These are failure of clinical governance inter and intra NBT and UHBT, failure of NHS Bristol to ensure that the two Trusts investigated and resolved the concerns and failure of NHS South West to performance manage NHS Bristol to do its duty to investigate clinicians' concerns about patient safety and protect patients from harm.
- 9.39** In a February 2008 email to Ms Lee, Dr Morse said **“I understand the RCPATH reluctance to be involved on the grounds that this is primarily an issue around working relationships, but I remain very concerned that given the discrepancies noted on the list of signal cases I provided to Jonathan for onward transmission that they allowed the relationship issue to prevail, given that a significant part of the relationship issue arises from just those reporting difficulties”** (3.209 Page 133)
- 9.40** In an 11th March 2009 email to Ms Lee, Dr Morse said **“Following some deliberation, the college felt it would not wish to be directly involved, on the grounds that it viewed the fundamental issue as being one of inter-personal relationship difficulties between the two departments, rather than a question of professional standards. You will be aware that I continue to feel strongly that this is a somewhat artificial distinction, given that in this instance there is self-evidently a considerable element of chicken and egg”**. (3.127, page 136)
- 9.41** This is clearly an artificial distinction Miss Jane Mishcon and Sir James Underwood, a former president of RCPATH, were unwilling to acknowledge, apparently preferring to mask the serious issues of corporate, clinical governance and public accountability by latching on to **“playground behaviour”**.
- 9.42** The Panel notes that Clinical and Corporate Governance was not included within its terms

of reference (43, Page 7). The Panel should have insisted that it was and investigated the governance of all the NHS organisations implicated in the failure to respond responsibly to the allegations of misdiagnosis.

- 9.43 The Panel says **“However, because the concerns about possible misdiagnosis were not reported through the proper channels, and because the investigation of those allegations was not conducted with any kind of systematic approach and was inadequate — mainly because of the underlying belief that they were vexatious — the systems and processes were untested and therefore it probably would not have been possible to identify if or how governance systems failed”**. (3.10, page 70)
- 9.44 The Panel has produced no evidence to assert that concerns were not reported through proper channels. It has seized on a letter written by NBT respiratory physicians in 2004 and claims that it “appears” that these issues had not previously been raised with Dr Morse, the former Medical Director of NBT. The Panel has presented no evidence to confirm its assertion nor does it appear to have enquired whether concerns had been reported through proper channels to Dr Morse’s predecessor.
- 9.45 Contrary to the Panel’s extraordinary statement in 9.42, of course it would have been possible to identify how governance systems failed. The Panel should have reviewed the governance processes to find out what should have been done, compare it to what actually happened, then the extent to which the governance processes had failed would be obvious.
- 9.46 The Panel should have investigated whether any aspects of the relationship between Dr Jonathan Sheffield, former Medical Director of UHBT, and the SHA contributed to the failure of NHS Bristol and NHS South West to hold UHBT to account to investigate the concerns.
- 9.47 Dr Sheffield was the South West Lead for the Darzi Review of the NHS and was awarded an OBE in January 2009 “for services to the NHS”, at least a year after NHS South West knew about the misdiagnosis allegations against his NHS Trust.
- 9.48 The Panel comments that **“we have absolutely no doubt that Dr Sheffield was trying to do his best”** (60, page 10), yet **“we formed the clear impression that this inquiry was only established because of the articles in Private Eye and, that, had it not been for them, the issues would have continued to be effectively addressed”**(65, page 10). Perhaps the Panel hoped that readers would not spot this, one of many ludicrous inconsistencies in its bloated 258 page report.

10. “NOTHING TO WORRY ABOUT UNDULY”

- 10.1 In this section I provide evidence to support my view that, at the outset of the Inquiry, UHBT and its Panel had a goal that the outcome would be **“nothing to worry about unduly”** and conducted it in a manner designed to achieve that.
- 10.2 Early in 2010, NHS Bristol was busy trying to persuade Local Authority Health Scrutiny Committees to endorse transfer of gynaecological cancer surgery from the Royal United Hospital (RUH) Bath, to UHBT’s St Michael’s Hospital Bristol.
- 10.3 On Wednesday 10th February, I attended South Gloucestershire Council’s Health Scrutiny Meeting. The Gynaecological review was on the agenda.
- 10.4 I was one of three patient advocates who challenged the planned transfer from the RUH due to serious concerns about lack of intensive care facilities at St Michael’s and the safety consequences of increasing the workload of UHBT’s histopathology service, that was the subject of serious allegations of misdiagnosis.

- 10.5** Also in attendance as a witness was Mr John Murdoch, Lead Gynaecological Oncological Surgeon from UHBT. During the course of the meeting, Mr Murdoch announced to all present (including members of the public) that the audit of specific cases of alleged gynaecological misdiagnosis had been completed and concurred with the diagnoses of the UHBT pathologist who reports on Gynaecology. He said that he had been given permission to say that. Mr Murdoch said the same to Bristol Health and Adult Social Care Scrutiny Committee on 17th February 2010, when he was accompanied by Deborah Lee, of NHS Bristol, and his Medical Director, Dr Jonathan Sheffield.
- 10.6** I am concerned that Mr Murdoch made the statement to South Gloucestershire Health Scrutiny Committee, giving the impression that there was no cause for concern, before he had met the Panel and before the Panel had considered the reviews of the 26 cases. I informed Miss Mishcon of my concerns that Mr Murdoch's comments had pre-empted the outcome of the Inquiry, but she did not reply and, months later, said that she regarded it as a matter for UHBT. I regard this as strange conduct from a woman who claims her Panel is independent of UHBT.
- 10.7** This is an extract from the transcript of my interview with the Panel on 3rd June 2010:
- Miss Mishcon:** You see, what concerns me, listening to you, Daphne, is that we don't know the results of the independent review, the conclusions that we will come to, we don't know the final conclusions on that but **let's assume on the one hand that there is nothing too much to worry about about the competence of the pathologists.** You say you want to move on and all the rest of it – everybody does – but what is going to restore confidence in the pathology service? You talk about trust but everything that has gone on over the last year and more, all it has done is to deeply entrench mistrust between the two Trusts and between the two pathology services. It seems as though, rightly or wrongly, you have been hearing things from one side and one understands how concerned you must be if these things are being told to you. You have every right to be concerned about it. But let's ask you then – you have heard these things more than anybody. You have heard the drip-feeding of concerns over a period of time – **how are you going to ever get to the stage where you can turn round and say, 'Well, actually I take all of that back. I accept now that there is nothing to worry about unduly about the competence of the pathologists'?** Are you ever going to be able to do that? And if not, then what is the way forward? You have talked about there maybe being one department. Do you think that will make any difference? Do you think that would be the way forward, that that would give you and other patients more confidence in the service?
- 10.8** An independent observer accompanied me to the meeting. Afterwards I asked her opinion, She felt Miss Mishcon was trying to test to what extent I would compromise on what I considered an acceptable report.

