1 **MONDAY 3 JULY 2000**
2 **THE HEARING RESUMED AT 10.24 A.M.**
3
4 MR CORKILL: A wahine, te Hore Ward, a patient who gave evidence to
5 this inquiry on the first day of its hearings, died on the 13 June last. In a
6 moment there is to be a poroporo aki for Ms Ward, but before that there is
7 one formality; at the time she gave her evidence, an order suppressing her
8 name and identity was made by the committee. Shortly before she died, my
9 colleague, Mrs Anderson, spoke with her, and Mrs Ward made it clear that,
10 as she put it, she wanted her story and her evidence to be public, that she
11 wanted her identity to be disclosed. She also expressed the same wish to
12 members of her family. Since she died, her family have provided me with
13 written instructions, confirming that they wish to have her wishes respected,
14 and accordingly, I am formally instructed to request that the suppression
15 order be discharged
16 CHAIR: Thank you Mr Corkill. In the committee's view, the suppression
17 order was only made at the request of the women affected who wanted their
18 identity suppressed. So, in view of the application, the committee sees no
19 reason to not grant it, but before doing so I would just ask, does any counsel
20 present have anything they wish to say on the matter? [No response] Very
21 well. The suppression order in respect of Mrs Ward is lifted. So, members
22 of the media, you are at liberty to print or publish any material you would
23 like about witness 8 – that's Mrs Ward.
24 MR CORKILL: I am obliged to the committee. The poroporoaki will now
25 proceed.
26 CHAIR: Thank you Mr Corkill.
27 [Poroporoaki proceeds) You have been received by the tipuna and the
28 multitude that awaits you in the glorious estate of god.

1
2
3 MS ANDERSON INTERPRETS IN ENGLISH POEM/PRAYER IN
4 HONOUR OF DECEASED
5 You are the treasure of all women and you are in our tears. You will never
6 be forgotten as the pillar of protection for womanhood. In your love we feel
7 safe that this tonga coria nua attacka hiatia tata katua. Together we will
8 ensure that this will never happen again. May the fragrance of your love and
9 sacrifice always linger in our hearts and in our memories.
10 REPRESENTATIVE OF THE DECEASED: Waiata Performed.
11 MS PARE NEINEI: Closes Waiata.
12 MRS BARRETT: I just want to acknowledge all of us coming together this
13 morning to acknowledge our whanau who has moved on during this Inquiry
14 and there isn't any doubt from my point of view that we mourn a loss of yet
15 another brave women and in this case a brave Maori women . I just want to
16 acknowledge the whanau who have come to the Inquiry this morning. I
17 acknowledge your presence, I acknowledge your sadness, and from the
18 Panel we wish you well for what is to happen in the future for your whanau,
19 and that you would never ever forget your loved one. Te Pare, I wish to
20 acknowledge you and Vicky for the moving motion that we had this morning
21 and we have broken protocol and I think it is good that we have done that in
22 terms of maori and with one of our brave women moving on I would say to
23 all of us Maori women here that we must remember them who have moved
24 on – not so much in this Inquiry, but brave Maori women who have fought
25 for the things that maori live for. If I sang you would all leave the room!
26 CHAIR: Thank you very much we will now adjourn for a short time.
27
28 SHORT ADJOURNMENT
29

INQUIRY HEARING RESUMES

PERFORMANCE OF KARAKIA AND WAIATA

MS KAPUA: I have introductory submissions to introduce the witnesses. Unfortunately Air New Zealand saw fit to offload our luggage this morning so I only have the committee copies and I will make the others available to other parties.
CHAIR: Thank you.
MS KAPUA: I appear on behalf of Te Runanga o Turanganui a Kiwi and Te Runanga O Ngati Porou kuia. Both are mandated iwi authorities for Te Aitanga a Mahaki Rongowhakaata, Ngai Tamanuhiri and Ngati Porou. Their involvement in this enquiry arose from approaches made by some Maori women who wished to raise through their iwi representatives matters that needed to be highlighted on the basis of the fact that they were maori. All women affected had had to bear an enormous burden as a result of what has occurred. These submissions in evidence are made in addition to what this Inquiry has heard and will hear from individual women and their families. The matters raised are those relevant to the cultural context and the delivery and implimentation of the programme in relation to that context. These submissions and the evidence to be called is relevant to numbers 3, 5, 6 and 8 of this committee's terms of reference. Having said that, the evidence to be called is offered against a background of a number of givens that are fundamental to the concerns of Maori women. These have been referred to in evidence presented on behalf of the Ministry of Health. The matters that are relied on and accepted as a true reflection of the position are first, prior to the establishment of the National Cervical Screening

1 Programme, the incidents of cervical cancer among Maori women was the
2 second highest in the world, second only to Brazil. Secondly, the figures
3 from 1983 to 1987 show that Tairawhiti had the highest death rate in New
4 Zealand from cervical cancer among women aged 20-64 years. In May
5 1991 the Department of Health described Tairawhiti as having the largest
6 percentage of deaths due to cervical cancer than any other Area Health
7 Board in New Zealand. Thirdly, the Tairawhiti region has a high proportion
8 of maori in its demographic make-up, being around 45%. Socio-
9 economically Tairawhiti is identified as a region containing some of New
10 Zealand's disadvantaged communities. Maori women were identified as a
11 priority group when the National Cervical Screening Programme was
12 established and since the late 1980's government policy has been directed
13 towards closing the gap in respective health figures between maori and non-
14 maori. Why these issues arise independently from those matters of concern
15 to all women is because there exists an obligation on the part of the
16 Government through its agent the Ministry of Health to Maori women to
17 deliver certain health outcomes. We have heard a lot about monitoring and
18 much of the evidence to date has concentrated on monitoring in relation to
19 the work of laboratories. There have been recommendations of working
20 parties, World Health Organisation guidelines for national screening
21 programmes and there is a consistent theme advocating monitoring and
22 quality control. In the implimentation of the National Cervical Screening
23 Programme the basic monitoring and quality control requirements were
24 dispensed with. They became desirable only. The programme was
25 significantly under resources, Gisborne women suffered the consequences of
26 departures from those recommendations. This occurred throughout the
27 programme and thus it cannot be said that what has occurred in Gisborne
28 cannot happen elsewhere. There has been little response that explains why
29 the Ministry allowed the monitoring process to be compromised. Much of

1 the evidence has pointed to the funding agreements and the Ministry's view
2 that the Regional Health Authorities and later HFAs were responsible but
3 the Ministry had another imperative for monitoring and that was the
4 espoused policy of the Government in respect of maori health issues. It is
5 not enough for the Ministry of Health to acknowledge the existence of the
6 policies and to dismiss its own ability to monitor the effectiveness of those
7 policies by arguing that health issues are many and varied and the cervical
8 screening programme was but one component or that its role was strategic.
9 The reality is that the National Cervical Screening Programme was the first
10 national population based cancer screening programme in New Zealand.
11 National co-ordination and leadership of the programme and management
12 of the register were provided by the Ministry of Health . Government policy
13 prioritised health outcomes for maori. The National Cervical Screening
14 Programme policy statement identified Maori women as a priority group
15 and recognised that in order to achieve equity of outcome for Maori women
16 there would probably be the need for a disproportionately high allocation of
17 resources to be made to achieve this end. That same policy statement talked
18 of providing a service that would meet the needs of Maori women, so
19 throughout the programme there can be no question of where the priority
20 law, what the outcomes sought were and what steps needed to be taken.
21 What no-one from the Ministry of Health has been able to answer at this
22 stage is how they assess the effectiveness of their policy and their priorities.
23 The monitoring undertaking by the Ministry appears to focus on numbers of
24 women enrolled on the register at intervals between smears. The statistical
25 reports show this and in that light Gisborne was a shining example,
26 particularly in respect of enrollment numbers of Maori women - the highest
27 percentage in the country. Those figures are a tribute to the women working
28 in the area. That is what they were required to do. That is how the Ministry
29 assessed the programme's effectiveness. However, nothing was done by the

1 Ministry, or any other body, to protect those women. We now know that
2 from 1991 to 1996, the reported rates of high grade abnormalities for the
3 Gisborne region were almost half that of the National average. Reporting of
4 low grade abnormalities for the Gisborne region was almost 1/3 of the
5 National average. The Health Funding Authority has done this analysis for
6 the purposes of this inquiry, but the question has to be asked, why was this
7 exercise not done before?
8 While statistics can be a complicated area, you do not need to be a specialist
9 statistician to ask questions when the region that has the highest death rate
10 from cervical cancer in the country has a high number of Maori women who
11 are considered to be at risk and yet has reported rates of abnormalities
12 significantly below the National average. Had the questions been asked,
13 some of the devastation that the women have faced may have been
14 alleviated.
15 Coupled with this were particular health objectives and government policy
16 aimed at closing the gaps between Maori and non-Maori. The Director-
17 General of Health's performance agreement specified this objective, the
18 Ministry produced screeds of documents setting out this policy, and yet no
19 monitoring was ever done to compare the incidence and mortality rates
20 between Maori and non-Maori. Commonsense would dictate that such an
21 objective would be assessed by a comparison between Maori and non-Maori
22 rates. But the evidence suggests that was not the case.
23 Effectiveness of service delivery was the subject of numerous government
24 papers and policy, from both the Ministry of Health and Te Puni Kokiri, and
25 yet no Ministry commitment of allocation of resources was made to an area
26 with almost 45% Maori population. No requirement was made of Tairawhiti
27 Healthcare Limited in carrying out its functions to ensure any outcomes in
28 respect of its policy.

1 What remains are empty words that government agencies point to as
2 examples of meeting their obligations under the Treaty of Waitangi to Maori
3 as tangata whenua. To that end, for Maori, it is the Ministry of Health that is
4 accountable for what has happened in Gisborne. And what has happened in
5 Gisborne could happen anywhere else, because the systems are not in place
6 to monitor the effectiveness of policy and commitment given by the
7 government through a National Screening Programme to Maori women.
8 The Ministry's evidence points to the appointment of a Maori co-ordinator
9 for certain periods, and Kaimahi hui is examples of its commitment and
10 implementation of its policy for Maori women. Such a response is
11 unacceptable. Information now collected from the Register for this inquiry
12 has always been available. It has not been requested. There has been no
13 requirement from the Ministry for any more than enrolment numbers and
14 smear turnaround times. The Ministry took no action when faced with rapid
15 erosion of resources for the programme in Tairawhiti.
16 In 1991 there were three people employed, a programme manager, a systems
17 administrator, and an educator. In 1992, the programme manager left and
18 was not replaced, and the educator position was reduced to half time. By the
19 latter part of 1993, there was only one person employed – the systems
20 administrator, who had become the programme manager. By December
21 1995, the National Cervical Screening Programme staff were also tasked
22 with other duties, due to internal restructuring, but by January 1996 there
23 was the hope of returning to screening programme duties. There was a lack
24 of resources, there can be no doubt. That there was a down-scaling of the
25 programme in an area of high incidence, there can be no doubt. That the
26 Ministry of Health did nothing about it, there can also be no doubt. And this
27 was despite their own policy and commitment on paper to Maori women.
28 The evidence that is to be called is to begin with traditional evidence from
29 two kuia, one from Rongowhakata, and one from Ngai Tamanuhiri. What

1 they are sharing with the committee and this inquiry is their view from a
2 cultural perspective of the sacredness to Maori of a woman's body, which is
3 something already recognised by the National Cervical Screening
4 Programme in terms of its recognition to appropriately meet the concerns of
5 Maori women in respect of the processes that are involved in cervical smear
6 taking. This leaflet is an example of that recognition.
7
8 Many of the hui and papers written over the years in respect of the
9 programme acknowledge the need to involve Maori women in the process,
10 and the need to do that in a culturally appropriate way. The kuia also refer
11 to the traditional role of women, as seen within a cultural context, as the
12 bearers of children of the next generation. The outcome of what has
13 occurred in Gisborne has ramifications that affect that concept and spreads
14 throughout whanau, hapu and iwi.
15 Tracey Tangihaere is the executive officer of Te Runanga a Kiwa, and her
16 evidence deals specifically with the reality of implementing existing
17 government policy. She concludes with proposals that are designed to go
18 some way toward meeting the espoused policies of government in a practical
19 sense and are directed at health outcomes for Maori, and in this case, Maori
20 women. It could bring about changes to a system that is not currently
21 serving Maori women well.
22 Maori are generally over-represented in negative health statistics. The
23 cervical screening programme is no different. Maori women were over-
24 represented at the outset in the incidence and mortality statistics. They are
25 over-represented in the results of the re-readings. The original reported
26 results showed 4,274 of 4,546 Maori women tested had normal or negative
27 results. The re-read results show that 3,530 of the 4,546 Maori women
28 tested had normal results. In the re-reads, those with cancer, Maori women
29 with cancer leapt from 6 to 16. Those with high grade abnormalities from

1 51 to 205, and those with low grade abnormalities from 94 to 217. As a
2 result of a lack of commitment, a lack of direction, lack of resources, and
3 lack of proper monitoring, this statistical picture will not change.
4 Government, through its agencies, has, by its lack of action, done a dis-
5 service to Maori, and this committee will hopefully make recommendations
6 that will give substance to what are currently empty words cloaked as
7 "Maori health policy objectives."
8
9 CHAIR: Thank you Ms Kapua, before you go on I would like to ask you
10 one question about your opening submissions. In para 12 you've referred to
11 there being no monitoring of incidence and mortality rates between Maori
12 and non-Maori. We heard earlier on in the inquiry about the impact of the
13 Kaitaki Regulations and the need to obtain permission to get information
14 about Maori women from the Kaitaki Group. Can you help the committee at
15 this point in time by saying what impact, if any, do you think the Kaitaki
16 Regulations and the need to go to the Kaitaki Group could have on the
17 ability to compare mortality and incident rates between Maori and non-
18 Maori?
19 MS KAPUA: My understanding of the evidence, some of which is still to
20 come before this inquiry, is that some information, through the National
21 Kaitaki Group, has been made available with Tairawhiti Healthcare, for
22 example, and one would assume through the Ministry of Health had they
23 asked, for statistics to be released, and it appears from the evidence that that
24 information was made available. The delay with the statistical analysis, the
25 force report if you like, that Ms Earp attached to her evidence is not a
26 situation that people would see as ideal, it would seem though that in terms
27 of all of the statistical reports, there has been a delay. I think the third
28 statistical report that was done to December 1995 was in fact not released
29 until 1998 in any event so I wouldn't consider that the Kaitaki regulations on

1 their own could be seen as a difficulty, certainly it would be better to have a
2 situation that doesn't have the delays across the board. The reason for the
3 Kaitaki group being set up in the first place is probably a matter that needs to
4 be reviewed at this stage, some of the information points to there being a
5 need to protect the information rather than having the response being that
6 people had gone into a community, taken all the information they wanted
7 from the community and gone and used it elsewhere for whatever purposes
8 and there was certainly a concern about protecting and having some say in
9 the information but having said that the information that is contained in that
10 report is not information that is aimed at monitoring the effectiveness of the
11 policies that were in place for maori in terms of health outcomes.
12 CHAIR: Thank you Ms Kapua.
13 MS KAPUA: In terms of the evidence, all three witnesses are happy for
14 their briefs to be taken as read.
15 CHAIR: Thank you.
16 MS KAPUA: Both Robin Ehu Thompson there on my right and Heni
17 Materoa Sunderland are happy to answer any questions. Seated to the far
18 right is Mr Hure Callaghan who is the interpreter.
19 CHAIR: Thank you Ms Kapua.

1
2 HURE CALLAGHAN, Interpreter (sworn)
3
4 MS KAPUA CALLS:
5 HENI MATEROA SUNDERLAND AND ROBIN EHU THOMPSON
6 (sworn in through interpreter)
7 KAUMATUA – MR MICHAEL BROWN formally opens and blesses
8 evidence of above witnesses.
9 CHAIR: Does anyone have any questions? Yes, Mr Hodson.
10 MR HODSON: My name is Hodson. I come from the District of the
11 Wairarapa, E nga kua, Tena korua maungataonga, Me momahara tatou, Nga
12 whakaaro o nga kupu. I am not maori. I am counsel for Dr Bottrill.
13 (Speaks in Maori) Thank you for your treasures. Let us all members of the
14 committee remember the thoughts of these words.
15 CHAIR: Thank you Mr Hodson. Does anyone else have any questions?
16 HURE CALLAGHAN: (maori)
17 CHAIR: Can you translate please in English first so everyone can
18 understand the question?
19 HURE CALLAGHAN: Can I ask which one you are referred to, which
20 number?
21 MRS BARRETT: To the queri ruhi.
22 HURE CALLAGHAN: Which part of the paper are you referring to?
23 MRS BARRETT: It is number 5.
24 HURE CALLAGHAN: The question being asked is in part of the
25 presentation she has mentioned the fact that in the old days matters
26 concerning some of women's health problems were never discussed publicly
27 and the question asked is how do we feel now that these things are being
28 publicly discussed by the different health organisations we have? Her reply,

1 if I can remember now, basically is that in her day only the old ladies had
2 this knowledge but she hasn't actually responded to your question.
3 (Mr Callaghan repeats the question and Mrs Thompson replies). She hasn't
4 got an opinion but is I suppose a little concerned that it now has become
5 public knowledge and I guess what she is saying is that she can't quite come
6 to grips with it.
7 MRS BARRETT: This is where I have great difficulty, and I own this
8 myself as an Inquiry member of the team, of the translation from maori to
9 pakeha, because it doesn't say the same thing. When I actually viewed her
10 evidence in maori (reads from transcript) – the translation tells me that
11 women took ill with cancer, and that's her evidence in English in 5, they did
12 not go to the Dr and that is exactly what she said. They knew when they
13 had cancer when their elders heard and we all know that as maori, that if one
14 of the women was ill with cancer or any sickness for that matter, they would
15 enquire as to how they became ill. What I really asked was that that for me
16 as a Maori women still stands today and so not to denigrate what Ms Kapua
17 said earlier about the Kaitaki group but is quite opposite from what the
18 Kaitaki group is the Kaitiaka over our taonga and ngari, they talk, the
19 kaumatua talk about it was open. There is a difference and that was my
20 whakaaro – arawhamai ko tene. I just asked her to bear with me, she being a
21 much younger woman that these kuia before me, for me to actually ask those
22 questions, but it's really relevant, I think, to this inquiry team about the
23 relevance, in times of old, still stands, for me, quite firm. And so I'm not
24 saying that should be a mockery about the Kaitaki Group, but I think that
25 some of us need to go back to very learned kaumatua, like we have in our
26 presence today – tena kotoa – to actually find the information that really is
27 necessary. So, this is quite opposite to what was stated about the Kaitaki
28 Group. You need to look at it.