11. COMPETENCE OF PATHOLOGISTS

- 11.1** The answer to Miss Mishcon's question what would make me say "**I accept now that there is nothing to worry about unduly about the competence of the pathologists**" is a retrospective, systematic audit, the methodology to be agreed with local patient advocates, of breast, gynaecological, respiratory and lung pathology, that proved unequivocally that the service was safe.
- 11.2** The Panel appears to assume incorrectly that my concerns about histopathology safety are based entirely on what I discovered from clinicians. Contrary to the Panel's unfounded, and possibly defamatory assertions in its report, these clinicians had no agenda other than patient safety. It should be noted that they are regarded as exceptional doctors by patients because of their obvious care and concern for the best interests of patients

- 11.3 The Panel knows, because it has seen the evidence, that my concerns have arisen through my participation in local NHS Service Reconfigurations and information acquired through the Freedom of Information Act.
- 11.4 The Panel knows that I had concerns about UHBT's pathology services in early 2007, several months before I became aware that clinicians had raised concerns. I saw the warning signs in the National Cancer Peer Review 2006 report for ASWCS. It is notable that the Panel does not comment on why these warning signs were ignored. This is another example of the Panel's lack of independence.
- 11.5 The Panel seems to make many excuses for UHBT to cling on to lung pathology, despite having no pathologists participating in lung EQA, yet there were nationally acclaimed experts Dr Nassif Ibrahim and Dr Ed Sheffield at NBT.
- 11.6 The Panel even asserts, on the basis of no evidence other than hearsay and speculation, that Dr Ibrahim was overly critical of the standards of lung pathology at UHBT as a way of getting more lung work.
- 11.7 The facts are much simpler than the Panel claims. In April 2008, Dr Sheffield informed NBT that his pathologists had not demonstrated to him a commitment to specialise in lung pathology and would therefore be moving the service to NBT when the service specification had been agreed. This is consistent with the Panel's own comments on UHBT's failure to specialise.
- 11.8 Concern for patients and patient choice seems unimportant to the Panel. Given the choice, lung patients would want their histopathology done by the team that has a specialist interest in lung pathology, not generalists. The Panel's remarks about those who raised concerns simply damage its credibility and that of its individual members.
- 11.9 Competency is defined as the ability of an individual to do their job properly. The Panel has a very narrow view of competence. It seems to believe that, as long as only a few serious diagnostic mistakes are made, nobody is incompetent. Any reasonable person would regard the following comments, made by RCPATH in its review of the 26 cases, as indicative of incompetence:
- repeated failures to seek other opinions on complex cases**
 - overconfidence in reporting and failure to acknowledge uncertainty**
 - Inadequate consideration of the possibility of a rare variant**
 - Serious lack of diligence over slide identification**
- 11.10 Buried in the report, the Panel says that competency must be judged on the **"quality of the service being offered. Patients deserve the best possible service"** (97, page 17). Elsewhere in the report, Panel has noted that UHBT has provided a substandard service in comparison with other centres, yet contradicts itself by concluding there is not a competency issue. **"There is little evidence that uniformly they have aspired to gaining national recognition as leaders in their field and yet they give an impression of defiant arrogance in the face of any criticism."**(2.12 Page 51)
- 11.11 The allegations of misdiagnosis were made against some consultant histopathologists who perform leadership roles within the histopathology department. Competence covers their performance in these roles, including their willingness to keep up to date with modern histopathology practice, not just their ability to interpret what they see under a microscope.
- 11.12 Performing a role because nobody else wants to do it, or because you don't want to give up some work is no defence for failing to respond professionally and responsibly to concerns raised about patient safety. Not to do so is incompetent, contravenes the guidance of the General Medical Council and puts patients at unnecessary risk.
- 11.13 The Panel does not seem to appreciate that the BRI Heart Inquiry focused on the surgeons'

failure to take action to protect patients when their work was called into question. Their clinical competence was only part of the issue. It is the same with the Bristol Histopathology problem. Doctors have a duty to protect patients if the safety of their work or other doctors' work is questioned.

- 11.14** The Panel has avoided investigating allegations that UHBT histopathologists had performed substandard work for the Bristol Coroner. I surmise that its reluctance is because that would undermine its inaccurate assertion that only NBT has expressed concerns about UHBT competence. Perhaps the Panel is not interested in the care of the dead and their families. It had the latitude to inquire into anything relevant. This is clearly relevant to the competency question.
- 11.15** As no external review of paediatric misdiagnoses was ordered, I assume that UHBT accepts that serious errors were made and that its adult histopathologists were not competent to perform paediatric pathology. But the Panel ignores this in its competency discussion. Would UHBT's Panel regard a car driver who tried to drive an HGV without a license as competent to do so? This Panel's bizarre and contradictory concept of competence leads me to think that it might.
- 11.16** On page 12 of the report, points 78 and 79, the Panel speculates as to why it had not heard of concerns from Trusts other than NBT. One of the Panel's witnesses provided this possible reason:

I believe it is essential that your review interviews the clinicians involved in the misdiagnoses, ie the pathologists at UHB, the gynaecologists, melanoma specialists, breast cancer specialists and lung cancer specialists. Also the review should interview the many pathology trainees who have been through the department, and now hold prestigious posts elsewhere in the UK as Consultant pathologists, and who can reveal the underlying problems.

If the review samples only simple pathology reports, and not the difficult specialist areas, the error rate will be low, effectively covering up the problem.

I would urge you to ensure that the money invested in this review (money that could have been spent on patient care) is responsibly spent by making this review an in-depth investigation into what many believe, but are too frightened to admit in public, is a dangerous histopathology service.

I too told the Panel that I believed people were too frightened to come forward.

The Panel ignored this evidence and advice. An in-depth review had the potential to derail the apparent goal of the Inquiry – **“nothing to worry about unduly”**.

- 11.17** The Panel's report notes that UHBT clinicians have not expressed concerns about their pathologists, yet has not acknowledged the awkward professional consequences for them if a proper independent, systematic audit was performed in specialist areas and found that there was a competence issue and that it had existed for many years.
- 11.18** The Panel is naïve to assume that clinicians at the hospital that regards itself as the “king pin” of the three Bristol Hospitals would admit, years after concerns were raised by NBT, that they too had concerns. Maybe they genuinely do not have concerns. However, they were not compelled to give evidence to the Panel under oath therefore the Panel cannot reliably conclude that they have no issues with their histopathology service.
- 11.19** An important area that the Panel neglected to investigate is the extent to which doctors' willingness to speak out is influenced by their personal agendas, and to what extent by the best interests of their patients.

- 11.20** The Panel has not investigated whether histopathologists' private work has contributed to the pressure on resources and ability to specialise, and thereby had an adverse effect on the quality of service provided to NHS patients.
- 11.21** Clinical Excellence Awards were introduced in 2003. They enable hospital consultants to earn pensionable financial awards on top of their salaries. Doctors require the endorsement of their Chief Executive and Medical Director to receive the awards. Therefore it is clear that there is a potential conflict of interest between doctors' desires to please their Chief Executives and Medical Directors, and the best interests of patients.
- 11.22** The Panel should have investigated whether personal financial considerations influenced doctors' willingness to speak out about possible concerns.
- 11.23** The substantive contracts of some UHBT histopathologists are with the University of Bristol and they have honorary contracts with UHBT. The Panel should have investigated whether this has influenced behaviours and attitudes.
- 11.24** The Panel's failure to conduct an in-depth review as suggested in 11.16, indicates that it deliberately did not do so because **"There is also evidence that, as with the heart scandal, a lot of senior NHS managers, consultants and the Royal College have known concerns about UHB's pathology department for some time. So there are powerful vested interests in not having another scandal"** (*Private Eye January 2010 – Bristol Update*).
- 11.25** And of course there is also NBT's and UHBT's wish to avoid litigation. This is the most probable reason why affected patients and their families were not told about the Inquiry.

12. DOUBLE REPORTING

- 12.1** It is pleasing to see that the Panel has recommended that there should be a national protocol for double reporting that is much narrower and more specific than the current RCPATH specification.
- 12.2** However the Panel's recommendation doesn't go far enough. Double reporting should be mandated, not only for specialities where double reporting is mandatory, but also when the skills and experience of individual pathologists cannot be relied on without double reporting.
- 12.3** It is unfortunate that the Panel's failure to ensure that the **"Heart of the Inquiry"**, the 26 cases, were transparently investigated, means that many people still have serious doubts about the safety of Bristol's Histopathology services. They are likely to demand second opinions from outside Bristol for themselves and their families, to minimise the risk of being harmed by avoidable diagnostic errors.

13. PAEDIATRIC PATHOLOGY

- 13.1** At the Inquiry Press Conference on 8th December 2010, Mrs Ruth Brunt, Chief Executive of NBT, informed the journalists that patients the subject of the 26 cases (or presumably their relatives, if they have died), would be belatedly informed about the Inquiry.
- 13.2** However, Mr Woolley has not confirmed that the parents of the children affected by the Paediatric Inquiry will also be informed about it.
- 13.3** All the patients and families affected should be treated equitably and told about the Inquiry.

UHBT and NBT should ensure consistency in their communications with them.

- 13.4** The Panel has not explained why there has been no review of the paediatric misdiagnoses. This indicates that UHBT accepts that serious diagnostic errors were made. This is relevant to the Panel's review of competency, yet is ignored.
- 13.5** History repeats itself. In the 1990s, BRI heart surgeons who performed adult heart surgery, also worked on paediatric cases, yet were not competent to do so. They carried on even when concerns about their safety were expressed by UHBT clinical colleagues. Exactly the same happened with Paediatric pathology. Also when NBT colleagues raised concerns about the ability of UHBT's pathologists to perform some specialist histopathology, the UHBT pathologists just carried on regardless.

14. PATIENT ADVOCACY AND NHS RELATIONSHIPS WITH THE PUBLIC

- 14.1** The Panel formed its view of Patient Advocacy without consulting any Patient Advocacy Organisations.
- 14.2** The Panel has a very out of date and paternalistic view of Patient Advocacy. It would prefer Patient Advocates to go along with the **"nothing to worry about unduly"** approach, when there is no evidence to do so, and to allow NHS Commissioners and Providers to escape accountability for compromising patient safety.
- 14.3** It is clear that the Inquiry Panel does not like any kind challenge to the way it works. When I met it in November 2009, Miss Mishcon told me **"Can I also just say -- I think it is endorsed by everyone -- that patients are very lucky to have an advocate like you"**.
- 14.4** I have not changed since November 2009. However it became apparent during the course of the Inquiry that the Panel did not like me raising concerns about the conduct of the Inquiry, particularly the secretive review of the 26 cases.
- 14.5** Mrs Katharine Tylko-Hill, a Patient Advocate interviewed by the Panel in Spring 2010, told me that the members seemed keen to achieve a good outcome for patients. However, when she saw the way Miss Mishcon responded to my concerns, she observed that it seemed as though the Panel had been "got at" during the course of the Inquiry.
- 14.6** Mrs Tylko-Hill, a MacMillan CancerVOICE trained advocate made this comment after reading the Panel's report: **Every patient advocate who uncovers information concerning patient safety, which the NHS has allowed to go unresolved for years, and which, if published, might damage patients' confidence, has to weigh up the risk to patients of publication against the risk to patients of non-publication. I am convinced that Mrs Havercroft weighed up the risks correctly and responsibly"**.
- 14.7** Another Patient Advocate, from another part of England, made this comment on reading the section in the report in Patient Advocacy **"I think they underestimate you and it is being patronising about patient advocates generally. Actually, I don't think they did underestimate you but are trying to devalue your input in order to justify their treatment of your input"**..
- 14.8** Miss Mishcon's reply to my Timeline and covering letter of 6th September 2010 said **"We note that you have required a formal written response to this letter. Can we remind you that no one can require an independent inquiry panel to do anything"**
- 14.9** I reminded Miss Mishcon, that, as she and the other Panel members have been paid for by public funds, they are ultimately accountable to the public for the conduct of the Inquiry.
- 14.10** A local member of the public, who is not a patient, observed that the Panel's, UHBT's, NBT's and NHS Bristol's attitude to patients and the public seems to be to **"treat us like serfs outside the castle walls"**. The Panel clearly regards the Timeline as an

inconvenience rather than important evidence of NHS Managers' failure to act in accordance with the Code of Conduct for NHS Managers to protect patients from harm.

- 14.11** The Panel's Inquiry has cost the public £700,000 and has not provided any reliable evidence to confirm the UHBT histopathology service is safe. But the Panel doesn't want patient advocates to publicly state the obvious and hopes that patients and the public believe that the issues are much too complex for lay people to understand. They aren't.

15. MEDIA HANDLING

- 15.1** The Panel says **"How it (UHBT) handles the publication of our Inquiry report will be a challenge for the Trust and we would recommend that it approaches it – and all future relationships with the media – proactively with an emphasis on openness and honesty and with the involvement of senior management, including the Chief Executive and clinicians"**.
- 15.2** Unfortunately the Panel has not set a good example with its own report, which, in my opinion, contains many examples of lack of openness and honesty, as I have described in this response.