1 CHAIR: Just to follow up from what Druis Barrett has said, it might help
2 you to look at paragraph 5, tab 2 in the Maori translation, and at tab 3 in the
3 English translation, where it is said that the woman would explain how she
4 was ill, how the illness may have started, and that it was all open, and so
5 they all knew. Am I right then in understanding that within the woman's
6 community everyone knew that she was ill and that she would need
7 treatment?
8 [Interpreter translates question to Mrs Thompson]
9 [Interpreter translates answer]: Yes, they would share what they knew of
10 the sickness with the old lady, with the kuia.
11 CHAIR: And would they share it only with the kuia, or with other members
12 of the hapu as well?
13 [Interpreter translates question to Mrs Thompson and relates answer]: To
14 the women of the family – immediate family, or extended family.
15 CHAIR: And was there seen any need to keep these matters of ill health
16 about a woman secret from others?
17 [Interpreter translates question and relates answer]: Well, they would share
18 it, particularly if their old kuia didn't understand, they would share it with
19 other old women and hope that this example will not be repeated somewhere
20 else, or they would understand why this particular woman has this particular
21 illness.
22 CHAIR: So they recognised, then, the importance of sharing information
23 with the kuia as a means of trying to ensure that you could stop it happening
24 again, if possible?
25 A: (Mrs Thompson) Yes, it was very important to share so that they all
26 understand.
27 Interpreter: Very important to share so that everyone can understand.
28 CHAIR: Thank you very much. I have no further questions. Ms Kapua, do
29 you have any other questions you wish to raise?

1 MS KAPUA: There are none, Thank you.
2 CHAIR: Thank you very much for coming, we appreciate it.
3
4 MICHAEL BROWN FORMALLY CONCLUDES EVIDENCE OF
5 ABOVE WITNESSES
6 MS KAPUA: The next witness is Tracey M Tangihaere.
7 TRACEY M TANGIHAERE (sworn)
8
9 CHAIR: Can this evidence be taken as read as well?
10 MS KAPUA: It can be.
11 CHAIR: Thank you. There is an amendment to the brief of evidence. I
12 don't know if everybody has a copy of Ms Tangihaere's evidence but in
13 paragraph 2 where it says she is a registered nurse it should be as a
14 registered enrolled nurse. Does anyone have any questions?
15 MS JANES: Just a few brief questions.
16 CHAIR: Yes Ms Janes.
17 MS JANES: Just at paragraph 6 of your brief, you have referred to the
18 failure by Tairawhiti Health Care …..
19 CHAIR: Excuse me Ms Janes is your microphone working it doesn't
20 seem very loud?
21 MS JANES: Is that better?
22 CHAIR: Yes.
23 MS JANES: At paragraph 6 you have referred to the failure of Tairawhiti
24 Health Care to provide for the health needs of Maori women , obviously this
25 is limited to the delivery of the National Cervical Screening Programme but
26 in that context has Tauranga Health taken up issues with Tairawhiti Health
27 Care with regard to lack of delivery of services?
28 MS TANGIHAERE: I believe the role of the Tauranga Health Company per
29 sey is as a secondary provider. The role of the Runanga and the Runanga

1 collective for Ngati Porou Runanga is the role of advocacy on behalf of the
2 maori health companies at the current stage that they are at. It is our
3 ambition and our role to advocate on behalf of the separate companies so
4 that it does not endanger of make their position with the Health Funding
5 Authority quite tangible. We actually support them in these issues.
6 MS JANES: So would Tairawhiti Health Care be aware of the fact that the
7 Runanga and the Iwi Health Authorities believe that they are failing to
8 delivery the Cervical Screening Programme?
9 MS TANGIHAERE: They may not be aware but as a result of the Inquiry
10 definitely they will be. I think these calls to Tairawhiti Health Care have
11 been made known but not specifically in this issue. I think there is so many
12 issues in terms of maori health per say in our community, they are taken as a
13 collective rather than a separate issue.
14 MS JANES: So delivery of the cervical screening programme hasn't been
15 taken up separately with Tairawhiti Health Care but as an overall delivery
16 of health services.
17 MS TANGIHAERE: Yes.
18 MS JANES: Does your organisation have a view on what would be an
19 appropriate involvement of maori in delivery cervical screening programme
20 to the women of Tairawhiti?
21 MS TANGIHAERE: Yes, I believe we have grown in terms of capability to
22 deliver health programmes in our community at the time of the beginning of
23 the cervical screening programme maori organisations had not been
24 established to deliver the programme per say but that has been over 12 years
25 now so the organisations are now established to take on the delivery of
26 programmes.
27 MS JANES: So in your view what steps are being taken currently that will
28 ensure better delivery of the cervical screening programme?

1 MS TANGIHAERE: Well it is our wish and our desire to participate with
2 the design and structure of the new district health boards to participate at
3 that level of planning to ensure that the strategic plan ensures operationally
4 that maori participate in every level.
5 MS JANES: And have those steps been responded to well by Tairawhiti
6 Health Care?
7 MS TANGIHAERE: I think there is goodwill in making those steps towards
8 partnering and the delivery of health services.
9 MS JANES: So you would be confident in the future that there would be a
10 better level of involvement?
11 MS TANGIHAERE: Not 100% confident but because of the particular
12 composition of our community and the lack of past empowerment of our
13 maori people, the struggle for sharing of that equitable resourcing will be a
14 struggle for us for the next 10 years. I have every intention of advocating on
15 our behalf, but the realities of this particular community may not enable us
16 to participate in a partnership relationship that we would like to see and
17 aspire to.
18 MS JANES: Based on that are you assured that there are mechanisms being
19 put in place that could work towards that given that it may well be a longer
20 term project.
21 MS TANGIHAERE: The current structuring of the new announcements of
22 this coalition government – we do have some concerns about. The total
23 ability for the district area health board t control the funds for the total
24 delivery of health services puts us in the somewhat tender situation. In
25 previous relationships with the Health Funding Authority maori
26 organisations and specifically iri hawora companies had the right to
27 advocate on their respective iwi behalf directly with an organisation in
28 Wellington and directly with the persons inside different health groups.
29 That objectivity may be lost with a locally elected board and in the

1 restructuring the is no technical partnership arrangement for each iwi to have
2 a separate arrangement with the Ministry of Health .
3 MS JANES: Have these concerns been relayed to the Ministry of Health ?
4 MS TANGIHAERE: Yes they have.
5 MS JANES: You indicate that neither Tairawhiti Health Care or Ngati
6 Porou have been involved in the delivery of services up to this point. Is
7 there now any involvement in the National Cervical Screening Programme
8 apart from the advocacy role.
9 MS TANGIHAERE: To my knowledge there is no set firm funding contract
10 to delivery any of the programme to date, Tairawhiti Health Care through
11 the public health unit still have that role and responsibility, however as per
12 normal, maori are asked to intervene when crisis points hit and in our
13 community both Hawora companies were then consulted to assist with
14 perhaps the remedial palliative care of some of our women who are suffering
15 in our communities. As a result of this crisis, they are now able to help with
16 the maori networks that the mainstream company is not able to facilitate
17 with.
18 MS JANES: And is there going to be an ongoing role in any respect or have
19 approaches been made to sub-contract delivery to?
20 MS TANGIHAERE: Here is our dilemma, we will continue to affeal
21 women regardless of any funding contract in place because we are not
22 detached from them physically. Our companies will continue in whatever
23 way they can with financial assistance but it is our role in the iwi
24 organisations to advocate that they are compensated for their efforts and
25 perhaps specialised contracts for this particular set of circumstances.
26 MS JANES: Is there any ability for smear-takers to come from the
27 hawora?

1 MS TANGIHAERE: I believe we have the capability within our hawora
2 companies to train maori women who would be specifically sensitive to
3 these issues in our communities.
4 MS JANES: In your view is there any benefit for the hawora organisation to
5 carry that out apart from Tairawhiti?
6 MS TANGIHAERE: From the 1991 government policies for the National
7 Cervical Screening Policies there was always a view that maori should
8 participate and deliver for maori. In our region that has not occurred to date
9 so we will still advocate and support that policy and the realities of what we
10 know in our community, we have to actually engage in political activity to
11 get that reality.
12 MS JANES: Just in terms of the Kaitaki which was something that was
13 covered with the takuia prior to your giving evidence, does your organisation
14 have a view on the role of the Kaitaki group. I raise this because we have
15 heard evidence about the Kaitaki being the caretakers of information and
16 there is a sense that perhaps obtaining that information may be an obstacle to
17 meaningful interpretation which could disadvantage maori women in terms
18 of access to health, but does your organisation have a view on the role
19 played by the Kaitiaka and delivery of services to maori women?
20 MS TANGIHAERE: Not my organisation but I personally have a view that
21 Kaitaki group is one of importance in terms of protection of the integrity of
22 the information but also because the women who are asked about
23 participating in the programme may need a sense of security that their
24 information is protected by a group outside of the medical profession. I still
25 believe that the kuia statements are very relevant today because there is an
26 issue about me as a person but also me as a part of a whanau, hapu have to
27 be protected in whatever way possible. The establishment of the Kaitaki
28 group was to ensure that that information and its integrity would be
29 protected. The technical appliance of the statistical information that they

1 might keep is another category altogether but the terms of reference may
2 need to be reviewed in light of the perceived barriers of access to
3 information for this inquiry. However if we reflect on some of the
4 statistical gathering and the compilation of reports, that may be too slow in
5 terms of having timely accessible data for analysis. So some of that
6 perceived barrier to the information might be one of encouraging the
7 necessity of the data compilation to be done in a timely fashion and be
8 available so that the gaps analysis can be done to assist the action on the
9 ground, and I think that's probably where some systematic error has
10 occurred.
11 MS JANES: Thank you, I have no further questions.
12 QD BY CHAIR: Mrs Tangihaere, in paragraph 6 of your brief of evidence,
13 you've said there that the issue from the perspective of the runanga seems to
14 be one of a lack of appropriate resources and that there has been an erosion
15 of quality control systems and a failure of robust monitoring systems that
16 have resulted in pain and suffering for Maori women. Does the runanga
17 have resources itself at its disposal which would enable it to obtain
18 information so that at an earlier stage it could realise something like this was
19 happening?
20 A: No, ma'am, I believe the runanga, and many Maori organisations, are
21 very much operating on a lean and mean budget, and I'm it – I'm the only
22 person really that they employ to monitor such situations as this. This is why
23 the relationship with the Crown agent is imperative for us to have an active
24 access to data, so that we can act as a Kaitaki on behalf of our respective
25 whanau, hapu and iwi. Before the announcements of the restructuring, both
26 runanga of this area were poised to take on that relationship with the Health
27 Funding Authority, but due to the structural changes this in fact has been
28 stopped.
29 Q: Do you know what is ultimately going to be put in its place?

1 A: I believe the Minister has made commitments to the continuance of
2 these relationships. It may be in a new form, however we would like to
3 maintain our independence out of the district health boards to ensure that
4 relationship is strictly with the Crown.
5 Q: Has the runanga approached the Kaitaki Group itself at any time to
6 obtain information?
7 A: Through our officer of Te Puni Kokiri, we have asked for that
8 information.
9 Q: And has the information been forthcoming?
10 A: Yes, it has ma'am.
11 Q: And has it been forthcoming in a timely fashion?
12 A: I believe not.
13 Q: Can you give an example of how long it has taken information from the
14 Kaitaki Group?
15 A: No, sorry, I can't give a definite time period, but because of the urgency
16 for analysis it seemed like a very long time.
17 Q: Would it be months?
18 A: Some weeks.
19 Q: Can you describe the working relationship the runanga has with the
20 Kaitaki Group?
21 A: Actually, we don't have a working relationship with the Kaitaki Group.
22 Q: Would it be of assistance to the runanga if it did?
23 A: I believe it would be of great assistance to our people if we were able to
24 access information that would help our advocacy role.
25 Q: Are you able to say what you see as the impediments or obstacles to
26 your having such a relationship with the Kaitaki Group?
27 A: I believe most of the impediments are basically resource-wise, and
28 seeing that the Kaitaki Group is so small and only meets four times a year,

perhaps they are not adequately resourced to feed information back to the people that deserve to know it.

Q: And have you made these concerns known to the Ministry of Health/

A: No, we have not. We have been asked to consult on the latest policy documents, and that's one of our submissions.

Q: In paragraph 8 of your evidence, you've referred towards of that paragraph about Gisborne being the only area where the Maori enrolment was higher in terms of eligible population and non-Maori enrolment, and you've said, "Despite this situation, resources were not made available for Maori providers, nor for a programme that was more appropriate for Maori women." Could you outline how resources could have been made available and in what way could it have been done more appropriately for Maori women?

A: Yes, para 8 actually covers a wide span of time. From 1991, I believe there was a grant to the Tairawhiti Area Health Board by the Hon Helen Clark, which was to establish the screening programme specifically to service the Maori communities. That was fine, but in 1992 that resource allocation was deemed inappropriate by the then Ethics Committee of Tairawhiti Area Health Board, who in their wisdom, assured the then National co-ordinator that the funds would be best spent in other areas of health – alcohol and drug prevention strategies. So, I believe that the targeted funds, at that time, were not expended for what they were proposed to be for, and I have no evidence to that, only that the evidence presented in Ms Glackin's evidence highlights that area. On the ground, and I am a person who operators on the ground, none of our hauora companies have been contracted to deliver any of the services. I believe in 1995/96 Tairawhiti Healthcare did employ a number of Maori women to be smear-takers at that time. Since then, that workforce has been depleted and I believe there's only one person currently employed in that area.

1 Q: That is a Maori smear-taker by Tairawhiti?
2 A: Yes.
3 Q: What type of working relationship does the runanga have with
4 Tairawhiti?
5 A: I believe it could be better. As I said earlier, it's a matter of resourcing
6 for the runanga to have, what I would call, "proactive" relationships with
7 various agencies, and given that we cover not only health, but socio and
8 economic areas for our people, our own resources to empower a relationship
9 are somewhat limited. However, we try to attend, might I say, at their call,
10 to their issues. And the issues of late relate to the normal things, as
11 pathologists, employment, as the issues around the coroner's requests –
12 those sorts of issues – we are reactive because the healthcare company needs
13 our involvement when it's dealing with the families of the people in their
14 system.
15 Q: From the runanga's perspective, what could it offer Tairawhiti Healthcare
16 if it were not impeded by lack of resources?
17 A: I believe it could actually help with its knowledge of its Maori
18 community, its real connection to communities in terms of our own
19 whakapapa links to our people in our communities; I believe it could offer
20 structural advice and strategic advice in terms of policy development for the
21 services of its community. I believe we have enough knowledge, paid,
22 voluntary and unpaid, to actively give advice to Tairawhiti Healthcare and
23 the Ministry of Health.
24 Q: In paragraph 9 you've talked there about the failure of monitoring and
25 you have referred to how a basic perusal of results concerning Maori women
26 would have shown a reasonably high number of normal smears for Maori
27 women in Gisborne when clearly Maori women in Tairawhiti had the
28 highest incidence at the outset of the programme. If the runanga applied to
29 the Kaitaki Group to get access to information about Maori women's smear

1 reading and then compared it with the incidence of cancer in the Cancer
2 Registry, are you able to say whether or not the Kaitaki Group would release
3 such information to the runanga?
4 A: I believe one of the objectives is to ensure that the health needs of Maori
5 women are addressed. I believe in good faith, if they were explained the
6 situation and the substantive information being imperative to addressing our
7 health gain in our community, I believe that group would give that
8 information.
9 CHAIR: Given the value that such information could have in terms of
10 assessing Maori women's health, can you see that there would be any
11 cultural objection to information obtained from Maori women's smear tests
12 being used in that way?
13 MS TANGIHAERE: Well I am a Maori woman and I have been a person
14 also in this issue of my own smears being misread. I believe that we do need
15 another Kaitaki group for ourselves to monitor indeed what is happening
16 with the community. I don't think any of our women would object.
17 CHAIR: In paragraph 11 on the last page you have said there that the
18 future looks bleak with further restructuring to take place with the
19 establishment of district health boards. Can you say why the future appears
20 bleak to you?
21 MS TANGIHAERE: To me our future looks rather bleak in terms of our
22 population and our demographics are due to exceed those of non-maori in
23 our area for the next ten years. I also believe that the restructuring events of
24 the past have not given any consistency in the delivery of services, therefore
25 the systematic service delivery may be impeded by the overall restructuring
26 of the health sector.
27 CHAIR: From the perspective of the runanga, do you think that the
28 delivery of the National Cervical Screening Programme could be more

effective if it were done by a centralised body rather than being split up between what will now be District Health Boards.

MS TANGIHAERE: Yes I believe that the centralisation of services for maori is an important one. However in respect of our own separate iwi aspiring to do for themselves we as two iwi groups in this area have worked together and will continue to work together to advocate on behalf of all whanau fatinua in our area. Our relationships is robust enough to address the resources issue for maori.

CHAIR: But from a perspective of the runanga wanting to ensure that there was good delivery of the Cervical Screening Programme would you find it better working with a centralised body.

MS TANGIHAERE: Yes I think we would find it a really good arrangement to work with.

CHAIR: You have said before, you have mentioned the importance of having a relationship with the crown, can you say why that is?

MS TANGIHAERE: The crown has its obligations and particularly in article 3 we would want to ensure that that relationship is robust and good faith is practised throughout its allocation of resources. The Ministry of Health will contract and provide funding contracts to the District Health Boards therefore we would like to obtain our independence from having a provider relationship to monitoring the funder.

CHAIR: When you say article 3 you mean article 3 of the treaty.

MS TANGIHAERE: Yes

CHAIR: Thank you. Ms Kapua do you have any re-examination?

MS KAPUA: That concludes the evidence.

CHAIR: Thank you Ms Kapua. We now have some matters of procedure to sort out so I suggest that we take this time now to discuss those matters or procedure. If members of the public and the media want to stay you are welcome to stay.

1 MR HINDLE: At the close of the hearings in May my colleague and I
2 were tasked to conduct a conference in Wellington to try and identify ways
3 in which the hearings might be expedited and to deal with a number of
4 matters arising. A formal minute has been issued and circulated as widely as
5 possible and to that was attached a memorandum which we had prepared
6 and what I propose to do really is to say no more than what is in those
7 documents but I think it important that they be said in those context so all
8 those listening will know what is happening. The first matter of report at a
9 very practical level is that as you will see we have changed the transcription
10 facilities so that those who are now involved can proceed at a speaking pace
11 and the transcript is being typed just a little way away but will be available
12 regularly throughout the day but it means we will be able to make better use
13 of the available time in that way. The second thing which needs to be noted
14 is that your committee has decided that our sitting hours will be five days a
15 week from 9:30 am until 5:00 pm with the exception of Mondays when of
16 course we all need to get here and sittings will be at 10 o'clock or as soon as
17 we are gathered. The next item that we have discussed amongst Council and
18 those representing various parties and people affected concerns the manner
19 in which evidence in chief is brought into the inquiry. In the first block of
20 hearings all of the evidence was read out but unfortunately exigencies of the
21 inquiry and the need to meet the available deadlines are such that we simply
22 don't have the luxury of that time any longer and I am pleased to report that
23 there is a consensus amongst all of those who were at the conference that it
24 would be appropriate to approach evidence on the basis that the written
25 statements now be taken as read so there will be no more reading of the pre-
26 prepared statements but I have asked all of those involved to make it their
27 business to notify you the panel if they have any objection on a case by case
28 basis. I repeat again what I said at the conference, if there are particular
29 reasons why particular evidence should be read, then I ask all of those

1 involved, my friends and those involved in producing evidence to make that
2 known at a time when something can still be done about it if necessary.
3 Hopefully there wont' be any difficulty of that nature and most of the
4 evidence will come in on an as read basis. I hasten to say that isn't intended
5 to cut across the arrangements that have already been replaced in terms of a
6 brief opening statement and Ms Kapua made such a statement this morning
7 and parties and those affected who are able to identify what it is that they
8 want to say to the Inquiry, should in my submission be encouraged to do so.
9 One practical consequence of taking evidence as read relates to the media
10 and the arrangements which have been put in place there, because obviously
11 the media have an interest in the timely release of the information, is that
12 anyone calling a witness is asked to provide three copies, one for the
13 television, one for the radio and one for the print media and my friends have
14 already indicated that they are willing to do that. From my point of view I
15 have no objection to the evidence being provided in advance of it being
16 given provided it is strictly on the basis that it is embargoed, any publication
17 of it whatsoever is embargoed until the evidence is actually called and given
18 to your inquiry and it must be the responsibility, the primary responsibility,
19 of the person calling evidence, to make it clear to the media when that
20 evidence is available for publication and in that way hopefully we can
21 proceed in a pragmatic way with the inquiry. As I say I see this procedural
22 pause in today's hearings to be an opportunity to take any objections or deal
23 with any issues arising out of that. Finally a tentative schedule has been
24 circulated, there is I regret to say one typographical error, Ms Sandra
25 Coney's name was omitted from the list that was circulated. It is as far as I
26 am aware, the order of batting that we are working to but experience shows
27 that these things are going to have to change and few are going to have to
28 juggle witnesses in order to keep the pace of the inquiry on, and I know that
29 my friends and those representing parties will assist the panel in that way.

1 That was all I really wanted to say by way of report from counsel's meeting,
2 and to then leave it to the panel to see whether there's anything any one else
3 wants to contribute.
4 CHAIR: Thank you Mr Hindle. Does anyone else have any comments to
5 make?
6 MR MURRAY: Ma'am, I don't, but as we are first up with more evidence
7 from now on, if there are any other general comments perhaps they could be
8 taken first, but then I could just indicate the four witnesses that we have – if
9 required – and I could just explain where we would go with that evidence.
10 But perhaps I had better pause for a moment in case there are any other
11 general points.
12 CHAIR: Are there any other general comments? [No further comments]
13 Perhaps I should say that this change in process has been brought about
14 because of the time constraints we are under. Dr Duggan leaves NZ on July
15 30, so we really have to complete all the evidence before then, and for that
16 reason it has seemed that it wouldn't be possible to have evidence read out
17 and cross-examined on. So, for this reason, we are now going to accept
18 evidence as read, and then it will be open to any one who wishes to question
19 on any matter of relevance. I understand that this may make it more
20 difficult to follow the evidence, particularly for the media and for the
21 persons sitting in the public gallery, and to the degree that it is difficult for
22 you I apologize for that but we do not have any choice; we simply would
23 not have time to complete the evidence if we carried on in the fashion that
24 we had done earlier. What I do propose, when briefs of evidence are
25 tendered, is before there is any cross-examination, to first give anyone the
26 opportunity to raise any objections to anything in the brief, because
27 ordinarily, if a brief of evidence were being read out, if there was something
28 objectionable at that point in time, any counsel or party appearing before the
29 inquiry would have the opportunity of making a formal objection to the

1 admissibility of the evidence. So, to ensure that those rights are preserved at
2 the beginning of the evidence, before any XXN starts, we will sort out any
3 questions of admissibility. So if anyone does have any concerns of that
4 nature, please feel free to raise them at that point. I realise that by accepting
5 evidence in this fashion it is going to put more pressure on counsel and
6 parties appearing, in the sense that we are going to get through more
7 witnesses each day, but equally issues that have to be raised with those
8 witnesses will have to be covered and prepared for, but we have no choice in
9 that.
10 The point about the evidence being embargoed for the media, I have no
11 objection to briefs of evidence being handed to the media before the
12 evidence is given, but you should be aware of the fact that the protection of
13 privilege which applies in this committee of inquiry only applies to evidence
14 given before the committee. So any publication of any written brief of
15 evidence, before it's actually been formally accepted as evidence at the
16 hearing, wouldn't have that protection. So, it's at anyone's risk, and I will
17 leave it with counsel to liaise with the media as to when the briefs of
18 evidence are distributed. I think it might also be helpful if there was a spare
19 brief of evidence available left with the registrar, that any member of the
20 public who wished to read through the evidence could look at. I want to
21 limit it, just because I'm aware that some of the briefs are fairly thick and it
22 would be quite a task making more than one copy, but I would like to have
23 one copy of briefs available for any members of the public who would like
24 to read through the briefs, and if you want to do so, I suggest you liaise with
25 the registrar about that.
26 In terms of the order of witnesses, you have a schedule, but I would like you
27 to bear in mind that the whole reason for the process we are adoptg now is
28 one of time constraints and, therefore, I want to avoid at all costs a situation
29 occurring where we finish with witnesses early in the day – say about 3.00

1 o'clock – and find that there was no-one else to carry on. That would be
2 unfortunate. So if all counsel could bear in mind that, given the amount of
3 time a witness is going to take will depend very much on the length of XXN,
4 so have other witnesses ready to take their place. I suggest that there be
5 more liaising with counsel at the end of each day as to who is likely to come
6 up – how many witnesses, and the amount of time XXN is likely to take – to
7 allow for better planning.
8 Does anyone have any matters they wish to raise as a result of my
9 comments?
10 MR CORKILL: Just one matter, ma'am, to do with the last point. As you
11 will be aware, briefs from 10 women affected have been filed. The medical
12 records in respect of 7 of those women are now also ready, and the balance
13 will be ready by later in the week. We will be able to interpolate women at
14 short notice, if there is a hiatus or a convenient time, when it would be good
15 to place that evidence before the committee. I just want to flag that so that
16 the committee is aware of it.
17 CHAIR: Thank you, Mr Corkill. Mr Murray, if you could outline the
18 witnesses you will be calling, please?
19 MR MURRAY: Yes, I am working off the schedule that was attached to
20 the committee's minute, and that contains a day by day summary for this
21 week: the four witnesses are Tracy Mellor to start with, then Dr Julia Peters;
22 thirdly, Ms Sandra Matcham, and Mr David Lambie from the Ministry of
23 Health. What I propose is that, with Ms Tracy Mellor's evidence, she would
24 just read the first five paragraphs, just to introduce herself, of her first brief;
25 she has circulated over the weekend a supplementary brief, and despite the
26 indication of not reading briefs there are some advantages in reading the
27 supplementary brief – which is only 10 pages long – and it would just, I
28 think, refocus the inquiry. Given that Ms Mellor is the first witness, it might
29 just re-focus us as it summarises where some of the issues that we covered

1 historically back in May. So there is some advantage there. I must say, I am
2 entirely in the inquiry’s hands, we can take it all as read if that’s what the
3 inquiry wants, but I believe it will actually facilitate our work if the
4 supplementary brief is read today, but on the understanding that there is
5 absolutely no pressure on anyone to cross-examine, because Ms Mellor will
6 come back, and in the third week of the inquiry we have Dr Annabelle
7 Farnsworth and probably Mr Jim DuRose from the Health Funding
8 Authority, and the advantage of Ms Mellor just now reading her
9 supplementary brief is that she will put before the inquiry the further report
10 which follows up the interim report, and this will be important to get this
11 before the inquiry panel, before counsel, so that everyone has it on the
12 record; there's no need to XXN on it, it has got some complicated material
13 in it about colposcopy outcomes. So I emphasise that, reading that 10 pages,
14 would re-focus the inquiry, bring the updated information that the inquiry
15 needs immediately in front of the July hearings, and then any difficult
16 questions can be saved up for later, and I must emphasise with Ms Mellor’s
17 evidence that Ms Tracey Mellor has played a major role in co-ordinating the
18 Health Funding Authority’s response to the Gisborne situation, but she is not
19 a clinician, she is not an epidemiologist, and I cannot emphasise enough that
20 we will waste a lot of time if people try to XXN Ms Mellor on medical
21 matters. That is not to say that those questions shouldn't be asked, but they
22 should be asked of the right people, and Dr Annabelle Farnsworth has
23 committed herself to come over on 18 July, so far as the re-reading work
24 goes; I've had an indication that Mr Ron Jones, the colposcopist/specialist
25 gynaecologist, would like to give evidence, and I will circulate a brief for
26 him. I understand that Dr Cox, who is on the Health Funding Authority
27 advisory committee will be giving evidence anyway and Dr Bruce Duncan
28 will be given evidence for Tairawhiti so one way or another the specialist
29 medical people that have been involved in the Health Funding Authority

1 work are available to be questioned on medical and epidermiology issues.
2 Ms Mellor's evidence is very much about process and getting it to the
3 Inquiry.
4 CHAIR: Mr Murray, your comments that the ten pages of Ms Mellor's
5 supplementary brief would refocus the inquiry is of some concern to me
6 because I am sure that most parties would think that if their witnesses read
7 out their briefs it would help refocus the inquiry again. I don't see that in
8 itself as being a sufficient reason to have this supplementary brief read out.
9 I would be concerned if parties were expected to cross examine upon it
10 today because as I see it by taking evidence as read in circumstances where
11 the briefs are distributed well in advance, in theory it gives every party the
12 opportunity of dealing with any adverse material because if the counsel or
13 person appearing reads the brief of evidence, any adverse issues they want to
14 raise or challenge, that can be done but of course if evidence is circulated
15 very late, it doesn't give people that opportunity.
16 MR MURRAY: That's the distinction with this witness.
17 CHAIR: Yes, well I would see that but if she were going to be cross-
18 examined on the supplementary brief today then I would say the only way of
19 dealing with it, given that it is coming late, would be to have her read it out,
20 but as she is not going to be cross-examined on it today, I don't see that
21 there is a need for her to do so.
22 MR MURRAY: It does have the advantage that the evidence is on the
23 record and later witnesses can therefore deal with it but …
24 CHAIR: That will still happen if the brief is accepted today, it will then be
25 formally in evidence in the inquiry and parties can read it and therefore deal
26 with it. Similarly with the first paragraphs of her briefs of evidence. Having
27 made a ruling that evidence would be taken as read except for limited
28 circumstances where parties are free to apply I wanted that to be truly the
29 exception and there to be strong reasons for doing so and at the moment I

1 can't see how it is really going to advance the inquiry if the early paragraphs
2 of her original brief is read out or the supplementary brief is read out. I'll
3 just canvas any other counsel to see if they have any comments on the
4 matter. Does anyone else have any comments on this? Yes Mr Grieve?
5 MR GRIEVE: I have something … I'm not quite sure if they are
6 comments or questions really … my learned friend has said that Ms Mellor
7 understandably cannot answer technical questions about the matters of
8 statistics or epidemiology that is contained in her supplementary brief and he
9 has given us a list of names of medical people, namely Messrs Jones, Cox
10 and Duncan, although Professor Cox is the exception to that description,
11 who can answer such questions. One of the concerns we have is that is the
12 identity of the person to whom those questions can be asked without getting
13 the answer, well that's not my field. I realise that probably Dr Farnsworth
14 is well qualified to answer those questions but in a way that is going to be a
15 little bit unfair on her because I suspect that she is going to be asked to
16 justify the accuracy of the based material whereas some of the questions
17 will be on the basis of assuming the base material is correct, what are the
18 conclusions to be drawn from it. Now if my learned friend is prepared to
19 indicate that the three witnesses that he has referred to are sufficient well
20 versed in those matters with specialist knowledge so that they can answer
21 the questions, that's fine, I will say no more. The other minor issue is that as
22 I understood it a Mr Viros? from the Health Funding Authority was going to
23 give evidence as well. Histology name hasn't been mentioned, I don't
24 know whether that was just an oversight, but I would have thought that he
25 will be an important witness on the issue of the reliability of the correlation
26 of the Sydney re-reading results with the New Zealand end of the data.
27 CHAIR: Well I have his name on the schedule of witnesses.
28 MR GRIEVE: Yes, its just that he wasn't mentioned until just now.

1 CHAIR: Well Mr Grieve in respect of your concerns really I think that if
2 you have questions you want to ask and you are not sure whether Ms Mellor
3 is the right person or not, I suggest that you ask them and we will wait and
4 see what her answers are and if she is out of her debt she can say so and then
5 we will know for sure. If it turns out that ultimately none of the witnesses
6 put up by the Health Funding Authority or the Ministry of Health can
7 answer your questions you may wish to raise that in your submissions but I
8 think that is probably the safest way of going about it rather than relying on
9 undertakings from Mr Murray about who can answer what etc.
10 MR GRIEVE: I understand the shortcoming in asking but I think he
11 recognises as do others here that it is not fair on Ms Mellor to be asked
12 questions that are quite obviously not in the field of expertise that she has.
13 CHAIR: Yes, but also she can simply say that. If she is out of her debt in
14 any area she can say she is and we will leave it at that. Do I take it, are you
15 actually able to cross-examine her on this supplementary brief.
16 MR MURRAY: No.
17 CHAIR: You're not. Not today. Alright. Look I think on this basis we will
18 accept the first brief today, she is going to come back is she to give
19 evidence.
20 MR MURRAY: Yes
21 CHAIR: I think with the supplementary brief then if you would
22 circulate it, we won't accept it formally today because I haven't seen it yet
23 and I don't know for example whether there is any issue about admissibility
24 so I don't want to accept it in those circumstances. So on that basis we will
25 take her first brief of evidence and I don't see any reason to have anything
26 read out.
27 MR MURRAY: As you please. Just before I call Ms Mellor I should
28 indicate that with the other witnesses, Ms Sandy Matcham, that evidence
29 relates to the register information and that's what the inquiry asked for

1 further evidence about and that brief has been sworn so we anticipated that if
2 there were no questions that it would be taken as sworn evidence to save
3 the witness even coming here. The same with Mr David Lambie, I gather
4 there was some need to question at least Mr Lambie but I just add with Mr
5 Lambie, he has actually been delayed overseas and probably would not be
6 available until later this week so we will have to keep the inquiry panel
7 informed on that.
8 CHAIR: Yes, well he's the one providing information about the
9 performance monitoring isn't he.
10 MR MURRAY: Yes.
11 CHAIR: Well I would imagine certainly the committee will have
12 questions to ask of him, it may also have questions to ask of Ms Matcham
13 too but we will let you know about that.
14 MR MURRAY: Yes. Alright well if everyone is really I am happy to
15 call Ms Mellor now.
16 CHAIR: Sorry yes Mr Hodson.
17 MR HODSON: Yes just before my friend does so I should like to be
18 clear that in light of the comments made by my learned friend Mr Grieve
19 about the status of the supplementary evidence, I first say it this morning, it
20 is quite clear that it contains very interesting and relevant information of a
21 statistical nature about the progress of the investigations and it is at pains to
22 say what it does not do. On the other hand it is not at least in my first
23 reading, particularly clear about what it does mean or say and on that basis I
24 suggest that rather than receiving in evidence so it becomes available for
25 publication, we await the return of Ms Mellor and the availability of – I have
26 counted something like 5 or 6 consultant pathologists who are going to give
27 evidence who can be asked about it – not to mention the obstetrician and
28 gynaecologist at the centre and an epidemiologist, so I don't think Mr Grieve

1 is going to be short of witnesses, but I do have the concern that, as raw data,
2 we don’t know what it means, we only know some of what it doesn't mean.
3 CHAIR: Mr Hodson, the supplementary brief is not being accepted in
4 evidence today; it will be circulated in the way that other written briefs are
5 circulated, so people will be free to read it, and the committee will certainly
6 be reading it in order to prepare any questions that the committee may wish
7 to ask. The whole concern about the brief at the moment is that no-one has
8 had any time to read it. So I think the sooner everyone gets it and is able to
9 digest it the better, but certainly it will not be formally received in evidence.
10 The only brief for Ms Mellor that will be formally received in evidence
11 today is her first brief of evidence.
12 MR HODSON: Thank you ma'am, that sounds entirely satisfactory if I may
13 say so.
14 CHAIR: Yes, and I think, too, the media should be cautious about
15 publishing anything from any supplementary brief, if it is given to you in
16 advance, because it isn't being accepted as evidence at the moment; no-
17 one’s had an opportunity to look at it at all.