16. WHISTLEBLOWING

- 16.1** Dr Phil Hammond on whistleblowing: **"I don't like the term whistleblower. It all goes back to the heart scandal in Bristol when an anaesthetist first raised concerns. The trouble with 'whistleblower' is that it's seen as a pejorative term – it sounds like you're a bit of a snitch.**
- "If we could change it to a culture of speaking up, where doctors, patients and their families were all united in speaking out about their concerns, we could get away from this idea of whistleblowers, snitches and people telling tales and the NHS would be in a much better place.**
- 16.2** I agree. The term is pejorative and, in the Bristol Histopathology case, it detracts from the fact that the doctors who raised concerns did so through proper channels and no effective action was taken by Medical Directors and Senior Managers.
- 16.3** **"The Panel would deeply regret it if this Inquiry and/or our Report in any way deters people in the future from reporting any concerns which they may have about a colleague's practice or competence. And we would hope that in future it is made easier for people with genuine concerns to pass those concerns on to those who can investigate them and, where necessary, deal with them appropriately". (Page 193)**
- 16.4** These are weasel words from the Panel. Its undermining of some doctors who raised the concerns, on the basis of no evidence, merely speculation and hearsay, has made it much more difficult for people to raise concerns in future. Therefore the damage the Panel has done to clinicians who raised concerns has increased the risk to patients because doctors will be even more reluctant to speak out in future.
- 16.5** The Panel "deplores" the manner in which NBT respiratory clinicians raised concerns in their 2004 letter (3.16, page 72) and notes that it "appears" that these issues had not previously been raised with Dr Morse, the Medical Director of NBT. The Panel has produced no evidence to prove that the doctors had not raised concerns before August 2004, either verbally or in writing with Dr Morse or any previous NBT Medical Director. The Panel should be certain of its facts before criticising witnesses. To criticise without firm evidence is bullying – and deplorable.

- 16.6** Bristol has lost two nationally acclaimed experts in Histopathology, Dr Hirschowitz and now Dr Ibrahim, who has resigned. Both resignations could have been avoided if local NHS Managers had handled their concerns responsibly.
- 16.7** The Panel says that anyone who reports their concerns should be treated with respect and discretion, yet has done the opposite by its unfounded questioning of the integrity of some of the doctors who raised concerns on the basis, not of evidence, but speculation, hearsay and tittle-tattle.
- 16.8** Extracts of some of the letters in which doctors raised concerns with Senior UHBT and NBT Managers show that patient safety was the doctors' priority:

“ In my opinion these errors could have been minimized or eliminated if pathologists share/ refer/consult with colleagues in Bristol, or send difficult cases outside Bristol before giving or suggesting a diagnosis to the clinicians.”

“Needless to say that we are all human beings and mistakes may happen occasionally but it is only by being made aware and acknowledging those mistakes that we can learn from them”.

and

“I feel compelled to request that you investigate the concerns. If they are shown to be groundless that will be reassuring for patients and clinicians alike.

All pathologists make mistakes or occasionally misinterpret histological findings. What is important is the way in which pathologists deal with such occurrences.

- 16.9** These comments are consistent with the Panel's own comments about the UHBT histopathology service, yet the Panel's report attempts to undermine the professional integrity of the doctors who made them.
- 16.10** The only logical explanation for this behaviour by the Panel is that is trying to protect the reputations of those senior managers in local NHS organisations who don't want another Bristol Health Scandal. Unfortunately they have already got one and have made it far worse by allowing UHBT's Panel to conduct the Inquiry in a manner that has created more suspicion that serious errors have been and are still being covered up.
- 16.11** I assume that the Panel would not endorse Dr Hammond's wish that doctors, patients and their families can unite to speak out about concerns, since the Panel clearly likes to believe that lay people don't understand clinical complexities.
- 16.12** Until the professional consequences for **not** raising safety concerns are more damaging to clinicians than speaking out to protect patients, nothing will change.
- 16.13** The Department of Health has issued a consultation paper on the NHS Constitution and Whistleblowing. The closing date is 20th January 2011.

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120349

I suggest readers' time is better spent responding to this consultation than paying much attention to the Panel's views on Whistleblowing, which I regard as insincere.

17. PANEL'S RECOMMENDATIONS

17.1 Some of the Panel's recommendations seem reasonable, but they are very high level and just state the obvious.

17.2 I disagree with the following recommendations:

D 1(f) - until a new integrated department is established, second opinions from the "other" Bristol department should be regarded as outside the department.

This is currently unworkable because NBT's entire team of consultant breast histopathologists has resigned. Between them, they also covered lung, skin Head & neck and endocrine histopathology. Replacements of the same calibre have not so far been recruited.

Unless UHBT's breast, gynaecological, skin and lung histopathology can be proved safe, with evidence, the Panel's recommendation that it offers a second opinion to NBT is unacceptable and could lead to patient harm.

I 1. The Department of Health and the Royal College of Pathologists should work together to improve further patients' understanding of the role of histopathology.

This appears to be an attempt to bamboozle patients into believing that histopathology is more complex and less certain than it actually is. Patients don't need to understand the role of histopathology, unless they have a particular interest in doing so. They need enough accurate and unbiased information to be able to hold the NHS to account to deliver safe, high quality services. They need to know the reliability of the results they are given and the consequences of any uncertainty for informed, shared decision making with their doctors.

I 3. Where a patient's care is going to be discussed at a multidisciplinary team meeting, patients should not be given information contained in histopathology reports until the reports have been considered by the multidisciplinary team.

The Panel has not consulted with any Patient Advocacy organisations before making this recommendation. It is not for the Panel to say whether patients should be given information about their histopathology results before MDT. This is a matter for local clinicians to agree, in consultation with their individual patients' wishes.

L 2. Consideration should be given to inviting the Inquiry Panel to return.

No. Ensuring a safe future is now the responsibility of Monitor and the Care Quality Commission and Healthwatch. The Panel lost sight of patients in its conduct of the Inquiry and will not be welcomed back to Bristol.

17.3 It is interesting to consider Recommendation A6. "**all future consultant appointments should be joint appointments between the two Trusts**". NBT has lost all its breast histopathologists and has not yet succeeded in recruiting suitable replacements. A new paediatric pathologist was appointed and then decided not to take up her appointment and I understand that three recent applicants for two joint NBT/UHBT GI histopathology posts withdrew their applications shortly after the closing date.

17.4 Bristol will not attract the best doctors in other specialities (e.g surgery, radiology), if they do not regard its histopathology services as reliable.