1 MR MURRAY called –
2 TRACY MELLOR (Sworn)
3 CHAIR: I think, Mr Murray, if you just take Ms Mellor through, to confirm
4 who she is, that this is her brief, and confirm the contents are true in the way
5 that you would with an affidavit, and then we will deal with any
6 admissibility issues
7 MR MURRAY: Ms Mellor, your full name is Tracy Mellor and you are
8 currently the Team Leader of the Quality improvement and Audit Team in
9 the Personal Health operating group of the Health Funding Authority; are
10 all those details correct?
11 A: Yes, that is correct.
12 Q: And you have a brief of evidence for the inquiry, the principal brief of
13 your evidence, and together with that brief you have 3 volumes of exhibits,
14 which takes us through to you producing Exhibits 1 to 85, is that correct?
15 A: Yes, that is correct.
16 Q: There may be some questions after we have clarified the admissibility of
17 the evidence.
18 CHAIR: Mr Murray, before we ask any questions, I would like to canvass
19 any admissibility issues that anyone might have. There are actually some
20 that I have. A large part of the brief of evidence goes towards explaining the
21 whole purpose of the re-reading, why it was done, and the manner in which
22 it was done. Whereas it is very helpful to have the re-reading from Sydney
23 put into the context, the evidence goes much further than that, and it doesn't
24 seem, in that sense, to be strictly relevant to the terms of reference; it’s
25 really more background material.
26 MR MURRAY: Prepared at the request of counsel assisting, ma'am. The
27 intend there was to give a blow by blow, chronological account of the Health
28 Funding Authority’s response of the Gisborne situation from March last year
29 if anyone needed it. And if they don’t need it, because it’s not relevant to

1 the terms of reference, for example, then the questioning will, in my
2 submission, have to be limited accordingly. The most significant exhibit
3 that we end up with the volumes is the production of the Sydney re-reading
4 results. So there is some context there, and it may be useful for everyone to
5 have that context, given that they have the brief, but if the inquiry indicates
6 that the chronological explanation leading up to that is not all relevant, then
7 questions could be limited accordingly. In my submission, the most relevant
8 part of the brief would be the first few paragraphs – up to about paragraph
9 25 – where the Health Funding Authority evidence covers the discovery of
10 the Gisborne situation. There is then a large block of evidence which need
11 not be traversed, because it is not directly relevant to the terms of reference.
12 The only exception would be engaging the Sydney laboratory and the
13 production of the re-read results in the interim report. If that exchange leads
14 to a ruling about what's relevant and what is it, then that will certainly save
15 time on the first part of this evidence.
16 CHAIR: Yes, well it seemed to me that it is not part of the inquiry's task to
17 comment on how well the Health Funding Authority has responded to this
18 issue, that's not how I read the terms of reference, is that how you see it?
19 MR MURRAY: Yes.
20 CHAIR: And the only other points I had was, I saw that at paragraph 10
21 you referred to the court documents – I think that is Young J's decision?
22 MR MURRAY: Yes.
23 CHAIR: Because that didn't seem to be relevant again to the terms of
24 reference, the fact that there was a court case obviously a matter of fact that
25 we can take into account, but I haven't read the judgement, I don't intend to
26 read the judgement, it doesn't seem to me to be relevant to our task.
27 MR MURRAY: I'm happy with that ma'am. It was relevant to the Health
28 Funding Authority's discovery of the Gisborne situation, that's why it's in

1 the chronological explanation of how the events unfolded and how the
2 Health Funding Authority reacted to them, that’s why it’s there.
3 CHAIR: Thank you, and the other point was paragraph 16, a discussion
4 there about Dr Teague and his view at that time about whether or not there
5 needed to be a review. That, again, doesn't seem to me to be strictly
6 relevant.
7 MR MURRAY: Whether it is or not, ma'am, can be perhaps left over
8 anyway, because I understand Dr Teague and Dr Tie will be giving
9 evidence, so perhaps that can be postponed until we get to that stage.
10 CHAIR: Yes, because we are not here to look at what people thought at any
11 given point of time as to whether the re-reading was necessary or not.
12 Thank you very much. Does anyone have any questions?
13 Ms BUNKLE: On the admissibility issue, I submit that the evidence about
14 Dr Teague and Dr Tie is relevant because the issue of review and their
15 recommendations about review at an earlier time are related to that evidence,
16 and I would also say that the evidence critically – the terms of reference do
17 relate to the contracting function of the Health Funding Authority – the
18 conditions of the contract, and the conditions around quality assurance and
19 responsibility for quality should be admitted from this evidence, even if the
20 whole chronology is not.
21 CHAIR: Yes, Ms Bunkle, there is no doubt that that is right. We are not
22 saying that those issues, in terms of health funding contracts aren’t relevant,
23 it’s just that from the time that the possibility of a misreading became
24 known, the manner in which the Health Funding Authority reacted to that
25 and the steps it took and at what time the steps were taken, falls outside the
26 terms of reference. I am open to be persuaded on that, but that’s my view of
27 them at the moment, and I don’t want us to get bogged down into questions
28 about whether or not the Health Funding Authority did the right thing and at
29 the right time, in terms of the re-read, and the only concern I had about para

1 16, with Dr Tie, it seems that the fact that at an early point in time he
2 thought a re-reading wasn't necessary, the fact is a re-reading did happen. I
3 also don't want to get into a situation where people who are not represented
4 before the inquiry are facing criticisms, perhaps implicit, made of their
5 conduct, which aren't essential to the inquiry.
6 MR GRIEVE: I wonder if I could be heard on that, on this issue that has
7 arisen because of your expressed tentative view about paragraph 16 and Dr
8 Tie -
9 CHAIR: Yes.
10 - made the point that he is representing – he is a signatory to the Royal
11 College statement in giving evidence. Secondly, I support what Mr Bunkle
12 said on this first point and I am in a position or will be in a position, if not
13 right now, I can do it straight after lunch, to address detailed submissions on
14 this if I had to. My submission would be that term of reference number 2
15 warrants the committee of inquiry to identify factors that are likely to have
16 lead to the under-reporting that is defined in terms of reference 1 and it is
17 going to be the submission of half of the women effected that one of the
18 factors that lead to that under-reporting or contributed to it, because it is
19 wider plainly the factors leading to under-reporting are widely than simply
20 Dr Bottrill's practices. As we know we have been looking at the whole
21 gamut of governmental involvement and it is our contention that some of the
22 professionals involved through their early knowledge of the situation in
23 Gisborne contributed to the under-reporting by failing to act appropriately at
24 an earlier time so that what will be submitted is that, in particular, the Royal
25 College through its representatives, doctors Tie and Teague had the
26 knowledge of the Gisborne situation significantly sooner than March or
27 April 1999 and failed to act on that knowledge promptly in a timely way.
28 Now in support of that submission it will be advanced that evidence tending
29 to prove an attitude to state of mind after an event is relevant to prove an

1 earlier existing attitude to any matter and so I submit that the attitude of Dr
2 Tie and Dr Teague will be apparent from Ms Mellor's evidence as
3 representing, specifically Dr Tie, the Royal Collect and Dr Teague – I'm not
4 sure at what capacity he was representing when he spoke to Ms Mellor but
5 they were both their together – in my submission that is relevant to the
6 attitude to the whole matter of the Royal College. Of course with your leave
7 and ruling as to admissibility will be asking questions of Ms Mellor about
8 that.
9 CHAIR: Yes. Thank you Mr Grieve well that is very helpful. It puts the
10 paragraph in another context. One of the reasons why I am raising issues
11 which I see as perhaps questionable in terms of admissibility is because I
12 want to ensure that everyone at the time a brief of evidence is put forward
13 has an opportunity to raise these issues so that there is no misunderstanding
14 and I can see that it could be easier for it to slip through with briefs being
15 taken as read so I would caution you all to read the briefs carefully and to be
16 prepared to take these points yourselves as I can't pick them all up myself.
17 MS PHIPPS: As Counsel representing the College I have not seen
18 this paragraph 16 nor the brief of evidence …
19 CHAIR: Well thank you. This brief of evidence was circulated at the
20 inquiry last time when you sat before so you may not have seen it but
21 certainly I had it available to me before we adjourned and let that be a
22 warning too that do read the briefs in advance. You will have to. So I had
23 hoped that we new way of doing things we would move through things but
24 we tend to get bogged down procedurally so perhaps now we will move
25 through so who would like to question Ms Mellor first?
26 MR GRIEVE: Well, I don't mind ….
27 CHAIR: Yes Mr Grieve.

1 MR GRIEVE: Ms Mellor is apparent from your brief of evidence that
2 the Health Funding Authority first began to get wind of a problem in
3 Gisborne some time in March of 1999, is that correct?
4 MS MELLOR: Yes, that's right.
5 MR GRIEVE: And although it is not entirely clear precisely when that
6 was, you got a letter in fact from me on the 1 of April didn't you, that is
7 referred to in paragraph 8 of your brief.
8 MS MELLOR: Yes, that's correct.
9 MR GRIEVE: Am I right that as a result of that plus reading into some of
10 the things that you have said in your brief as a result of perhaps other
11 information that was filtering through, the Health Funding Authority
12 decided to do something about it, is that right?
13 MS MELLOR: Yes, that's right.
14 MR GRIEVE: And so can I assume that the letter that you received
15 from me was taken seriously by the Health Funding Authority .
16 MS MELLOR: Absolutely, yes.
17 MR GRIEVE: And acted on, along with other reasons for so acting.
18 MS MELLOR: There were a number of pieces of information which
19 came to us around the same time.
20 CHAIR: Sorry to interrupt, could you say what those other pieces of
21 information were.
22 MS MELLOR: We had information from media articles which I
23 believe were around the Court case and we were also approached by Dr
24 Bruce Duncan who is effectively the medical officer of health for the
25 Tairawhiti region with information about some other cases which appeared
26 to be similar.
27 MR GRIEVE: Now I was going to come to that, you refer to that at
28 paragraph 11 of your brief giving the date of 15 April as being the day you
29 were contacted by Dr Duncan, is that right.

1 MS MELLOR: Yes.
2 MR GRIEVE: And in that paragraph you refer to the fact that he had
3 been made aware of, as you state "another case involving the same
4 pathologist".
5 MS MELLOR: Yes.
6 MR GRIEVE: So was it just one other case or other cases as you said a
7 moment ago.
8 MS MELLOR: It was other cases, I think at this stage we were not
9 clear whether it was one or more.
10 MR GRIEVE: Right. And where you given any details of that other
11 case, and I just want you to understand at the moment I am not asking you to
12 tell us the name but did you have a name, a patient name.
13 MS MELLOR: No.
14 MR GRIEVE: But it wasn't long before you got patient name or
15 names was it? (pause) Perhaps I should be a little more clear, was it at the
16 meeting in Gisborne that you had with the general practitioners on 26 April
17 referred to in paragraph 17 of your brief.
18 MS MELLOR: I don't believe at that stage I was aware of names at all.
19 If you look at paragraph 17 it says information about further misread slides
20 was brought to my attention in a way which did not identify the women but
21 provided evidence to inform the development of the project plan, so
22 we didn't know the names of the women we had details of their cases.
23 MR GRIEVE: Sorry, my microphone is causing problems. Oh its not
24 mine, its yours. Could you move a bit closer please, we can't hear your
25 answers. Perhaps lift it up a bit, just a fraction. Give it a push it is pretty
26 robust.
27 MS MELLOR: Is that better?
28 MR GRIEVE: Yes.

1 CHAIR: Its actually not that much better. Madam Registrar is there
2 anything we can do?
3 (microphone adjusted)
4 MS MELLOR: Is that better?
5 MR GRIEVE: That's better. Alright so am I right that as at 26 April
6 you didn't have patient names?
7 MS MELLOR: That's right we had details about cases as opposed to
8 names of patients, yes.
9 MR GRIEVE: Right, now I am sorry to be a bit obtuse about this but
10 what do you mean by details of cases if you didn't mean names?
11 MS MELLOR: We had the information about the women so we had
12 some information about the fact that the women had had smears originally
13 read and that there appeared to be some misreading but to be able to act on
14 that information I did not need to know who those women were and so that
15 was not information that was given to me at that time.
16 MR GRIEVE: You mean you were prepared to do something about the
17 potential problems without having names.
18 MS MELLOR: I had sufficient information from the medical
19 practitioners responsible to ensure that there was enough there that we had to
20 act on yes.
21 MR GRIEVE: Right, so that coming forward to paragraph 19 of your brief
22 for a moment, because I have got to go back, but coming forward to 28 April
23 when you met with Dr Teague and Tie you still didn't have names.
24 MS MELLOR: No.
25 MR GRIEVE: But you knew that there could be or were other cases in
26 addition to patient number 1?
27 MS MELLOR: We were quite clear from the information that we had
28 that we were not talking only of patient no. 1.

1 MR GRIEVE: If you would just go back please to your exhibit 6
2 which you refer to at paragraph 12 of your brief. In that paragraph you
3 explain how you really got approval to move ahead with your investigation
4 don't you.
5 MS MELLOR: Yes.
6 MR GRIEVE: And then exhibit 6 is your report or a definition of the
7 problem as you saw it.
8 MS MELLOR: Yes it was an initial project brief.
9 MR GRIEVE: Alright. And if you look at page 3 of that document at
10 the end of the first paragraph you refer there don't you about being made
11 aware of other complaints. See that.
12 MS MELLOR: I'm sorry, on the …
13 MR GRIEVE: First paragraph under the heading background to case,
14 last sentence "we have also been made aware of other complaints …."
15 MS MELLOR: Yes.
16 MR GRIEVE: Now then you go on to say, and this as I understand it is
17 a document prepared by you on 20 April according to its date on page 1, you
18 go on to say at page 4, just above the heading media interest in the case, you
19 refer to your contact with the Royal Australasian College of Pathologists, do
20 you see that.
21 MS MELLOR: Yes.
22 MR GRIEVE: And you say that the President, Dr Tie has indicated
23 that he does not support our proposals and you are awaiting a copy of a letter
24 from him which he was in fact going to send to me in reply to my letter to
25 the College, correct?
26 MS MELLOR: Yes, that's correct.
27 MR GRIEVE: Can you tell me please about the nature of your contact
28 with the College and presumably Dr Tie.

1 MS MELLOR: At that stage it had simply been a telephone, I believe
2 one maybe two telephone conversations with Dr Tie. We met with him
3 later in April to discuss the situation in more detail.
4 MR GRIEVE: So at this stage sometime around about, well its got to
5 be prior to the 20 doesn't it, you made your first contact with the College
6 through its representative Dr Tie.
7 MS MELLOR: yes.
8 MR GRIEVE: Some phone calls.
9 MS MELLOR: Yes.
10 MR GRIEVE: And he then told you, what, at your initial discussion,
11 that the College didn't support your proposal to re-read the smears?
12 MS MELLOR: That would be my recollection, yes.
13 MR GRIEVE: Did you tell him that the primary Health Funding
14 Authority purpose in conducting the re-read was to protect the health of
15 Gisborne women about which you had concerns.
16 MS MELLOR: I couldn't be sure that that was a part of the initial
17 conversations. I advised from a range of sources as to what the Health
18 Funding Authority could or should do. Certainly, when we met with Dr Tie
19 and Dr Teague later in April –
20 MR GRIEVE: I will come to that. I want you, please, to focus on these
21 early discussions.
22 A: I couldn't say whether that was what we had talked about at that stage, it
23 was one of a number of phone calls in a very short space of time.
24 Q: Were you aware, then, about, for example, the British experience about
25 which we've heard from Professor McGooghan, Inverclyde or Kent and
26 Canterbury – did you know about those inquiries?
27 A: Prior to the beginning of March, I had no knowledge beyond anybody
28 else in relation to cervical screening. So at that stage, no. Early in April, as
29 it became clear that we needed to take action in relation to this case, I took

1 steps then to try to find out a little bit, and as is indicated in the first project
2 brief, it looked at some information to do with the Kent and Canterbury
3 situation. At that stage I wasn't aware of Inverclyde.
4 CHAIR: Is there a date on the project brief?
5 MR GRIEVE: On the front page, ma'am, 20 April.
6 A: I think it would be fair to say that there were people in the public health
7 operating group of the Health Funding Authority who would have
8 considerably more knowledge of those cases than I, at that time, and they
9 were advising me in terms of the detail of developing this project.
10 Q: Well, let me ask you this: Dr Tie told you his view. Was it his view or
11 the College's view – did he tell you that?
12 A: I don't think I'd be able to distinguish at that stage.
13 Q: All right, well, let's assume that it was his view, speaking for the
14 College. Did he tell you why it was that he didn't support the steps you were
15 proposing?
16 A: We are still talking specifically about the early telephone conversations?
17 Q: Yes.
18 A: I have to say it's a little difficult for me to recollect details of those, but
19 I believe it was on the basis of the false negatives. So the basis that any
20 pathologist could miss cases which could be found on reviewing those cases.
21 CHAIR: Mr Grieve, if you could just pick a time that is convenient for you,
22 because we are at 1.00 o'clock now.
23 MR GRIEVE: Thank you, Madam Chair. He was obviously, at the time of
24 these early discussions, aware of the patient one case, wasn't he?
25 A: Yes.
26 Q: Did you make him aware of the fact that, to your knowledge, there were
27 likely to be other cases in addition?
28 A: I think I'd have to check back through my records, the evidence, to be
29 clear about exactly what happened and when. Things happened very quickly

1 at that point, and we weren't immediately aware of the other cases; things
2 happened over a period of a few weeks.
3 Q: You see, what I am trying to just ascertain whether this was, to put it
4 bluntly, a knee-jerk, closing of the ranks by the College, or whether it was an
5 informed objection, based upon some sort of appropriate evidence for
6 opposing what you were going to do.
7 CHAIR: Mr Grieve, how can this witness answer that question? She would
8 be giving us her opinion on the view she formed of Dr Teague at that time.
9 You are permitted to ask Dr Teague that question, certainly, but we are in no
10 position to evaluate her judgement on what was motivating Dr Teague.
11 MR GRIEVE: I will get at it another way.
12 CHAIR: If she can describe body language or something like that, which
13 would allow us to come to a certain conclusion, fine, but I can't just rely on
14 her opinion of what she thinks was driving Dr Teague.
15 MR GRIEVE: I accept that, and that's probably a convenient time. Could I
16 just ask the witness if you've got your notes that you've just mentioned
17 available, could you look at them over the lunch break, please.
18 CHAIR: We will adjourn until 2.15.
19
20
21 LUNCHEON ADJOURNMENT 1.02P.M. – TO 2.15P.M.
22
23 MR GRIEVE: During the course of those discussions it became apparent
24 that he knew of any cases in addition to patient one?
25 A: No, it's quite clear, I don't have any additional notes with me but I have
26 gone back through the project brief and on p4 there it's quite clear that I've
27 said that Andrew Tie had not been aware of any other allegations against the
28 pathologist, Dr Bottrill.

1 Q: All right. That leads on to the next question, then. During those
2 discussions, did you tell him of the other cases, or case, about which you had
3 some knowledge?
4 A: I believe that at that point we would have – I would have indicated to
5 him that we believed that there were some other concerns, but it wasn't until
6 I'd met with Dr Duncan up in Gisborne that I had any details about that, and
7 it was after that meeting that we met with Dr Tie and talked to him in some
8 detail about the wider issues.
9 Q: So just to get the chronology right, your meeting with Dr Duncan was
10 on the –
11 A: The 26th
12 Q: And that was a meeting attended by other GPs in Gisborne, wasn't it?
13 A: Yes.
14 Q: And your notes of that meeting appear at your exhibit 8?
15 A: Yes.
16 Q: And, in particular, does the information that's recorded at the top of the
17 first page of Exhibit 8, is that the information that you got from Dr Duncan?
18 A: Yes, that's right, the notes are of that meeting.
19 Q: They are your notes, are they?
20 A: Yes.
21 Q: And he gave you, according to the notes, information about a specific
22 patient, although no name is mentioned? It would appear that she was a
23 patient of Dr Pauline Smales?
24 A: Yes.
25 Q: And that there were 3 smears, 1991, 1993 and 1996 involved, correct?
26 A: Yes. With just the two from 1993 and 1996 appearing to be those to
27 have been read initially by Dr Bottrill.
28 Q: I think, in fact, factually that's slightly incorrect.

1 A: that was what was recorded at the time. That was what I understood at
2 the time.
3 Q: You've got further information subsequent to that about this patient,
4 haven't you?
5 A: I would imagine that I have, but I haven't connected these notes with the
6 records of any individual woman, so I still don't know who this woman is,
7 consciously.
8 Q: Well, would you look, please, at your Exhibit 9. You see the reports
9 from Hamilton Medlab, or a report, dated 12 April 1999
10 A: Yeah.
11 Q: The Dr concerned is Pauline Smale – you see that?
12 A: Uh huh.
13 Q: And the three smears about which the Hamilton laboratory re-read are
14 91, 93 and 96 smears? Do you see that?
15 A: Yes.
16 Q: And it makes it clear that although the report is dated 12 April 1999, the
17 1993 smear was re-read by Hamilton in October 1998. You see the note for
18 the 93 smear, a recent review of this slide at Medlab Hamilton of October
19 98.
20 A: Yeah.
21 Q: And that was one where Dr Bottrill had reported initially as
22 "satisfactory, no atypical cells", Hamilton reported it as high grade
23 malignant?
24 A: Yes.
25 Q: did you relate that report in your mind to the note that you recorded of
26 information from Dr Duncan?
27 A: Yes.
28 Q: Do you now know the identify of that woman?
29 A: I don't believe so. If I do, I don't recall.