18. FUTURE OF HISTOPATHOLOGY SERVICES

- 18.1** The Panel recommends that UHBT and NBT should develop proactive and constructive relationships with patients and patient advocates. Unfortunately there are no signs of this happening in the foreseeable future.
- 18.2** At the 8th December 2010 press conference to launch the Inquiry Report, Mrs Ruth Brunt, Chief Executive of NBT assured journalists that new management teams were in place in both Trusts to take forward the recommendations.
- 18.3** I do not understand Mrs Brunt's reference to new management. She knew about the pathology concerns in 2004 as she was copied on the letter written by the NBT respiratory physicians. Mr Woolley, UHBT's Chief Executive knew from 2007 correspondence that I was concerned about pathology standards. They are members of the Senior Management cohort in both Trusts that knew about the allegations and took no effective action.
- 18.4** Both Mr Woolley and Mrs Brunt have accepted the Panel's report in full, despite the serious flaws with the conduct of the review of the 26 cases. Neither they nor the Panel seem to understand that an integrated service cannot successfully be established while there are unresolved concerns about the competency and commitment to patient safety of some histopathologists in the city.
- 18.5** NBT's immediate problem is how to resolve the disintegration of its own histopathology services, following the resignation of its entire team of Frenchay Histopathologists.
- 18.6** If NBT and UHBT try to resolve this crisis by piling more work onto the UHBT histopathologists, whose safety and competency has not been proved to the satisfaction of many patients and members of the public, it will increase the risk patient safety and cause contention.
- 18.7** NBT's predicament has disturbing echoes of the disintegration of UHBT's paediatric pathology services where UHBT pathologists took on specialist work that they did not have the specialist skills and experience to perform safely.
- 18.8** The Lay Engagement for the Bristol, North Somerset and South Gloucestershire Review of Pathology Services has had a difficult start, prompted by the NHS appointing its own Lay Members without consultation with local people. Four members of the Lay reference Group issued the statement of censure in **Attachment 5**. The two NHS appointed Lay Members whose participation was paid for from public funds, have now resigned.
- 18.9** The Lay Engagement process was approved by the Healthy Futures Programme Board, comprising the Chief Executives of Bristol, North Somerset and South Gloucestershire PCTs, UHBT and NBT. The Board is chaired by Deborah Evans, Chief Executive of NHS Bristol.
- 18.10** During the past 18 months, it has been very clear that Ms Evans has not liked my public exposure of the fact that NHS Bristol knew about serious allegations of misdiagnosis in 2007, yet took no effective action to deal with them. I believe that the Lay Engagement for the Review of Pathology Services was deliberately designed to dilute the influence of local people and hamper their ability to hold Ms Evans and her colleagues to account.
- 18.11** The NHS is relaunching its Pathology Review Lay Engagement process in January 2011. The relaunch will not succeed unless local NHS organisations deal properly with the

ongoing concerns about Bristol's histopathology safety that UHBT's Inquiry Panel has failed to address, are prepared to be held to account by the public for failing to deal with the concerns when they first became aware of them, and stop treating the public like **"serfs outside the castle walls"**.

19. CONCLUSIONS

19.1 The Panel says the 26 cases are at the Heart of the Inquiry. Based on the evidence I possess, I regard the conduct of the reviews of the cases as a cover up, designed to achieve an outcome of **"nothing much to worry about unduly"**. I believe this is deliberate and not simply incompetence.

19.2 I made these predictions to the Panel in June 2010:

"If the NHS, with or without endorsement from the Panel, is unwise enough to attempt to integrate pathology services without a fully transparent investigation into the specific allegations to determine whether there have been avoidable misdiagnoses that have caused serious harm or had the potential to do so, this is what will happen:

1. UHB pathologists who believe they have been exonerated will find themselves working alongside NBT pathologists who believe they have escaped justice – with the inevitable further damage to relationships.

2. Agreement on consistent, safe, high quality protocols will be very difficult to achieve.

3. Good pathologists will leave Bristol and will not be easily replaced because the best people will not want to work here with the cloud of unresolved allegations hanging over the City.

4. Good, specialist pathology registrars will leave Bristol for consultant posts elsewhere.

5. Patients will form an opinion of which pathologists in the integrated team should be avoided and may request second opinions from outside Bristol.

6. The Panel will be remembered in Bristol for having missed the opportunity to be seen to act truly independently of UH Bristol, and people will feel betrayed.

7. Bristol will be left with a run down pathology service whose quality is not trusted.

8. Clinicians will not report future concerns about quality and safety because they will regard it as a futile waste of time and potentially damaging to themselves – patients will suffer.

Most of these predictions have already come true, or are on the brink of becoming true.

19.3 I do not regard the Panel as independent. I assert that its priority was the protection of the vested interests of senior NHS managers whom I believe covered up what appears to be another Bristol Health Scandal. The Panel lost sight of patients. Perhaps it never had them in its sights.

- 19.4** The Panel made the reviews of the 26 cases the “**Heart of the Inquiry**”, but ignored the warnings in my Open Letter (**Attachment 1**) and failed to ensure that they were conducted transparently. It let Drs Sheffield and Burton select the cases for review and allowed UHBT to control the audits.
- 19.5** The Panel commissioned RCPATH to review the results of Source BioSciences review, but appear to have allowed conclusions to be drawn based only on the findings of two RCPATH reviewers per case, without consideration of all relevant reports, including those of the Source BioScience reviewers. The Panel has provided no evidence to show that all relevant slides, reports and external opinions have been considered by appropriately experienced and specialist pathologists.
- 19.6** The Panel has handed the people of Bristol, North Somerset and South Gloucestershire nothing except false reassurance, based on no credible evidence, and thereby increased the risk to patient safety.
- 19.7** By its conduct of the Inquiry, I believe the Panel has not only further damaged the reputations of the local NHS organisations that I believe it sought to protect, but damaged its own reputation and that of its members.
- 19.8** The Panel has failed to heed its own words, when considering the legacy of the Kennedy Report on the BRI Heart Inquiry “**a lack of openness can lead to suspicions or accusations of intentional concealment**” (155, page 26)

20. RECOMMENDATIONS

- 20.1** A review by the General Medical Council is required into the extremely suspicious conduct and management of the audit of the 26 cases, and the extent to which doctors, including past and present Medical Directors and UHBT's former Chief Executive, failed in their obligations to protect patients.
- 20.2** An independent, retrospective, systematic review of ALL specialist areas of histopathology should be performed for both UHBT and NBT, that properly reflects the caseload for each speciality. The methodology for this review should be developed in consultation with local patient and public groups and the outcome must be made public.
- 20.3** As UHBT provides a regional breast screening service, an independent, retrospective, systematic review of the pathology provided by UHBT to the Breast Screening service is required. The report must be made public.
- 20.4** The systematic reviews would provide a much needed baseline of the quality and safety of each Trust's service and must be used to inform the Review of Pathology Services. It has been argued that such a review would be expensive, but no information has been provided to confirm the cost. Expense considerations did not prevent £700,000 being spent by UHBT on a Histopathology Inquiry which has failed to provide evidence to confirm the safety of its histopathology services.
- 20.5** All patients and relatives whose cases have been the subject of concerns (including the paediatric cases and those excluded from the 26 case reviews), should be informed of the Inquiry, its outcome, and the actions to be taken in response to the concerns about it.
- 20.6** An independent, public inquiry should be instigated to investigate the following:

- a. the failings of clinical and corporate governance of UHBT, NBT, NHS Bristol and the SHA that enabled serious concerns to remain unresolved despite UHBT and NBT knowing about them since at least 2004, and NHS Bristol and NHS South West, since at least 2007.
- b. why £700,000 of public money has been spent on an Inquiry that has failed to provide evidence that the UHBT histopathology service is safe, and why UHBT has invited the Panel to return in 12 months at more public expense.
- c. the performance of the Non-Executive Boards of the Organisations listed in 20.6 a. particularly the role of the Chairs, to discover why they appear to have failed to take appropriate action to protect patients.