1 Q: All right. Will you accept it from me that it will be established that the
2 woman is known to this inquiry as Patient Number 9?
3 A: Yeah.
4 Q: Now, two days after this meeting in Gisborne you met with doctors Tie
5 and Teague and that is referred to in paragraph 19 of your brief, isn't it, that
6 meeting?
7 A: Yes.
8 Q: Now, you say in paragraph 19 that a number of matters were discussed?
9 A: Yes.
10 Q: Quality assurance mechanisms associated with labs?
11 A: Yes.
12 MS MELLOR: Yes.
13 MR GRIEVE: Do you remember what was said about that?
14 MS MELLOR: Not specifically although I believe one of the things we
15 were talking about there was what's called an external quality assurance
16 process whereby laboratories read a sample of slides.
17 MR GRIEVE: Right. I take it that the purpose of this meeting was to
18 enable the Royal College Representatives to give you their views about your
19 proposal to re-read. Is that right?
20 MS MELLOR: Yes. For us to get a better understanding of their work
21 and their perspective.
22 MR GRIEVE: Of their work did you say.
23 MS MELLOR: Their work.
24 MR GRIEVE: You mean in connection with this Gisborne matter or in
25 general.
26 MS MELLOR: No in general. As I said before I didn't have previous
27 experience of cervical screening programmes and neither did Jim DuRose so
28 we were taking every opportunity to learn more as we went along.

1 MR GRIEVE: Well now you knew from your earlier involvement with
2 Dr Tie on the phone that he did not support the Health Funding Authority
3 proposal. What was said about that at this meeting.
4 MS MELLOR: As I have indicated in my evidence I don't have notes
5 of that meeting but my recollection is that we discussed a number of issues
6 and that both Dr Tie and Dr Teague accepted that from the Health Funding
7 Authority perspective it was important to do any reading of some sort
8 although they did not believe that the evidence that they had at that time
9 supported that that was necessary in itself.
10 MR GRIEVE: Did they tell you what evidence they had?
11 MS MELLOR: My understanding was that they had information about
12 patient no. 1 from the initial court case and the disciplinary hearing which
13 Dr Teague had been involved in and we gave them some further
14 information which we had by then about the suggestion that there were other
15 cases.
16 MR GRIEVE: Right. Now there was also an indication that you would
17 be sent a copy of the College's response addressed to me. Correct.
18 MS MELLOR: Yes.
19 MR GRIEVE: And you got a copy of that letter which is in your
20 bundle of exhibits no. 7.
21 MS MELLOR: yes.
22 MR GRIEVE: And without going into all the detail, could I summarise
23 by saying that in that letter the College records its view about why there
24 shouldn't be a re-reading based upon the facts relating to patient 1's case.
25 MS MELLOR: Yes that's right.
26 MR GRIEVE: Presumably, although your meeting pre-dated your
27 receive of this letter, they re-iterated, did they at the meeting, the substance
28 of what is in that letter.
29 MS MELLOR: Yes, a very similar approach, yes.

1 MR GRIEVE: Alright. Did you regard it as significant that you were
2 getting information about cases additional to patient 1's.
3 MS MELLOR: Yes.
4 MR GRIEVE: And when you made that information known to Dr
5 Teague and Tie did they reappraise their assessment of whether the re-
6 reading proposal should be supported?
7 MS MELLOR: I think it would be fair to say that, as I have already
8 said, they acknowledged that we would and should do the re-reading
9 whether they reconsidered their view I think is probably not something that I
10 can comment on.
11 MR GRIEVE: Well … their acknowledgement that it should go ahead
12 was independent of their view that they didn't support it, wasn't it. They
13 thought it should go ahead for public relations reasons.
14 MS MELLOR: They agreed that it was important that people could
15 have confidence in the work done by laboratories and the whole of the
16 programme and for those reasons it should go ahead.
17 MR GRIEVE: But what I am asking you is this. Having been told by
18 you that to your knowledge, albeit sketchy at the time, there were other cases
19 as well as patient 1, did they say anything to you at the meeting which
20 indicated that they were prepared to in the light of that additional
21 information re-assess their support of otherwise for the Health Funding
22 Authority proposal to re-read?
23 MS MELLOR: I think their position in terms of their support for the
24 reasons why we did it did not change.
25 MR GRIEVE: Alright. Thank you.
26 CHAIR: What did you base that view on?
27 MS MELLOR: That they continued to indicate that they did not feel
28 that there was sufficient evidence of under-reporting by the individual
29 pathologist to warrant the re-reading.

1 CHAIR: They said that to you did they?
2 MS MELLOR: At the meeting that would have been.
3 CHAIR: Thank you.
4 MR GRIEVE: Now you said that you passed on or gave some
5 indication that you were
6 A: I couldn't be absolutely sure of the detail, it basically would have been
7 that same sketchy information that we've just referred to that at that stage we
8 were beginning to collect, so we weren't able to give them very detailed
9 information, it was simply a collection of views that there were other cases
10 that were beginning to emerge – there was nothing specific, I don't think at
11 that stage, that we could give them. It's difficult to recall. A great number
12 of things happened in a very short space of time and a lot of people's views
13 changed very quickly. To actually getting back to pinning down what and
14 when is really quite difficult.
15 Q: Did you pass on the detail of what you've recorded of what Dr Duncan
16 told you two days before?
17 A: Yes, I would have had the notes of the meeting with Dr Duncan with me
18 at the time.
19 Q: that's not quite what I asked. I understand that you would have had
20 your notes, but did you tell doctors Teague and Tie, for example, that there
21 was another case, a patient of Dr Pauline Smale, three smears, 91, 93 and
22 96?
23 A: I have to say I cannot recollect that meeting in sufficient detail to be
24 sure.
25 Q: Did Dr Teague tell you that he knew already about that case?
26 A: No, I don't believe so.
27 Q: You'd remember that sort of thing, wouldn't you – the coincidence of it,
28 you getting information about a case from Dr Duncan two days earlier and
29 then being told, when you passed that on by Dr Teague, that he knew of it as

1 well. I suggest to you that that's something that, if it occurred, you would
2 remember?
3 A: Yeah, I'm getting half a memory back, and I'm sorry, I would have
4 thought I would have remembered that and I don't. But I have a recollection
5 of something of a discussion and I can't quite put my finger on quite what it
6 was I'm sorry.
7 CHAIR: How significant would it have been to you at the time if Dr
8 Teague had told you that he knew of someone else?
9 A: I think it would have been significant, because we had already
10 understood from Dr Tie that they were not aware of other cases. If I can just
11 – the question that's in my head at the moment, there was some discussion, I
12 believe, with Dr Smale, that she had asked for this case to be referred to the
13 College, to go through their process which they've set up whereby cases that
14 are subject to any sort of judicial type processes can be re-read in an
15 anonymous way, in a number of different laboratories. Now, I think that
16 when that was raised with the college, that they did not have an awareness of
17 that and it appeared that that process had not been followed through, but it's
18 not something that I recorded and can go back and confirm, so that's why
19 I'm hesitating because I do believe there was sort of a discussion, and what I
20 can't get to in my head is quite blocked out what that was. So I believe that
21 we had expected that there would have been some awareness somewhere in
22 the College of this process, but I'm not sure that I ever got to a conclusion as
23 to whether it was or wasn't.
24 MR GRIEVE: And there's something of that, I suggest, in the top right
25 hand corner of your note of Exhibit 8, where you say, or record, "Dr Pauline
26 Smale advised this re-reading slide from 93 would be referred to Royal
27 College of Pathologists of Australasia Clint Teague
28 A: Yeah, so that's that same discussion, yeah.

1 Q: Yes. But to the best of your recollection, at least now, you can't
2 remember that Dr Teague mentioned this to you at this meeting on 28 April?
3 A: I think that it hadn't got that far, and I think that we thought there must
4 have been some breakdown in the system and I didn't pursue it any further
5 than that. So I think that would be where that would have been left.
6 CHAIR: Ms Mellor, your note of Dr Smale sending something to the
7 College is recorded on 26 April, isn't it?
8 A: Yes.
9 Q: And so your meeting with Dr Teague was two days later.
10 A: After that, yeah.
11 Q: Do you have any knowledge when Dr Smale referred this slide for re-
12 reading to the college and to Dr Teague?
13 A: I think it would have been at the time that the slide was re-read, which is
14 going back to I believe October 98.
15 MR GRIEVE: That's what the report says.
16 A: So there's quite a time – it wasn't immediate. It hadn't been referred in
17 the immediate past.
18 Q: Did you get the impression, from what he said, that Dr Teague agreed
19 with Dr Tie's lack of support from the proposal to re-read?
20 A: I had no reason to believe that I was getting different views from
21 different people.
22 Q: Did you know, when you had this meeting, that Dr Teague had given
23 evidence at the High Court trial in Auckland for Dr Bottrill?
24 A: Yes.
25 Q: In your appendix 2 of your interim report of 6 March 2000, where you
26 deal with the criteria for laboratory selection, this is when you chose the
27 Sydney laboratory, one of the criteria was "no demonstrable conflict of
28 interest". Did it occur to you that Dr Teague might have a demonstrable

1 conflict of interest when supporting the view that the Health Funding
2 Authority shouldn't go ahead with the re-read?
3 A: When we met with Dr Teague we were aware that he had acted for –
4 given evidence for Dr Bottrill in one case, and against Dr Bottrill in another,
5 and at that stage we were happy that that demonstrated a balancing of the
6 conflicts in terms of the advice we were receiving at that stage.
7 Q: the fact that he had changed sides?
8 A: He had, in effect, been objective.
9 MR HODSON: My friend is indirectly attacking the character of Dr
10 Teague, who I called as a witness in the litigation. And as my friend well
11 knows, and as the witness just said, he gave evidence for patient No. One at
12 the disciplinary hearing. It is entirely inappropriate of my friend to make a
13 suggestion that he "changed sides". The position is, as my friend well
14 knows, is that he was called as an independent expert witness and he gave
15 the same evidence essentially of what he had done both times. He was then
16 cross-examined from different points of view. That's all there is to it.
17 CHAIR: Who called him at the disciplinary hearing?
18 MR HODSON: The predecessor to my friend, Mr Wilson QC acting for
19 patient No. One.
20 CHAIR: Well, in any event, he was called as an independent expert witness
21 by Patient Number One's counsel in respect of one hearing where Dr
22 Bottrill's conduct was in question, and in another hearing he gave evidence
23 for Dr Bottrill?
24 MR HODSON: In the same capacity.
25 CHAIR: Yes, well I have no objection to the questioning continuing.
26 MR GRIEVE: I am not going to pursue it.
27 CHAIR: You will have to take these matters up with Dr Teague if you want
28 to rely on them?

1 MR GRIEVE: I will be certainly doing that Madam Chair. Was Dr
2 Teague present at the meeting with you as a representative of the College or
3 was he there as an expert that the Government had relied upon over the
4 years? What was his capacity as far as you saw it?
5 MS MELLOR: We had asked to meet with the representatives of the
6 College but were aware that Dr Teague had had this involvement with this
7 particular case and so I guess we were viewing him in those capacities not in
8 terms of his previous involvement with the programme to any great extent.
9 MR GRIEVE: So am I right in the assumption that it was the College's
10 decision to have him come along with Dr Tie rather than yours.
11 MS MELLOR: Yes.
12 MR GRIEVE: We have been served with a statement from the Royal
13 College to which one of the signatories is Dr Tie and he said that, or he will
14 say, according to that statement, that on 8 May he issued a press release
15 supporting the FHA review. Did you have any subsequent dealings with
16 him after 28 April in which he told you that he supported the review?
17 MS MELLOR: I had a number of telephone conversations with Dr Tie
18 after 28 and as I have previously said he had acknowledged on 28th that we
19 would have to do the review so he had not objected to the review even
20 though he had said he didn't believe it was necessary - we then continued to
21 keep in touch so they knew the action that was being taken by the Health
22 Funding Authority, yes.
23 MR GRIEVE: Just one question arising out of your supplementary
24 evidence. At page 18 of exhibit 87 which is the action update report you
25 refer to getting statistical advice. From whom did the Health Funding
26 Authority get statistical advice.
27 MS MELLOR: I'm sorry I'd need to have a look at it.
28 MR GRIEVE: Oh you don't have a copy.
29 MS MELLOR: No, I didn't think I was doing ….

1 CHAIR: The committee doesn't either.
2 MR GRIEVE: It's the only question, Madame Chair, I am not going to
3 expand I just want to know.
4 MS MELLOR: Where am I looking?
5 MR GRIEVE: Page 18 of exhibit 87 which is the action update report
6 under paragraph 7.5 data quality.
7 MS MELLOR: Oh OK the statistical advice on the sampling protocol?
8 MR GRIEVE: Yes.
9 MS MELLOR: That was done by an analyst from within the Health
10 Funding Authority . I'm not sure exactly who the person was and that was
11 simply on determining a sampling protocol for our audits.
12 MR GRIEVE: You would accept obviously that there are complex
13 statistical issues surrounding the analysis of all these comparative results
14 aren't there.
15 MS MELLOR: Absolutely and that is not what this is referring to. This
16 is simply referring to statistically advice on a sampling protocol for us to be
17 able to determine the number of cases to audit to be sure of our data quality.
18 This is not about analysis of the information.
19 MR GRIEVE: Right. Thank you Madam Chair.
20 CHAIR: Thank you Mr Grieve. Yes Ms Bunkle.
21 MS BUNKLE: Ms Mellor in your evidence you include a copy of my
22 press release of 29 April. It is exhibit 10. In that press release I called for a
23 review of all the relevant smears. Do you recall a telephone conversation
24 earlier that day in which I asked you questions about review of the smears?
25 MS MELLOR: At this stage I can't specifically recall a conversation
26 but if you ask a question it might well trigger the specifics.
27 MS BUNKLE: Do you recall telling me that you had received
28 professional advice that such a review was not necessary?

1 MS MELLOR: That certainly would have been the position at that
2 stage yes.
3 MS BUNKLE: Do you recall telling me that the advice had been
4 offered by Dr Teague?
5 MS MELLOR: I don't specifically recall but I am quite happy to accept
6 that that could well have been what I said yes.
7 MS BUNKLE: At what point subsequent to our conversation did you
8 conclude that such a review of smears would be a good idea?
9 MS MELLOR: Prior to that conversation we had agreed the initial
10 project brief which was to undertake a review of a sample of slides. At the
11 time that I was talking to you we were in a process of moving from that view
12 to a recognition that there were actually a range of views as to whether that
13 was an appropriate way to go into the establishment of the advisory group
14 which has guided us since the beginning of May and it was the first meeting
15 of that advisory group which recommended to the Health Funding Authority
16 that we should in fact review all slides and not the sample of slides that had
17 initially been proposed so what I was indicating in that conversation was one
18 of the different views that we were becoming aware of which meant that the
19 initial proposal was unlikely to proceed.
20 MS BUNKLE: Thank you. In your evidence you present my press
21 release of June 2nd. Its exhibit 31 and in that press release I give some
22 details of a conversation I had with you during the lunch period of June 2nd.
23 Do you recall me asking you whether Dr Bottrill was still contracted by the
24 Health Funding Authority as a supervising pathologist in Gisborne?
25 MS MELLOR: Yes.
26 MS BUNKLE: Where you able to answer that question immediately?
27 MS MELLOR: No, that was the first time that I had personally realised
28 that Dr Bottrill's name was still on the contract, although I was confident at
29 that stage that he hadn't been doing pathology work. Your questions clearly

1 raised the question, which we then needed to confirm, as to whether he had
2 been doing any work in relation to the laboratory.
3 Q: So, at that time you were not aware, until I asked the question, that he
4 was listed in the contract as the supervising pathologist?
5 A: It wasn’t something that I was personally aware of at that stage, no.
6 Q: when I asked you about why he was listed in the contract, one year after
7 he had retired from practice, do you recall telling me that it was because the
8 contracts had simply been rolled over?
9 A: I can't recall specifically, but I would imagine that would have been my
10 understanding that contracts had continued, and that is my understanding.
11 Those contracts continued. That contract, from 1996, then continued until
12 very recently.
13 Q: Were you able to give me an assurance that there were no other doctors
14 who were not, who had retired from practice or no longer held a valid
15 practising certificate still listed in specialist capacities on Health Funding
16 Authority contracts?
17 A: it’s difficult for me to remember specifically what I said to you at the
18 time, but certainly my recollection was that on becoming aware of the fact
19 that Dr Bottrill’s name was on the contract, that it was something that we
20 needed to check throughout that contract. We did that immediately.
21 Q: When you told me that the contracts had simply been rolled over, do you
22 recall telling me that there was no process of ensuring compliance with
23 quality assurance in the monitoring of your contracts?
24 A: I’m sorry, can you repeat that question?
25 Q: When I asked you about why the contracts had simply been rolled over,
26 I asked you whether you had any way of being sure that the quality
27 assurance guidelines had been met in your contracts. Do you recall your
28 answer?
29 A: No, I’m sorry.

1 Q: I will try and put it another way. My recollection is that you told me
2 there was no mechanism for reviewing the contracts for compliance with
3 quality assurance. Do you think that that's an answer that is true?
4 A: What I would have expected was, I would have talked about there not
5 being a detailed process of checking all parts of the contracts and therefore
6 checking that those names were names that could and should be on there;
7 that's something that would have been left to the responsibility of the
8 individual laboratory, to keep us informed rather than for us to have actively
9 gone to them to check. So, I think that's a very specific piece of the contract
10 as opposed to a wider quality assurance statement which I would not expect
11 to have made.
12 Q: Thank you, your answer actually is what I recall too, and it's a more
13 accurate statement of what I was wanting to say.
14 CHAIR: Does this mean that the Health Funding Authority was relying on
15 laboratories to come forward to it and advise it when a medical practitioner
16 in charge of the laboratory ceased to be on the Register?
17 A: Yes, that would be the case.
18 Q: why were you relying on the laboratories to do that rather than taking a
19 proactive approach yourself?
20 A: I would need to check the specific contract, but I believe in all contracts
21 – and I believe there are many, many contracts which we have with
22 providers – that that would be an expectation on them. So their contract puts
23 requirements, in terms of the qualifications and experience of their
24 individual practitioners and it would then be for them to keep that up-to-
25 date. We would expect to check that perhaps on an random audit basis
26 rather than on a routine all contracts basis.
27 Q: well, what type of checking process do you have in place in order to
28 ensure that the people you contract with are actually discharging their

1 contractual responsibilities in that regard and advising you of changes within
2 their institutions when they arise?
3 A: I don't believe there is a formal process to check that with every
4 contract.
5 Q: So you are relying on the responsibility of the person you've contracted
6 with?
7 A: Yes.
8 Q: And if that person does not act in a responsible manner, would you
9 agree that the Health Funding Authority could be vulnerable, in terms of the
10 contractual expectations it might have not being carried out?
11 A: In a sense, yes, but the Health Funding Authority has a whole series of
12 arrangements whereby we do have relationships with providers, we have
13 locality teams where the members of those teams their job is to manage the
14 contracts and to have an ongoing relationship with providers which would
15 enable them to be aware of major changes and issues.
16 Q: Who are those people?
17 A: They are called locality managers. There are teams of locality
18 managers, 5 teams throughout NZ.
19 Q: And who employs them?
20 A: For each operating group. So, the personnel health operating group has
21 a team of locality managers for each of its districts.
22 Q: Are they Health Funding Authority employees?
23 A: They are Health Funding Authority employees, yes.
24 Q: What I am trying to find out is whether or not you just rely on faith and
25 honesty of the people you contract with to discharge their contractual
26 obligations, or whether you actually have some systems in place to check
27 that people are performing their contractual obligations appropriately?
28 A: so the locality managers have a relationship – contract management
29 specific. There is Health Benefits Ltd who audit compliance with the

1 contract, more from a financial perspective, but that's an ongoing
2 arrangement where they all carry out checks and audits on a regular basis.
3 And there is, since the introduction of the Health Funding Authority, my
4 team which is the Quality Improvement and Audit Team, who can carry out
5 a variety of audits, ranging from the detailed investigation that we've done
6 here in Gisborne, through to a more routine audit of particular providers.
7 Q: What sets in train the audit process?
8 A: It will vary according to which kind of audits. An investigation such as
9 this would generally be the response to a complaint or a series of complaints.
10 The Health Benefits Ltd audits are a combination of routine audits and
11 audits which are triggered by something which appears to be unusual in their
12 claiming patterns, or complaints. And then we also have a series of audits
13 which are planned in relation to service improvement issues, so where we
14 believe there is a need to change the way we purchase a service we would –
15 yeah.
16 Q: How do you identify when there is such a need?
17 A: for which?
18 Q: For the last one?
19 A: The service improvement?
20 Q: Yes.
21 A: That can come from a range of ways, either from a general agreement
22 within Health Funding Authority the providers that this is a particular area
23 which could benefit from improvement, an area which is high on the
24 Government's priority list for example so that would often be the way …
25 MS BUNKLE: What determines whether or not something is high on the
26 priority list?
27 MS MELLOR: In terms of the Government's priority list they issue
28 priorities in their policy statements and that would come down through the
29 Health Funding Authority through the funding agreement.

1 MS BUNKLE: I am trying to work out whether the response, apart from
2 health benefits, tends to be reactive, more or less like a squeaky wheel
3 syndrome as opposed to pro-actively going out to ensure that quality services
4 are being provided. Can you help me on that?
5 MS MELLOR: Yes I think we are moving increasingly to a recognition
6 and attempts to implement more routine, but I think it would be fair to say at
7 this stage that mostly it is a responsive situation in the sorts of areas that you
8 are interested in in relation to this inquiry.
9 MS BUNKLE: Right. In terms of Tairawhiti Gisborne does that have
10 a locality team.
11 MS MELLOR: Yes.
12 MS BUNKLE: And would you have expected the locality team to have
13 discovered anything about Dr Bottrill's reporting of smear tests.
14 MS MELLOR: Not on a routine basis but in terms of when the issues
15 became apparent to the Health Funding Authority at the end of March it was
16 to the locality team that that was initially referred by those that became
17 aware from within the Health Funding Authority and they then passed it to
18 my team which is a more specialised team to investigate.
19 MS BUNKLE: Would you have expected the locality team to pick up
20 the fact that Dr Bottrill's name was still on the contract to provide laboratory
21 services even though he had retired.
22 MS MELLOR: In advance of this situation?
23 MS BUNKLE: Yes.
24 MS MELLOR: In an ideal world I think that is probably something that
25 - we are not operating in an ideal world and they will prioritise the areas that
26 they believe they need to work through in that level of detail. Certainly the
27 locality team were the ones who would manage that once it became
28 apparent.

1 MS BUNKLE: Is it right to assume that the organisation now of the
2 Cervical Screening Programme and other health services is dependent on
3 these contractual arrangements being put in place and being acted on.
4 MS MELLOR: Sorry can you just say the question again.
5 CHAIR: Yes. Is it correct to assume that the delivery of the Cervical
6 Screening Programme and other health services, in terms of its organisation
7 and structure, is now dependent on contractual arrangements being in place.
8 MS MELLOR: Predominantly yes, certainly there are contractual
9 arrangements there and the contractual arrangements should reflect any
10 legislative requirements which would overwrite that.
11 MS BUNKLE: And in terms of monitoring the performance of the
12 contractual arrangements – please answer this if you can – on a percentage
13 basis – how much of the Health Funding Authority role would be dependent
14 on reacting to issues that came up rather than proactively going out to ensure
15 that those you have contracted with are actually performing according to the
16 contracts terms.
17 MS MELLOR: I think it is a very difficult question to get down to in
18 terms of percentages. It is particularly because we do use a range of
19 different techniques to monitor so if we talked about the detailed
20 investigation then that clearly is a responsive one but there are a number of
21 levels which contracts are monitored more or less formally on a more routine
22 basis.
23 MS BUNKLE: Would you agree that the contractual arrangements you
24 have in place to ensure that services are provided that the quality of those
25 services are really only going to be as good as the contractual terms and
26 whether or not those terms are actually adhered to.
27 MS MELLOR: No, I think the contracts are increasingly going a long
28 way to defining and explaining for everybody what those standards are but
29 there is still a considerable reliance on the professional integrity and ability

1 of those providers who are actually delivering that service and it is a long
2 slow process to actually define and establish the standards for all services
3 and we aren’t there yet.
4 MS BUNKLE: So in that sense although you are forming contracts
5 with health providers you are still really dependent on trust and those
6 providers being professionally confident.
7 MS MELLOR: I think yes, the relationship is one where we have to be
8 able to rely on that for them to provide that service, the contracts are a
9 mechanism for us to define and be able to monitor and pay for those
10 services.
11 MS BUNKLE: So you are really trust them to do their jobs properly
12 rather than actively monitoring the contracts to ensure that that is taking
13 place.
14 MS MELLOR: I don’t know that there is so much of an either/or. I
15 think that as we are able to develop better our monitoring of those services,
16 it helps them to understand the service that they are providing so we jointly
17 shift everything to another level of people understanding what is happening
18 so I don’t think it is an either/or but certainly a substantial part of managing
19 those contracts is the acceptance that those providers are the best place to
20 deliver that service.
21 MS BUNKLE: And at the moment, if a health provider isn’t actually
22 performing well and not measuring up, is if fair to assume that you don’t
23 know about that until an incident such as this happens.
24 MS MELLOR: That is not always the case. There are times when that
25 will be the case. There are other times when the mechanisms which we do
26 have in place will identify them whether that is through the HBL or the other
27 more informal monitoring processes which we have.
28 MS BUNKLE: But my understanding is the HBL is really looking at
29 financing isn’t it – its paying benefits.

1 MS MELLOR: Yes.
2 MS BUNKLE: So in terms of the quality of work being performed it is
3 not looking at that is it.
4 MS MELLOR: Not specifically although it can through its analysis of
5 claiming patterns indicate an area where there might be concern which we
6 would then look at more closely from a quality perspective as well as a
7 financial one.
8 MS BUNKLE: Well how often does that happen.
9 MS MELLOR: Relatively small numbers in comparison with the
10 number of providers but it does happen.
11 MS BUNKLE: Could you put a percentage on it.
12 MS MELLOR: It would vary from different providers so general
13 practice, maternity providers, dentists, laboratories, they are all different.
14 MS BUNKLE: With laboratories could you put a percentage on it?
15 MS MELLOR: With laboratories I am not aware that the HBL work
16 has triggered any closer investigation.
17 MS BUNKLE: So on that basis it would be fair to discount the HBL as
18 a means of discovering whether or not a laboratory was providing a quality
19 service.
20 MS MELLOR: I think up to now that has been the case yes.
21 MS BUNKLE: And so we are then left with the locality managers and
22 the quality improvement and audit team.
23 MS MELLOR: Yes.
24 MS BUNKLE: And in terms of the locality managers can you identify
25 what they could actually do which would identify to the Health Funding
26 Authority any poor performance in a laboratory?
27 MS MELLOR: What they could do or what they do do?
28 MS BUNKLE: I'd like to know both please.

1 MS MELLOR: What they do do is have a relationship with all the
2 providers in their geographical area which they are managing.
3 MS BUNKLE: What does that actually mean?
4 MS MELLOR: For this region there is a locality manager for the
5 Tairawhiti region who is responsible for all of the personal health contracts
6 in the region so that would mean the hospital, any maori providers, general
7 practitioners, pharmacists, laboratories, dentists, child health providers, all
8 of those providers in the area, are known to and contractually managed by
9 the locality managers so what that means is that there is a relationship and a
10 network which would enable them to hear perhaps more quickly if the work
11 concerns about an individual practice or part of a practice.
12 MS BUNKLE: So again when you talk about this relationship you
13 really mean that if there is an incident it will come to their attention and they
14 can then take it up and look into it?
15 A: Yes, yes. They also monitor regular returns from the providers, so most
16 providers – and I'm not absolutely sure about the laboratories, most
17 providers within the contract will have either a quarterly or a 6 monthly
18 reporting pattern where the provider is required to report back into the
19 locality, in terms of volumes of work done and any issues which are arising
20 from the perspective of the provider
21 Q: Did that happen in 1996 and earlier?
22 A: Yes, where there were contracts, direct contracts. As we heard from
23 Chris Mules with laboratories, at that stage they were still on a s51, which is
24 effectively a claiming mechanism rather than a direct contractual
25 arrangement.
26 Q: And then again, if I understand your evidence correctly, the locality
27 manager was reliant on the provider bringing the issue to the locality
28 managers attention?
29 A: A provider, yes, yes.

1 Q: So, for example, if a provider was performing inappropriately, but
2 perhaps not recognising that, you wouldn't expect the provider to bring that
3 to the attention of the locality manager would you?
4 A: if the individual provider felt they were less lively.
5 Q: well, there are times when people who are performing badly don't
6 realise that they are performing badly?
7 A: No. Then, in that case, that would only come to the attention of the
8 locality manager through the concerns of another provider or another person
9 in the area. Or if there had been some process of routine monitoring.
10 Q: But there wasn't at the time?
11 A: Not against these. And, as we've said, in order to monitor, certainly an
12 area as complex as this, there is a need for those standards to be established
13 in order to be able to monitor against them, and that's work which is
14 currently in hand and was not in place at that time.
15 Q: And is there any monitoring going on at the moment by the locality
16 managers?
17 A: Of laboratories?
18 Q: Yes.
19 A: Most of the work around laboratories at this stage has been done by my
20 team, because of this and the laboratory review, or by the cervical screening
21 team, which Dr Peters heads.
22 Q: And has your team been doing monitoring?
23 A: We've been doing the laboratory review, which Jim DuRose will talk
24 about later, which is a detailed working through with all of the community
25 laboratories.
26 Q: And until this incident arose, is it likely that your team, by taking any
27 steps itself, could have come upon any concerns about the misreading of
28 smears in Gisborne?
29 A: No.

1 Thank you.
2 MS BUNKLE: Ma'am, you've covered much the same territory very well
3 indeed. May I just ask Ms Mellor, is the information that you've just given
4 the panel essentially the same as the information which you gave me on June
5 2nd, to the best of your recollection?
6 A: I would believe so.
7 Q: So the fact that you were unaware that Dr Bottrill was still contracted to
8 the Health Funding Authority means that no audit had been done of that
9 contract?
10 A: yes, that is correct.
11 Q: And at that time no audits had been triggered on any community
12 laboratory?
13 A: Not that I'm aware of.
14 Q: During the telephone conversation of June 2nd, why did you repeatedly
15 say to me that it didn't matter that Dr Bottrill was still named as the
16 supervising consultant pathologist for the Gisborne region?
17 A: Because we had been assured that Dr Bottrill had not been acting as a
18 pathologist since his retirement in 1996.
19 Q: when I asked you whether it reflected badly on the Health Funding
20 Authority, that they were unaware that a specialist who was no longer
21 qualified to practice medicine was named in your contract, why did you tell
22 me that it didn't matter?
23 A: I think that was in the context of where we were at that stage, and that
24 our priority at that time was to sort of what was going to happen in terms of
25 re-reading of the slides. So it didn't matter, in the sense of we only had to
26 re-read slides up to 1996 because we had assurance that Dr Bottrill had not
27 been part of the re-reading since then, and that that re-reading had been done
28 by – that reading of slides had been done by another laboratory. It wasn't

1 meant to indicate that it didn't matter at all, in terms of the Health Funding
2 Authority, but just in terms of our priorities at that stage.
3 Q: Is it still the practice of the Health Funding Authority to role over
4 contracts without checking that the doctors who are named in those contracts
5 are qualified to practice medicine?
6 A: I can't talk on behalf of all of the locality managers who work for the
7 Health Funding Authority, and that might well be routine practice for some,
8 if not all of those, but it isn't – yeah, I think that's probably.
9 Q: Do you think that it would be wise to have a policy - for the Health
10 Funding Authority to ensure that the doctors with whom it contracts to have
11 a valid current practising certificate?
12 A: I think that would be a perfectly reasonable suggestion. I think perhaps
13 even more important than that is that the contract itself states that that is a
14 requirement, in that that is quite clear to everybody involved, and then that
15 kind of audit is simply a confirmation that that is happening, that we've
16 initially been very clear that that's what's required.
17 Q: Approximately two weeks after June 2nd you visited my office. At that
18 time you said you were confident of the steps which the Health Funding
19 Authority was taking in Gisborne, although that still didn't include a full
20 review of all the smears. Why were you confident at that time that that was
21 sufficient?
22 A: I'm sorry, when was that meeting?
23 Q: I think it was approximately 2 weeks after June 2nd, it would have been
24 mid-June. You came with Mr Eady.
25 A: So by then we had announced that we were re-reading all of the cervical
26 cytology slides –
27 Q: No, I questioned you about the re-reading, and you said that you were
28 considering doing a sample but you did not consider that you needed to
29 follow up with re-reading all the slides involved in Gisborne, and I put it to

1 you that the evidence was then so strong that you couldn't draw the
2 parameters of error and it was going to be necessary to review all slides.
3 A: Do you mean all slides beyond the cervical cytology slides – is this
4 talking about the histology?
5 Q: No, I'm talking about cytology.
6 A: I can't recall when we would have met, but in May we announced that
7 we were re-reading all of the cytology slides, so I'm a little confused as to
8 what that conversation would have been.
9 Q: It is possible, ma'am, that I have the date of that meeting wrong, so I
10 won't pursue that line of questioning further until I've had an opportunity to
11 check that date. Thank you.
12 CHAIR: Before we go on to anyone else, Ms Mellor can you help me. My
13 understanding is that the contract with the Health Funding Authority in
14 respect of Gisborne was signed in March 97, I think?
15 A: Perhaps I would need to check this sounds right, yeah.
16 Q: In 1999 it seems the Health Funding Authority still hadn't picked up
17 that Dr Bottrill's name was on the contract, is that correct?
18 A: Yes.
19 Q: If a Dr was de-registered or suspended. How would the Health Funding
20 Authority become aware of that if the Dr did not tell the Health Funding
21 Authority?
22 MS MELLOR: I am not aware of a mechanism by which we would
23 routinely become aware – I am not aware of it.
24 CHAIR: Right so if a pathologist were suspended or deregistered and that
25 pathologist did not him or herself inform the Health Funding Authority of
26 that event, it is quite possible that you might not know of it.
27 MS MELLOR: I would need to check I think whether the people – I am
28 not aware of the system but I think I would need to go back and check

1 before I could give you a clear answer as to whether that is the situation. We
2 can do that.
3 CHAIR: Well is it not part of your brief as the Head of the Quality
4 Improvement and Audit Team to be aware of whether or not there are such
5 mechanisms for providing you with that information independently of the
6 medical practitioner.
7 MS MELLOR: It might well be but it isn't something that I have
8 addressed.
9 CHAIR: Earlier to Ms Bunkle you were talking about the need to make
10 it clear in contracts what the expectation was in terms of receiving
11 information. Do you have any penalties in the contracts if the provider fails
12 to provide you with the information that he or she is contractual obliged to
13 provide you with?
14 MS MELLOR: I think I would have to check individual contracts to be
15 sure what these were.
16 CHAIR: Has any thought been given to your knowledge as Head of the
17 Quality Improvement and Audit Team to including any penalty provisions in
18 contracts?
19 MS MELLOR: There has been some discussion around as the Health
20 Funding Authority was moving to develop single nationally consistent
21 contracts for its providers which was a major initiative which the Health
22 Funding Authority undertook around 18 months ago to start to move
23 towards that. Now I would have to go and check back to see where that
24 finally ended up in terms of the contracts that it was looking at which were
25 initially hospital contracts and that process is clearly slowing down now that
26 we are moving into a restructuring of the system which will not put so much
27 emphasis on the national consistence.
28 CHAIR: As the Head of the Quality Improvement and Audit Team has
29 it ever been a cause of concern for you that the Health Funding Authority

1 might have in place extensive contractual arrangements with health
2 providers which on paper required them to do a number of things which in
3 fact they may not be doing and it seems that there is no system to checking
4 to see that they are being performed. Has that ever worried you?
5 CHAIR: Yes and the need for us to move more actively into the routine
6 monitoring of providers is something that the Health Funding Authority in
7 general is aware of and is moving to address but as we have said before
8 there is a need to establish clear standards against which providers can be
9 monitored in targets and so on and we have prioritised the work that we have
10 done and that is something that we are moving towards now much more
11 actively but it is not as comprehensive perhaps as it could be.
12 CHAIR: Has it taken time to actually get agreement on what
13 appropriate standards are to measure performance under the contracts?
14 MS MELLOR: Are you referring to laboratory contracts or contracts in
15 general?
16 CHAIR: Yes we'll focus on laboratory.
17 MS MELLOR: The laboratory contracts Dr Peters will be able to talk to
18 you a lot more about that, there is a great deal of work has gone in to trying
19 to establish the standards for the Cervical Screening Programme all levels
20 of the programme laboratories and the other components and that work is
21 coming to a conclusion now but has been many months in getting to that
22 point.
23 CHAIR: Given that it is difficult to monitor performance until you have
24 agreed clear standards and given that it can take time to get agreed clear
25 standards in place, have you had any interim stop gap measures in the
26 meantime just to ensure that things are running relatively smoothly in terms
27 of delivery of health services under the contracts?
28 MS MELLOR: Again in relation to the laboratories that is the work that
29 Jim DuRose has been doing which we started around September last year.