Those selected to give evidence to the public inquiry should be compelled to attend and required to give evidence under oath. The Inquiry must be fully conducted in public.

- 20.7** The regulators Monitor and the Care Quality Commission must work with local NHS organisations and local public and patient organisations, to respond to the serious concerns about the conduct and outcome of the Inquiry, agree the actions required to restore public and patient confidence in Bristol's Histopathology services and ensure they are implemented.
- 20.8** The UHBT Governors must, independently of the Trust Board (both executive and non executive members), conduct a review of the conduct of this Inquiry and its outcome with its members and produce recommendations on the actions required to restore patient and public confidence.
- 20.9** A formal review of lessons learned from the conduct of the Histopathology Inquiry and any public inquiry must be conducted. This should involve local GP consortia so that these lessons can be carried forward into future consortia commissioning practice.
- 20.10** There must be an end to NHS inquiries conducted in secret, by panels appointed by and paid for by the NHS organisations under investigation.
- 20.11** For any future NHS inquiries, Panel membership and Terms of Reference must be agreed in consultation with local patient and public groups as well as clinicians and NHS managers.
- 20.12** NBT and UHBT must be merged to form one NHS Trust for Bristol, with a new Chief Executive, Medical Director and Board Chair, as minimum. A criterion for appointment must be proven success in working proactively and co-operatively with patient and public organisations.

Attachment 1

Dear Miss Mishcon,

Bristol Histopathology Inquiry – Open Letter

I write concerning the 26 alleged cases of misdiagnosis that UHB (University Hospitals Bristol NHS Foundation Trust) arranged to be externally reviewed. They cover four specialist areas:- respiratory, gynaecological, breast and skin.

From UHB and NBT (North Bristol NHS Trust) Freedom of Information Act responses, I understand the following:

1. NBT identified the 26 cases following histopathology case review, with little involvement of the clinicians who raised the allegations.
2. The patients affected (if still alive) and/or their families, appear not to have been informed that their case is part of the Inquiry and invited to give evidence to the Panel, as demonstrated by the Jane Hopes case reported in the Sunday Telegraph 11th April 2010.
3. UHB's laboratory staff extracted slides to send to Medical Solutions, a company with a financial relationship to UHB, for review by pathologists whose names are secret.
4. Pathologists who raised the concerns were not asked to verify that the slides, reports, existing external opinions and any other material that UHB sent for review are the ones that are the subject of the allegations.
5. There appear to be no formal plans to communicate the findings of the external review to pathologists who raised the concerns and those whose work is the subject of the concerns, to allow them to comment on the findings.
6. UHB's Acting Chief Executive has confirmed that, of the 26 cases, there were **"2 cases of misdiagnosis leading to patient harm where the Trust admitted liability and a settlement was reached"**. He does not say whether the settlement included a "gagging" clause that prevents the families from meeting the Panel.
7. The 26 cases may be the tip of the iceberg. UHB's apparent reluctance to investigate this indicates that fear of litigation overrides exposure of the facts. The 26 cases are a small sample of the caseload in the four areas of concern. If an audit of just these subspecialities was performed, covering all years for which allegations have been raised, the error rate may be higher than the 1-2% claimed as a "normal" error rate by the Trust.
8. The 3,500 random audit of cases or specimens (it has never been made clear which), commissioned by UHB for 2007, includes large specialities for which no concerns have been expressed. As well as causing anxiety to pathologists in those specialities, the audit is likely to mask the extent of any serious errors made in the specialities of concern.

The public wants to know whether or not serious, avoidable misdiagnoses have occurred, which have harmed or could harm patients; not whether UHB's Histopathology Department had an overall error rate of less than 2% for 2007.

The public wants the truth about the extent to which the concerns were dealt with in an open, honest and constructive manner. Or have no lessons been learned from the Bristol Heart Inquiry?

All histopathologists make some mistakes. However UHB has admitted that two of the 26 cases involved patient harm. We want to know whether other avoidable mistakes have been made that harmed patients, or had the potential to do so if not spotted and corrected by colleagues in other Trusts.

We want to understand whether histopathologists working in the areas of concern have been performing to standards that are expected of their position as specialist pathologists in a tertiary referral centre and whether all have been participating in EQA (External Quality Assurance) schemes for the subspecialities of breast, respiratory, gynaecological pathology and dermatopathology.

The secretive conduct of the review of 26 cases does not inspire confidence that these questions will be answered.

Public confidence will be further undermined if the Panel is not seen to acknowledge this and demonstrate its independence now by insisting on full transparency in the investigation of the 26 cases.

Adverse public and press reaction is inevitable when the organisation against whose staff the allegations have been made, selects the evidence for investigation without any input from those who made the allegations, pays for its existing contractor to handle the evidence and engages and pays for a Panel to provide assurance that all is well.

I am confident that the Panel has the opportunity to exert its independence by ensuring full transparency in uncovering and publicly reporting the facts about the 26 cases as an urgent prerequisite for developing the consistent high quality, safe pathology services that Bristol desperately needs.

The issue is whether the Panel has the will to seize this opportunity.

I hope that this letter is helpful to you and your colleagues on the Panel in clarifying the expectations of patients and members of the public.

Daphne Havercroft

Patient Advocate

14th June 2010

Attachment 2

The Breast Core Biopsy Grading Discussion with the Panel.

Q. I will be corrected by you, James, if I am wrong: my understanding is that in fact, pathologists do not need to grade in these cases. We are not trying to belittle this in any way whatsoever but I am just asking you because again this is all something that we have to take into account, but if in fact the pathologist concerned had done what is accepted practice, that you don't need to grade at all, then there would be no criticism of the pathologists at all, because they would have picked up that there was something wrong; they just would not have graded it. Does that make any difference? I know that in this case they did and that there was a difference of opinion about it. But can you see there are so many different things that have to be taken into consideration when you are looking at competence, mistakes and whatever? What do you say about a situation like that?

A. I think first of all the minimum dataset for breast pathology does have a section on there for grading of core biopsy. Therefore if it is on that dataset, why is it on there if it is not normal practice for someone to grade at that point in time?

Sir James Underwood: It is listed as an option.

A. Right. In that case, if it is an option, then if it is a case of a pathologist not being able to do it with any certainty, then take the option that says, 'I don't grade it'. But there is another aspect to this because I did follow this up. I have no idea who the patient is, because of obvious patient confidentiality, but I had some information back from Robert Woolley at UHB who told me that it was only diagnosed by UHB as grade 3 on the lumpectomy specimen, whereas what I have heard from NBT is that, 'No, we diagnosed it as grade 3 on exactly the same specimen that UHB diagnosed it as a grade 1'. So whereas I think patients would appreciate that the difference between a grade 1 and a grade 2 might be quite difficult to interpret, from our perspective the difference between a grade 1 and a grade 3 – you think, well, why has one hospital group graded it as a 1 and then three pathologists from another hospital a grade 3?

Comments added to the final version of the transcript

Where is the evidence to say that grading of breast core biopsy is not accepted practice in the Avon, Somerset and Wiltshire Cancer Services Network (or in any other network)? My understanding is that it is normal practice in ASWCS. If it isn't why would the UH Bristol Pathologist have bothered to grade it? If the UH Bristol pathologist graded the core biopsy without being willing to accept responsibility for the content and accuracy, that breaches the guidelines in the RCPATH Quality Document **“At all stages, it must be absolutely clear who is taking responsibility for the content and accuracy of the report and for communicating the report to clinicians”** .

Therefore there appears to be a clear question of competence and failure of duty of care to patients to grade a core biopsy without apparently being confident that it is an accurate diagnosis. If the UH Bristol pathologist was unsure, the right thing to do would have been to not assess the grade and ask NBT for a second opinion. If she was sure, I cannot accept that to grade the biopsy 1 when 3 other pathologists graded the same specimen 3 can be anything other than a question of competence. I do not understand what are the “many different things that have to be taken into consideration”. It's very simple. To not grade a core biopsy because one is not sure of the grade is understandable and the right thing to do for patient safety. However, for one pathologist's grading to be so out of step with the unanimous verdict of 3 colleagues may be a rare and very unfortunate error. Or it may be a competence issue.

Regarding the “difference of opinion” The opinion that prevailed is NBT's and the patient was treated appropriately for grade 3 breast cancer, which is very different to the treatment for grade 1, and much more gruelling for the patient. If the opinion of the UH Bristol Pathologist had prevailed, and the error not been spotted, the patient would have been under treated and may even have

died. The Panel still refers to this as a “difference of opinion”. Given that this serious incident is over 6 months old, there can surely no longer still be a difference of opinion. What did the Medical Directors do to resolve the difference of opinion? Very little, it seems. This exchange between Mr Woolley and me, April 2010:

DH Have the NBT Pathologists, the UH Bristol Pathologist and the NBT Breast Multidisciplinary Team been formally informed of the outcome of the investigation?

RW The UH Bristol Pathologist is fully aware of the investigation and its outcome. A formal response was sent to North Bristol NHS Trust, which is responsible for further dissemination.

It's the same old pattern that seems to have prevailed for many years. Diagnostic disagreements not resolved in an open and amicable way. Does UH Bristol accept their diagnosis was wrong, in which case what have they done to make sure it doesn't happen again? If they believe their diagnosis was correct, presumably they believe that NBT has over treated a patient, in which case, what have they done about it?

How can the two pathology teams ever be expected to work together when we do not know whether NBT bothered to disseminate UH Bristol's findings to its clinicians? If UH Bristol breast pathologists are uncomfortable about grading core biopsies, why do they try to do it? NBT does it as a matter of course – and double reports so that if any errors are made, they can be immediately identified and corrected. The NBT way of working is what patients want and expect. That is why Frenchay is highly regarded by patients across the country.

NBT patients who visit UH Bristol for part of their care have a right to expect consistent, high quality care from both Trusts. By grading the core biopsy, the UH Bristol pathologist must surely have intended NBT to take it as correct because she did not take the option not to assess the grade. Therefore she had a duty of care to ensure that it was correct by arranging for it to be double reported by a UH Bristol colleague, or asking NBT to double report it.

Also I have to ask whether the Panel takes the same view of core biopsies which are deemed benign. The NHS Breast Screening Programme minimum histopathology dataset has nine variants of benign. If doing other than saying whether a core biopsy is benign or malignant (which still seems to cause UH Bristol difficulties, according to the allegations. 5 cases in the letter to Martin Morse describe alleged failure to even correctly differentiate between benign and malignant conditions - cases 1, 2, 3, 4 and 8), what is the point of having all the variants and gradings on the datasets?

Mr Woolley's comments tell me that someone is trying to mislead me about this case and I don't believe it is the NBT Breast Team. They have no reason to do so.

Attachment 3

Letter sent to the Panel 6th September 2009.

Dear Panel,

Enclosed is a timeline relating to the actions of Senior NHS Managers from various organisations. Most of it should already be known to you. However I felt that summarising it would be helpful to me and others.

I sent it to Dr Phil Hammond for an opinion and he asked for my permission to send it to you; I agreed. He also asked me to send you any relevant cross referenced documentation. For completeness, I have sent all the documents cross referenced in the timeline to David Jones of Verita.

It is very clear from this timeline that some very senior NHS Managers, including NHS Bristol's former Co-Director of Commissioning, now on secondment to UHB, have known since at least October 2007 that clinicians had concerns about UHB's Pathology. They also knew that some patients and members of the public had concerns at that time. Yet it appears that some undisclosed agenda may have discouraged NHS Bristol from ensuring that the concerns were swiftly investigated directly with the clinicians, to demonstrate that patient safety was the PCT's top priority.

Therefore I would caution against the Panel producing a final report that does not make it absolutely clear that NHS Bristol has known about Pathology concerns since at least October 2007 and, without any evidence that patients were not being put at risk, did not take them seriously until informed about them again, eleven months later, in September 2008, following Dr Tomson's July 2008 letter to ASWCS' Mary Barnes.

Even then NHS Bristol's attempts to get the NBT and UHB Medical Directors to take the concerns seriously appear weak and ineffectual, such that it was only exposure in Private Eye that secured an investigation, nine months after NHS Bristol's attempts to start treating the concerns seriously. As Dr Hammond said prophetically in a Private Eye "Bristol Update" **"There is also evidence that, as with the heart scandal, a lot of senior NHS managers, consultants and the royal college have known concerns about UHB's pathology department for some time. So there are powerful vested interests in not having another scandal"**.

Then we have NHS Bristol's Chief Executive, in writing, in June 2009, denying knowledge of any Gynaecological allegations, yet documentary evidence exists to prove that she knew about them since at least September 2008. It must have been very inconvenient for the local NHS community to have known of serious concerns about the quality of UHB's Gynaecological histopathology when they were desperately trying to transfer Gynaecological Cancer Surgery from Bath to Bristol. This would obviously have added to the pressures on an already stretched BRI Histopathology Department.

Perhaps the pressure to centralise Gynaecological Surgery at UHB explains why the Gynaecological allegations were not included in UHB's 19th June 2009 announcement of an Inquiry, when UHB and NHS Bristol knew very well that they existed.