1 CHAIR: Right, and that arose as a result of your concern about
2 misreading in Gisborne?
3 MS MELLOR: Yes.
4 CHAIR: Would it have happened if there hadn't been such a concern?
5 MS MELLOR: No. I think it is fair to say that prior to this laboratory
6 services were not considered one of the highest risk areas of the Health
7 Funding Authority .
8 CHAIR: Thank you. I'm sorry I have taken so long but I just wanted to
9 run through a number of questions. Yes, Ms Bunkle?
10 MS BUNKLE: Ma'am, Mr Eddie has very helpfully confirmed that the
11 meeting I referred to occurred on June 15. We do have one question that
12 we would like to ask.
13 CHAIR: Certainly, follow that up and then we will break.
14 MS BUNKLE: Thank you. Ms Mellor I have just had confirmation
15 that the meeting in my office took place on June 15. At that time I asked
16 you some question about when and which women were to be informed that
17 they were at risk in Gisborne. At that time you replied that it wasn't
18 considered necessary to inform them. Who gave you that advice or how did
19 you form that opinion?
20 MS MELLOR: I'm sorry, I said that it wasn't necessary to inform who?
21 MS BUNKLE: That it wasn't necessary to write and inform the women
22 in Gisborne that they were at risk. I suggested to you that there needed to be
23 not only a reading of all of the smears but a recall of the women themselves
24 and appropriate follow up and you gave me the advice that it was considered
25 not necessary to do that. I'm just wondering how you formed that opinion or
26 who gave you that advice.
27 MS MELLOR: I'm not sure that perhaps I was terribly clear at the time
28 but by then we had already done a lot of work publicly to make it clear that
29 the were concerns which were being investigated, we had made smears free

1 for all of the women in the area. I believe by then we had already
2 established what we called the facilitation contracts with the local iwi
3 providers for them to contact their women and encourage them to come back
4 for a smear particularly if they hadn't had one and we had written
5 individually to every woman whose last smear was recorded as being one
6 done by Dr Bottrill's laboratory and who we had no record of them having
7 been back for a further smear so we had already taken a number of steps to
8 make women aware of the need for them to return, the recommendation that
9 they did come forward and have another smear in advance of us being able
10 to get through the anticipated six months that it would take us to re-read the
11 smears so I am not sure why I was given an impression that we didn't want
12 to do that unless it was about specifically writing to each individual and we
13 didn't consider that that was going to be the most effective way of reaching
14 the women.
15 MS BUNKLE: My recollection is that it was about that. It was about
16 using the cancer register to contact the individual women …
17 MS MELLOR: The Cervical Screening Programme Register.
18 MS BUNKLE: The Cervical Screening Programme Register to make
19 sure that you had contacted them. I also raised the issue at that time of
20 whether there would be any follow up of the women on the national cancer
21 register who had developed invasive cancer. As we know that hasn't yet
22 happened. In your opinion would it, in light of what we have learned since,
23 do you think it would be a good idea for there to be a review of the women
24 who have developed invasive cervical cancer in the Gisborne region?
25 MS MELLOR: I believe that a proposal is already in front of the
26 inquiry and yes we have indicated in my supplementary evidence that in
27 order to get a full understanding of the impact on the individuals that kind of
28 case by case review is going to be the only way to get a detailed
29 understanding.

1 MS BUNKLE: Thank you very much.

2 CHAIR: Thank you, we will adjourn now. Because we will be sitting
3 until 5 o'clock each day we will stop at 3:30 and go from 3:30 until 3:45
4 unless some questions run over in the way that that has happened today. So
5 come back at 3:55.

6

7 SHORT ADJOURNMENT

1 INQUIRY RESUMES
2 CHAIR: Does the Counsel have any questions?
3 MR HODSON: I have some question?
4 CHAIR: Are you happy if Mr Hodson goes first, have you worked out
5 any order between you?
6 ?? I have no problem with that ma'am.
7 CHAIR: Do you think it more appropriate you go first Mr Hodson?
8 MR HODSON: I have two questions?
9 CHAIR: You go.
10 MR HODSON: Ms Mellor is the contract between the Health Funding
11 Authority and the various bodies that have been hired to assist in the
12 investigation, and in the particular clause, you will see it to refresh your
13 memory at exhibit 70 in which the body your contracting with undertakes,
14 and I quote "to use its best endeavours to promote and protect the interests
15 of the Health Funding Authority". Now what for example is expected of Dr
16 Farnsworth's laboratory in that context?
17 MS MELLOR: This is a standard contract which was used on the basis
18 of some urgency in order to allow us to get this contract into place and have
19 the re-reading done. It has no specific meaning and it does not constrain in
20 any way the reporting of the re-read results by Dr Farnsworth and Douglas
21 Hanley Moir Pathology Laboratories.
22 MR HODSON: So as far as the Health Funding Authority is concerned
23 it is quite meaningless.
24 MS MELLOR: No that is not what I said I said in this case it has no
25 specific meaning and does not constrain any of the reports which he gave
26 back to us.
27 MR HODSON: Suppose Dr Farnsworth had found something which
28 indicated that the Health Funding Authority had been in fault in some way,

1 what would be expected of her and what would be her obligations that
2 contract?
3 MS MELLOR: In that circumstance her obligations would have been to
4 have advised the Health Funding Authority and made that quite clear what
5 she had found and what it meant from her prospective in exactly the same
6 way as she would be expected to report anything else that she had found
7 back to us.
8 MR HODSON: Thank you.
9 CHAIR: Ms Mellor if the contractual term has no specific importance,
10 then insofar as this contractual arrangement is concerned it is a meaningless
11 term isn't it.
12 MS MELLOR: Can you just …. I am not quite sure where it is in the
13 document.
14 CHAIR: No, well I have been trying to find it as well but assume
15 because Mr Hodson said it was there that it was there. Can you help Mr
16 Hodson.
17 MR HODSON: Yes certainly, the contract with Dr Farnsworth's
18 laboratory starts off in the same way as does the exhibit 70 and in that
19 exhibit, page 3, the contract in that case of November 1999 between
20 Southern Community Laboratory and the Health Funding Authority, Dr
21 Farnsworth's contract is exhibit EMCA7 and that exactly the same clause
22 with a different date, different party to the clauses in paragraph 2.2.
23 CHAIR: I see yes, 2.2. Do you have that Ms Mellor?
24 MS MELLOR: I think in effect for this contract it is a meaningless
25 statement in this particular instance yes.
26 CHAIR: When the Health Funding Authority contracts with other
27 parties does it tend to use standard form contracts.
28 MS MELLOR: Yes, normally.

1 CHAIR: Does it make any attempt to alter those contracts by deleting
2 any clauses which are not going to be meaningful to that particular
3 contractual relationship.
4 MS MELLOR: Yes that would be an effort that would be made but this
5 was a contract that was put together very quickly and the priority in this
6 contract was on getting the schedules right which was the description of the
7 work that had to happen more than on the contractual clauses that
8 surrounded it, they were simply largely seen as a vehicle which enabled us to
9 actually get the re-reading underway.
10 CHAIR: So insofar as there has been use made of a standard form
11 contract which does not accurately in all respects reflect the contractual
12 relationship between the parties, this would be an exception rather than
13 what one might generally find with the Health Funding Authority's
14 contracts?
15 MS MELLOR: Normally our contracts we would be confident would
16 be relevant as far as we could possibility make them.
17 CHAIR: Thank you. Any other questions?
18 MS PHIPPS: I'd like to turn you back to the meeting of 28 April,
19 that's paragraph 19 of your brief.
20 CHAIR: Could you please just adjust the microphone?
21 MS PHIPPS: Is that better?
22 CHAIR: I think it needs to come closer to you. Its probably better now?
23 MS PHIPPS: Is that better.
24 CHAIR: Yes, thank you.
25 MS PHIPPS: Ms Mellor can you hear me.
26 MS MELLOR: Yes.
27 MS PHIPPS: That's good. At the time of that meeting I think you
28 have described yourself as needing more information on this subject
29 because your knowledge was evolving at the time. Is that correct?

1 MS MELLOR: Yes.
2 MS PHIPPS: And that would have been the case when you attended
3 the meeting in Gisborne on 26 April?
4 MS MELLOR: Yes.
5 MS PHIPPS: Now at the meeting on 28 April, if we put the
6 information you had at its highest you knew that Dr Bottrill had been the
7 subject of disciplinary proceedings is that right?
8 MS MELLOR: Yes.
9 MS PHIPPS: And the finding made was of conduct unbecoming
10 which was the lowest type of finding that could be made. Are you are of
11 that?
12 MS MELLOR: Yes.
13 MS PHIPPS: So the press release that we have been referred to when
14 it refers to disgraceful misconduct is incorrect isn't it.
15 MS MELLOR: Yes, my understanding is that it is the phrase that you
16 just said.
17 MS PHIPPS: Conduct unbecoming.
18 MS MELLOR: Yes.
19 MS PHIPPS: So you had that piece of information and that was in
20 relation to patient no. 1.
21 MS MELLOR: Yes.
22 MS PHIPPS: The other evidence that you had was the statistical
23 evidence which showed that Dr Bottrill's laboratory was within the
24 acceptable range. Is that correct at that time?
25 MS MELLOR: Yes I believe we had that at that stage yes.
26 MS PHIPPS: And you had information which you described as
27 evolving that had been communicated to you at a meeting in Gisborne two
28 days before.
29 MS MELLOR: Yes.

1 MS PHIPPS: And that consisted of concerns being expressed in a
2 general way with health specifics is that right?
3 MS MELLOR: With specifics about one or maybe two cases yes.
4 MS PHIPPS: And one of those cases was going to be referred for
5 review as at the 26th.
6 MS MELLOR: On the 26th the general practitioner I believe had
7 thought it had been referred for review at that stage but that doesn't appear
8 to have been what had actually happened with it.
9 MS PHIPPS: If you look at your note under tab 8, I think what you
10 have written says it would be referred.
11 MS MELLOR: That she had been told that it would be I think is what it
12 says. She had been advised that it would be referred and I think that that
13 was a historical rather than a current understanding.
14 MS PHIPPS: Right. And we know that this information had been
15 formally reported by letter dated 12 April of that same year, 1999. That's
16 tab 9.
17 MS MELLOR: Yes.
18 MS PHIPPS: And so on the basis of that information the College at
19 that point in time expressed that a holding of a re-reading was not supported
20 by the evidence but as you acknowledge this was an evolving process as
21 more information came to hand.
22 MS MELLOR: That is correct.
23 MS PHIPPS: Thank you I have no further questions.
24 CHAIR: Any other questions? Yes Mr Hindle?
25 MR HINDLE: Just make sure that I am properly wired for sound. Ms
26 Mellor can I start with the meeting of the 28th April 1999, because I don't
27 that you're exhibits include a copy of the note you made at that meeting, but
28 I have a copy of it here that might help you.
29 A: Yeah.

Q: So I will just ask the registrar to circulate that document. Do you recognise that document?

A: Yes.

Q: Is that your handwriting?

A: Yes, it is.

Q: And that's your note of the meeting that took place on the 28 April 1999 between yourself, and is that Jim DuRose?

A: That's right, yes.

Q: And Dr Tie and Dr Teague for the Royal College?

A: Yes.

Q: Now, I am interested in this document for other reasons than the questions you've been asked by my friends, but do have a look at it and just see if it refreshes your memory in any way about the subjects that you were asked.

A: Yes, I think it confirms my memory that one of the substantial things we were talking about was the false negatives and that there was an acceptance by Dr Tie and Dr Teague that there was a need for review and what I see here is we obviously had some discussion about what the most appropriate nature of that review might be.

Q: I was particularly interested to ask you about the note in the bottom left hand corner on the first page. I think it begins "more likely. Can you just read what that note says?

A: It's referring to under-reporting and it says that it's more likely to be found on re-screening, which is likely to pick up 80 to 85% of cases first missed if knowingly reviewing and, if not, pick up 12 to – I'm not sure if that is 13 or 15, it looks like 13%.

Q: Do you remember who made that observation, why you came to write that down?

1 A: It would have been Dr Tie or Dr Teague, but I wouldn't recall which
2 one, and why I wrote it down was because this was, as I said very early in
3 my learning and this was me trying to figure out false negatives and the
4 increased sensitivity around re-reading exercises.
5 Q: And the concern, in essence, was that if the person who is looking at the
6 slides knows that they are conducting a review they are, can I say “biased”
7 towards finding mistakes – they are more likely to find mistakes than if they
8 think they are just looking at the slides for the first time?
9 A: Yes, that’s true, although I do think that this was talking more in the
10 context of relatively small numbers than the large numbers that we ended up
11 re-reading.
12 Q: Yes, it talks about cases first missed, so it’s talking about slides where
13 presumably there is some abnormality to be seen, isn't it?
14 A: Yes.
15 Q: and am I right to think that that’s the same concern that we find in the 6
16 March interim report, where I think it’s acknowledged quite candidly by the
17 Health Funding Authority that there is an issue of bias in a re-screening
18 exercise?
19 A: Yes, I think we have to be aware that there is an increased awareness of
20 the fact that slides have been re-read and a potential for more abnormalities
21 to be found than would be found on a routine screening.
22 Q: And I have no idea what the basis for those figures are and I don’t
23 imagine you do either, but it’s potentially quite a significant potential for
24 that kind of bias, isn't it?
25 A: It is, but as I say, I do believe this conversation was largely in the
26 context of the College’s review process, which is about reviewing a very
27 small number of slides about which there is concern, such as in the case of
28 patient Number One, as opposed to the large scale re-reading which was
29 done by us later on, which is effectively putting so many slides through that I

1 think we were in a somewhat different situation. So, this one I think was
2 talking about small numbers of slides. That would be my recollection rather
3 than –
4 Q: Except that's slightly different, although the March report does make it
5 clear –
6 A: We still acknowledge, yes.
7 Q: Does it not, that the screeners in – if I can refer to it as the Sydney
8 laboratory, did know that they were reviewing slides?
9 A: Yes.
10 Q: They could tell that these were different slides they were looking at
11 from their normal work?
12 A: Yes, that's very true.
13 Q: I would like to ask you to produce the document.
14 CHAIR: I have already said earlier on today that that supplementary brief
15 would not be accepted in evidence today.
16 MR HINDLE: I'm just trying to find what exhibit reference to give it,
17 because this supplementary is given some numbers which I mustn't use
18 again.
19 CHAIR: I'm sorry, I don't understand.
20 MR HINDLE: The bundle I have includes 6 exhibits and I am looking for
21 the number to give this one.
22 CHAIR: To give this document a number, thank you.
23 [Exhibit TM/HFA/ 091]
24 MR HINDLE: And just if I could pick up on a question that my friend Mr
25 Hodson was asking you about, concerning the contract that the Health
26 Funding Authority had with the Sydney laboratory. If I can take you to tab
27 70 of your exhibits, that's actually a media release and behind it there seems
28 to be a contract for services between the Health Funding Authority and

1 southern community laboratories, and in fact that's for the breast screening
2 review, is that right?
3 A: Yes, that's right.
4 Q: But that's the form of contract, if I can put it that way, that was used for
5 Douglas Hanley Moir Pathology, the Sydney laboratory, is that so?
6 A: I believe so.
7 Q: Perhaps if you go to p6, and if you look at the second para beginning
8 "The principal aims of the investigation", just read that.
9 A: Yes.
10 Q: Do you see that it ends with the sentence: "The Health Funding
11 Authority has also been concerned to maintain public confidence in the
12 National Cervical Screening Programme. It looks as though that must have
13 come from the Sydney contract, because this was about breast histology and
14 not the cervical screening programme. Are you happy to accept that the
15 contract between Sydney and the Health Funding Authority had that
16 provision saying that the Health Funding Authority was concerned to
17 maintain public confidence in the National Cervical Screening Programme
18 A: I believe we've actually produced the schedule for the Sydney re-read
19 and we would be better to go directly to that.
20 CHAIR: Perhaps if we could go to the contract itself rather than looking at
21 a contract which reflects what the contract between Health Funding
22 Authority and Sydney reflects.
23 MS MELLOR: I don't think the full contract is there but the schedule is.
24 MR HINDLE: If you could find the schedule I would be grateful. The full
25 contract is in Dr McGooghan's exhibit.
26 CHAIR: Well, it might be better if we actually don't speculate and actually
27 look at the real contract.
28 MS MELLOR: Exhibit 37 has the schedule for the re-reading contract.

1 CHAIR: is the full contract in Dr McGooghan's exhibits. Let's look at the
2 full contract rather than just a schedule. In that way we can be 100% sure
3 and it avoids duplication then too. What exhibit of Dr McGooghan is it?
4 MR HINDLE: EM/CA/ 007. So if we go to page 6 of that documentation,
5 its just as well that we did because its slightly different from the one that I
6 was looking at, it says in the final sentence of the second paragraph that the
7 Health Funding Authority is also concerned to maintain public confidence
8 in the National Cervical Screening Programme and to actively encourage
9 enrollment in it as the best available protection against cervical cancer. Do
10 you see that?
11 MS MELLOR: Yes.
12 MR HINDLE: Obviously one of the things that is of concern to the Health
13 Funding Authority understandably is always to maintain public confidence
14 in the screening programme but do you think it is possible if there had been
15 information which might have had a contrary effect that Sydney would have
16 been obliged by that clause that Mr Hodson referred to not to articulate it or
17 deal with it in its report.
18 MS MELLOR: Absolutely not and even that clause requires them to
19 use their best endeavours to promote and protect the interests of the Health
20 Funding Authority. I can see no way in which the interests of the Health
21 Funding Authority would be well served by the laboratory reporting
22 anything other than what they found.
23 MR HINDLE: Perhaps I will take you to tab 72 of your exhibits. Now
24 that's minutes of an advisory group meeting which took place on 1
25 December 1999 a number of subjects were discussed. I wonder if I could
26 ask you to go to 5.3 on that report. Do you see it refers to results where Dr
27 Bottrill had reported high grade abnormalities that were not reported by the
28 re-reading.
29 MS MELLOR: Yes.