I appreciate that it may have been difficult for a Panel with little knowledge of Bristol, other than what they were told about "dysfunctional relationships" by people who perhaps had their own agenda, to fully understand the nuances and complexities of the long and torrid history of power struggles and financial machinations between Senior Executives in local NHS organisations (exacerbated by what is perceived by many as the bullying culture and influence of the SHA), in respect of service reconfigurations and the effect on pathology services. Consequently I recognise

that this may have made the Panel vulnerable to people with powerful vested interests who do understand these organisational, as opposed to clinical complexities, but perhaps have their own agenda.

If the Panel's final report does not address the issues I set out in this document, it will give me some concern that some information that has been provided to the Panel has come from individuals in positions of power, with their own agenda, the full context of which perhaps the Panel had not fully evaluated.

You see, Panel, what greatly concerns me about the terms of reference of your Inquiry and your draft report is that you have not even touched on the damage caused to Bristol's Pathology by the agenda of the PCTs, SHA and ASWCS to reconfigure services by SHA driven deadlines and the controversial quality of the way in which these reconfigurations are done. No right minded person can accept that the claim of NHS South West that very senior people, including its Chief Executive, did not know about the very serious allegations (including a woman's death) until June 2009, yet its Medical Director knew about them since at least August 2008 and its Associate Director of Performance was discussing them in regular reviews with NHS Bristol since at least November 2008.

And are we seriously expected to believe that the SHA was unaware of Richard Spicer's concerns? When he retired in 2008, he was still concerned that the shortage of skilled pediatric pathologists meant that UHB could not provide an acceptably safe service. Meanwhile, the SHA, PCTs and ASWCS continued to try to pile more specialist clinical services into UHB (whose Board was striving for Foundation Status and wanted to suck in more services to bolster its claim to be a regional "centre of excellence" for cancer), without any consideration of the effect on an already overstretched adult histopathology department.

Robert Woolley told me you had the latitude to inquire into all matters that you deemed relevant. The culture, attitudes and behaviour of the SHA, PCTs and ASWCS, as well as that of the Provider Trusts, are key to understanding what has gone wrong with Histopathology in Bristol. Yet you have ignored this. You have also ignored the serious concerns expressed about the secrecy of the conduct of the review of 26 cases where UHB and Source Biosciences, a company with whom it already had a commercial relationship, controlled the process for review of the cases. Clinicians who raised the concerns were not consulted about the process and the credentials of the external reviewers. They were not even allowed the basic right to check that all relevant material had been collated, documented and sent for external review.

You seem to expect the local community to ignore all these things and put our faith in the SHA, ASWCS and PCT managers, whom we believe have deceived us, whom we do not trust and who accept no accountability for Bristol's Histopathology problems, to deliver a high quality pathology service for the future. It is a recipe for disaster.

These same people are entrusted with the current Review of Pathology Services, and are already trying to rush it through without time for proper consideration of the Panel's final report and without proper consultation and involvement of histopathologists, clinical service users and members of the public, to meet aggressive SHA imposed deadlines and perhaps to earn some Heads of Pathology their Clinical Excellence Awards. This will make the quality and safety of Bristol's Histopathology worse, not better.

It's that Bristol disease again – denial of serious problems without investigating them, never implement lessons learned if you can avoid it and evade being held publicly accountable to deliver measurable quality and safety when reconfiguring services.

It's a disease of bad management and lack of public accountability and the Panel has failed to investigate it.

I'm sure that the Panel can appreciate that if, before concluding its work, it does not investigate and produce acceptable recommendations to deal with these very serious issues of public probity and accountability, I shall formally request release from the confidentiality agreement I have signed so that I can pursue these very serious issues with my Member of Parliament.
I require a formal, written response to this letter, please.

Mrs Daphne Havercroft

6th September 2010

Attachment 4

NHS Bristol Freedom of Information Response FOI 1011 033 – Also FOI 1011 -051

My Question

Please would you advise whether, after hearing the clinicians' concerns about UBHT's pathology services at the meeting of 15th October 2007, Bristol PCT took any action to investigate and resolve those concerns with the clinicians, to their satisfaction?

If any action was taken, please provide details of the actions taken, the dates of the actions and the dates Bristol PCT deemed the actions closed.

NHS Bristol's answer

Bristol PCT invited the North Bristol Trust Medical Director to substantiate, in writing and with detail, the verbal allegations made during the JOSC meeting.

This action was taken on 15th October 2007.

NBT did not provide any evidence in support of the allegations made at the JOSC meeting and the action was closed until further written allegations were received on 22 September 2008.

Attachment 5

Letter from four members of the Review of Pathology Services Lay Reference Group concerning a meeting held 15th September 2010

It was agreed at the above meeting that a statement should be issued by the Group to publicly communicate its position on the process that the NHS had used for lay engagement, including appointment of what it initially called "Independent Lay Members", now referred to as "NHS Appointed Lay Members".

After discussion, some members of the group decided they did not wish to put their names to this statement if point 6 remained. However the four members who have put their names to it feel strongly that point 6 must remain to emphasise the very serious issues with the process the NHS used to establish Lay Involvement in the Review.

The main concerns are:

1. The Review was instigated before the establishment of a Lay Reference Group, thus precluding any lay input to the process of the review initiation and subsequent procedures.
2. Appointment of NHS Appointed Lay Members to the Project Board was through an NHS recruitment process, without consultation with the Lay Reference Group, against the wishes of a local coalition of patients and members of the public, and against the recommendation of Bristol Health and Adult Social Care Scrutiny Commission.
3. The NHS publicly accepted that it should have consulted with local lay people on lay engagement prior to the start of the review, yet, regardless of that, carried on with appointing its own Lay Members without carrying out any such consultation.
4. Well established best practice for lay engagement has not been followed for the Pathology Services Review, and no reason has been given for not using best practice despite there being well recognised precedents (e.g. Breast Review and Head & Neck Review)
5. Concerns were raised with Mr Chris Born, Project Board Chair, about the process several months previously, yet the responses received are not regarded as satisfactory and some concerns remained unanswered.
6. It had been formally stated several times that the process used to appoint NHS Lay Members inevitably cast doubt on their true independence of the NHS. As they have been appointed by the NHS, we feel that this creates the potential for problems relating to true independence, and are very concerned that the NHS Project Documentation does not reflect this. Therefore it could be wrongly construed by the public, by the Health Overview and Scrutiny Committees, and by the media, that the appointments were fully supported by all members of the Lay Reference Group, when that was not true.

A majority of the group felt that the lay engagement process had been flawed because the group had not been consulted about the process (5 supported this position, two abstained). The NHS Appointed Lay Members voluntarily did not participate in the vote, though both affirmed their commitment to independence.

We request that this statement is recorded in the Project's Lessons Learned Log, copied to Local Authority Health Overview and Scrutiny Committees and posted on the Pathology Services Review website.

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