1 MR HINDLE: And it was agreed that those cases, 15 at that point, should
2 be reviewed individually subject to meeting privacy requirements.
3 MS MELLOR: Yes.
4 MR HINDLE: And perhaps if you would just go to the next tab which is
5 tab 73 notes of planning meetings held a week later in Gisborne and at item
6 2.4 you will see a reference to the same subject.
7 MS MELLOR: Yes.
8 MR HINDLE: That is I understand it at least 15 cases at this point
9 where Dr Bottrill called high grade abnormality and Syndey missed them. Is
10 that right?
11 MS MELLOR: Its where Dr Bottrill reported high grade and Sydney
12 did not report high grade.
13 MR HINDLE: Do you know what has ever become of those in the
14 follow up is there any information on that?
15 MS MELLOR: There is a little bit of information about them in my
16 supplementary evidence.
17 MR HINDLE: I hasten to say I haven't seen that evidence so you need
18 to know you are discussing this with someone who hasn't seen or digested
19 that more recent evidence but I can take it that the question of what was
20 found on reviewing those 15 cases is discussed in the supplementary brief.
21 MS MELLOR: No, what's in the supplementary brief is a description
22 of what we found by comparing the slides both ways so that you can see
23 quite clearly where there has been a difference one way or the other. In fact
24 we haven't yet done a detailed look at the individual cases, those 15, so
25 although that is agreed in here we haven't actually specifically gone through
26 the individual cases. Those women have been notified of the results of part
27 of the ongoing follow up of all women but we haven't reported specifically
28 on those 15 case studies, we haven't reported on any case studies.

1 MR HINDLE: But if Dr Bottrill called those 15 as high grade
2 abnormals, surely something happened after that, surely there was some
3 follow up of those women and presumably some time ago because after all
4 he finished reading slides at the beginning of 1996. Isn't that so.
5 MS MELLOR: I'm sorry what do you mean by follow up of those
6 women. Do you mean were they referred into treatment.
7 MR HINDLE: I am asking what is known about the clinical outcome
8 of those 15 cases.
9 MS MELLOR: Insofar as its answered, it is up to you, but more of that
10 information is in the supplementary evidences, that's the work that we have
11 been doing over the last few weeks but I have to be clear that we don't have
12 individual case histories of any women to work through the details of that.
13 What we have is some high level figures that tell us what has happened.
14 CHAIR: Can you tell the inquiry this – are you able to say at the
15 moment whether these 15 reports which Dr Bottrill read as high grade
16 abnormalities and Sydney read as normal were in fact normal. In other
17 words was Sydney misreading them or was Dr Bottrill misreading them?
18 MS MELLOR: I am not in a position to be able to give you an answer
19 as to which ones are read correctly.
20 CHAIR: Has it ever concerned the Health Funding Authority that the
21 result of reading a slide as being high grade could have resulted in these 15
22 women undergoing Colposcopy examinations?
23 MS MELLOR: Its clearly something that we were aware of but it has
24 not been our priority. Our priority has been to focus on those who should
25 have had colposcopy and haven't rather than those who have and maybe
26 need not have.
27 CHAIR: So at the moment then it may well be the case that there are 15
28 women who have had colposcopy examinations that they didn't need to have

1 and they don't know about it and the Health Funding Authority is not in any
2 position to inform the committee of inquiry about whether that is so or not?
3 MS MELLOR: All women have been informed of all original results
4 and all re-read results so any individual who had a slide which was reported
5 as less severe on the re-reading than on the original reading has been
6 informed and has the opportunity to discuss that with their own general
7 practitioner or smear-taker as to what the impact of that might have been on
8 them. We have not individually followed those up. It is something we
9 would have liked to have done but it isn't something that we actually have
10 done.
11 CHAIR: Right. And is it something that you are going to do?
12 MS MELLOR: Its not something that's planned immediately. It is
13 something that we need to consider as to whether if that is something we
14 need to do in the longer term.
15 CHAIR: And is that because of limited resources and the time
16 constraints you have been under?
17 MS MELLOR: Time constraints, resources really have not been an
18 issue in terms of this re-reading , resources in itself is not an issue, but
19 certainly time constraints and prioritisation.
20 CHAIR: But would that indicate that given the priorities that you have
21 imposed you don't actually have the available staff to look into the issue of
22 these 15 women to see what the clinical outcomes were in their cases.
23 MS MELLOR: Yes, I guess … we've done other things rather than
24 that.
25 CHAIR: Right. And are you able to say if it is going to be done or not.
26 MS MELLOR: It is something that can be done. It is not a decision
27 that has been taken at this stage.
28 CHAIR: So really what you have done is you have left it up to the
29 women concerned, in the sense you have advised them that Sydney has read

1 their smear tests as normal or not as high grade and you have left it up to
2 them as to what they choose to do about that.
3 MS MELLOR: Can I just have one minute to have a look for ……
4 A: Okay, what we actually have is one result which was initially reported as
5 a cancer and re-read as an ASCUS-H, so they would actually both be high
6 grade in the follow-up sequence that we've talked about, and one was re-
7 read as normal. We have 11 which were initially read as high grade but
8 were re-read as low grade. And 7 which were initially read as high grade
9 and re-read as normal. So, there are actually 8 cases in there where the re-
10 reading suggested that they were not abnormal at all, the others still
11 indicated abnormalities although not necessarily the same degree. So the
12 numbers vary as you get further into the analysis.
13 CHAIR: Is the Health Funding Authority satisfied that, in terms of
14 providing those women with the information of their Sydney re-read that
15 they would have understood the implications of that re-read in terms of any
16 invasive treatments they may have received as a result of Dr Bottrill's
17 reading? In other words, they would have realised, by being told that
18 Sydney has read their slides as normal, that whatever invasive treatment they
19 received was unnecessary?
20 A: I think the first comment I'd have to make there is that it may have been
21 unnecessary rather than it was. There is always a possibility that the Sydney
22 re-reading was different.
23 MR HODSON: With respect ma'am, I don't think it could be said that in
24 any case any actual investigation would be unnecessary on the basis of one
25 call of one smear of a woman. You would have to know the rest of the
26 history to know whether or not the investigation was necessary or
27 unnecessary.
28 CHAIR: Yes, this is my concern, that if all the women have been told is
29 that Sydney has read their smears differently they may well have been

1 subject to unnecessary treatment but be in no position to make that decision
2 themselves, and therefore if the Health Funding Authority isn't making any
3 inquiries about it, these women will never know. Is that a possible
4 assumption?
5 A: I guess it's possible. Certainly, in one case, I have received a letter from
6 the woman indicating that she's very aware of that potential. But as Mr
7 Hodson said, we would have to look at each individual case in substantially
8 more detail to know whether that was in fact the case. And it isn't
9 something that we've done to date.
10 PROFESSOR DUGGAN: Can you just clarify for me, then. These 15
11 women that had a report of high grade by Dr Bottrill, do you know if they
12 actually colposcopic investigation?
13 A: I'm just trying to see whether I can work it out from here. We haven't
14 tracked individual women all the way through the process to any great
15 degree, so I can't be sure. It looks likely that there are 8 – no, I can't,
16 because what we found as we've gone into details of some women, is that a
17 number of women have been in colposcopy, regardless apparently of the
18 original results that they have been receiving – they've received colposcopy
19 even though the original results didn't indicate that was necessary. So, we
20 would need to look a lot more closely at individual cases to be able to
21 answer.
22 Q: As part of this investigation, is there going to be a follow-up analysis on
23 the colposcopic investigation of these women?
24 A: There is some analysis of that has been done by Mr Ron Jones, who is
25 the gynaecologist who has worked on the Advisory Group, and he's
26 planning to present evidence to the inquiry in respect of that, so that is some
27 initial work that has already been done around the colposcopic evidence and
28 the histology results.

1 MR HINDLE: If I may. We may be at cross purposes I think. Professor
2 Duggan was asking you about these 15 women.
3 PROFESSOR DUGGAN: Well, that's right. Obviously there's a variance
4 here in the reports. We have one pathologist who's calling a number of
5 smears high grade and another pathology group calling them negative. You
6 would agree that in that circumstance, when you have a disagreement, that
7 the most careful route to follow is to offer a colposcopic investigation to all
8 of the women, and I would like to know if the results of that colposcopic
9 investigation will be made available to the inquiry?
10 A: If you want them, I can do that. We can go through those individual
11 women and present what's happened with them.
12 CHAIR: I note this Exhibit 72 is dated 1 December 1999 and at clause 5.3
13 it says "it was agreed that these cases – 15 to date – should be reviewed
14 individually, subject to meeting privacy requirements." So if it was agreed
15 to review the cases individually, what has been done up until now about
16 carrying out that review?
17 A: That's what I'm saying, that hasn't been done, it was agreed that was
18 the advice we received from the Advisory Group. We have not done that.
19 So, I guess, in a sense, we have a decision that does say we will do it, so it
20 will be done at some point. We will have to go back through all of these
21 details and check that we've done everything that we've said we would do.
22 At this stage we've been focused on getting the priority things done.
23 Q: Who actually checks through these documents and audits whether or not
24 you are ultimately carrying out the things that you've agreed to do, because
25 it seems to me, with a number of documents like this with decisions being
26 made, they could ultimately become forgotten.
27 A: They could. The minutes go back to the Advisory Group, so the next
28 Advisory Group meeting would receive information back from what had
29 happened from the previous one and then we record at that time, if

1 something still isn't done, and that brings it forward to the next one. So, in a
2 sense, they are monitoring, and certainly it is something I would
3 acknowledge that the Advisory Group have indicated to us that they do think
4 needs to be done. It’s just that we haven't actually done it at this stage.
5 MR HINDLE: The figures that you were reading out before when you were
6 talking about 7 cases reviewed as low grade and I think 8 cases reviewed as
7 normal by Sydney of this smaller group of 15 women, am I right to think that
8 comes from the information in the supplementary material?
9 A: Yes.
10 Q: So we can have a look at that and then come back to the issue?
11 A: Yes.
12 Q: I will take you to the interim report if I may at tab 85. And at p5 there
13 are a few miscellaneous questions. You will see that, about half way down
14 on p5, key points from the report quoted directly from Dr Farnsworth,
15 approximately 50% of the slides require re-coverslipping as up to 20% of the
16 material in these cases was not captured by the original cover slip. Do you
17 know, has data been kept on exactly how many slides required re-
18 coverslipping?
19 A: No.
20 Q: Can we recreate that – could we find that out if it was important?
21 A: No, I don’t believe so, but I think that Dr Farnsworth will be able to
22 give you a better indication. No, we didn't keep records – she didn't keep
23 records.
24 Q: So I take it, it follows from that, that we’ve got – subject to Dr
25 Farnsworth may have to say – no way of correlating the high grade recalls
26 with incidence of re-coverslipping?
27 A: No, I don’t believe so, no.

1 PROFESSOR DUGGAN: As part of the contractual agreement, was there
2 not an accounting for any preparation of the slides, i.e. if the Sydney
3 laboratory had to re-prepare the slides they bill for that – is that correct?
4 MS MELLOR: I would need to look more closely at the contract – I
5 didn't write the details of that contract but I believe that we expected that
6 there would be a need for that and that that was taken into account in the
7 overall price rather than a specific billing for that work.
8 PROFESSOR DUGGAN: If that is so the answer to this question could be
9 determined from the billing that is how many slides had to be reprepared.
10 MS MELLOR: If that was the case but I don't think it was, I think we
11 simply paid a price per slide which took account of the possibility that they
12 might need to do work on them because of the fact that they were so old. If
13 that had happened it would have given you a mechanism but I don't think it
14 did.
15 MR HINDLE: A slightly different subject again the 6 March report
16 attaches a report from the Sydney laboratory which was the report that was
17 made public by that laboratory was it not?
18 MS MELLOR: Sorry can you ask the question again.
19 MR HINDLE: The 6 March report from the Health Funding Authority
20 includes as an attachment the report that the Health Funding Authority got
21 from the Sydney laboratory.
22 MS MELLOR: Yes that's right yes.
23 MR HINDLE: And that was not its final report but certainly the report
24 that was intended to be put in the public domain as at the middle of March of
25 this year.
26 MS MELLOR: Yes.
27 MR HINDLE: Is there any reference that you are aware of in that
28 report to these 15 cases where Dr Bottrill called them abnormal and Sydney

1 called the normal or low grade? Can you remember if that was discussed in
2 that report.
3 MS MELLOR: In which report, the report from ….
4 MR HINDLE: The report attached to the Health Funding Authority
5 ….
6 MS MELLOR: The report from the Sydney laboratory?
7 MR HINDLE: Well anywhere in the Health Funding Authority report
8 of 6 March.
9 MS MELLOR: OK.
10 CHAIR: What exhibit is that?
11 MR HINDLE: Its tab 85 …. Look I can come back to that tomorrow if
12 it would help but I am interested to know whether this issue that there are 15
13 women or 15 smears I should say which have been called abnormal by Dr
14 Bottrill and normal by Sydney were included in this interim report of 6
15 March.
16 MS MELLOR: Certainly the numbers would have been included
17 because the tables in here refer to all slides reported but I don't believe we
18 specifically identified slides that have been differently reported in the sense
19 of having been reported as less severe by the re-reading laboratory and
20 that's what we did in the supplementary and in the action update report
21 which is included in the supplementary evidence.
22 MR HINDLE: Was the question of how to deal with those slides called
23 higher by Dr Bottrill and by Sydney something that was considered or
24 discussed by the advisory group?
25 MS MELLOR: Yes I have already said quite clearly that that was
26 discussed with them.
27 MR HINDLE: Do you recall what the tenor of that discussion was?

1 MS MELLOR: I'm not quite sure. Their advice was that we should
2 look at those cases individually and I have already acknowledged that we
3 haven't done that.
4 MR HINDLE: That's the December advice. Has it been the subject of
5 discussion since then that you can recall?
6 MS MELLOR: I believe it has been mentioned since yes.
7 MR HINDLE: With what result?
8 MS MELLOR: Clearly the same result because we haven't yet done
9 that work.
10 MR HINDLE: But obviously this is something that the advisory group
11 has remained interested in.
12 MS MELLOR: Yes.
13 CHAIR: When are you likely to get to doing the work.
14 MS MELLOR: I think given the interest that I am hearing today we will
15 have it done by the time I am back in the witness stand.
16 MR HINDLE: If I could just talk to you a little bit about what was
17 done to prepare the Sydney report of 6 March 2000, that's tab 85 …
18 MS MELLOR: The Sydney report or our interim report.
19 MR HINDLE: Well that's really what I want to ask you about. If you
20 look at paragraph 111 of your evidence, talking there about the advisory
21 group meeting of 1 December 1999 and in paragraph 111 you talk about the
22 advisory group considering the implications of this inquiry and I think the
23 last full sentence on that page talking about their draft report from Dr
24 Annabelle Farnsworth in respect of the re-reading of slides you say it was
25 noted that this draft report was not accurate in all respects and that revisions
26 were required.
27 MS MELLOR: Mmm hmmm.
28 MR HINDLE: Can you remember in what respect Dr Farnsworth's
29 report was not accurate.

1 MS MELLOR: The one particular example that I recall was that Dr
2 Farnsworth's report had indicated that no slides had been broken and in
3 actual fact we knew that one or two had got broken on the way back from
4 Sydney to New Zealand and that was of some concern to the project
5 manager who wished that to be recorded specifically. So there were very
6 minor amendments as I recall.
7 CHAIR: Well at the time Dr Farnsworth wrote her report the slides
8 wouldn't have been broken would they.
9 MS MELLOR: They would have been broken at the time she wrote it
10 but after they had left her laboratory to return to us.
11 CHAIR: Yes so she could not have known about the fact the slides were
12 broken.
13 MS MELLOR: When she wrote the report quite probably not no.
14 Which was about us making sure that it didn't say something that was
15 inaccurate because she wasn't aware of the information.
16 MR HINDLE: I am curious to be honest that there were any revisions
17 at all because of course that piece of information was accurate at the time
18 she wrote her report but putting aside that kind of thing can you think of any
19 other revisions that the Health Funding Authority were suggesting Dr
20 Farnsworth should make to her report?
21 MS MELLOR: I don't particularly remember. That's the particular one
22 that sticks in my mind.
23 MR HINDLE: I suppose if anyone was sufficiently interested it would
24 be possible to find the draft reports received from Dr Farnsworth and see
25 what she had said in them.
26 MS MELLOR: I would imagine that would be possible.
27 MR HINDLE: So if I can just take you to paragraph 126 of your
28 evidence then. You have talked there about a meeting on 26 January which
29 considered the first draft interim report in some detail and made a substantial

1 number of recommendations for changes to this report, am I right to assume
2 that those were not changes to Dr Farnsworth's report but to the rest of the
3 report that the Health Funding Authority produced.
4 CHAIR: Mr Hindle paragraph 126 I can't find any reference to January
5 I'm sorry.
6 MR HINDLE: I'm sorry its under the bold heading the page before.
7 This is evidence being given about a meeting of the advisory group on the
8 26th of January 2000 which is considering the first draft.
9 CHAIR: 123? Are you working from a different brief.
10 MR HINDLE: No ma'am I just picked the date up for the purpose of
11 my question . Mr question was about paragraph 126.
12 CHAIR: Right.
13 MR HINDLE: I obviously didn't express it very well but I just wanted
14 to confirm that at that meeting when you were considering the first draft of
15 the interim report that was subsequently published on 6 March the
16 substantial number of recommendations for changes to the report were what
17 the Health Funding Authority were writing not what Dr Farnsworth was
18 writing.
19 MS MELLOR: That's right yes.
20 MR HINDLE: Now I want to ask a few questions really about the
21 objectives of the review work and I hasten to say two things first of all I
22 haven't as you know seem the supplementary material so if what I asks you
23 takes us into that territory just let me know because I am not aware of it and
24 secondly if you feel someone else should answer the question just let me
25 know who I should ask. I don't want to take you into territory that you are
26 not familiar with. But if we could start by looking at tab 34 which is the
27 investigation for the Sydney review, which is the investigation brief for the
28 review that was carried out. That was a public document issued in June

1 1999, and at p3, in the second paragraph, it sets out the principal aims of the
2 investigation. Do you have that?
3 A: Yes.
4 Q: And they were “to ensure that women received the appropriate treatment
5 for their health and wellbeing, and to determine the extent of the problem
6 regarding the pathologist concerned.” [Tab 34, p3 of the Exhibit, second
7 paragraph]
8 A: Yes.
9 Q: Even as at June 1999, and indeed earlier I think it is fair to say the
10 Health Funding Authority was describing this as “the problem” regarding
11 the pathologist, wasn’t it? The Health Funding Authority considered that
12 there was a problem with the pathologist?
13 A: I’m sorry. We tried quite hard, I thought, not to make that assumption,
14 and that we were carrying out an investigation into allegations about
15 concerns as opposed to treating it as a problem. It could well be that in some
16 documents, in a sense as a short-hand, that was used, but our efforts were
17 not to make that assumption and to investigate. We clearly had concerns and
18 sufficient concerns to carry out the investigation, but the problem was not
19 language – certainly is not language that we had intended to use.
20 Q: Yes, but it is the language of the investigation brief, isn't it?
21 A: It’s quite possible that that’s there.
22 Q: Well, let’s look at the first of these objectives, which is to ensure that
23 women receive appropriate health treatment, and if you go to p8 of the
24 document, you see there set out the objectives and the methods that are
25 going to be used in the study, and if you look at objectives 1, 2 and over the
26 page 3, they are all about making sure that women get the right information
27 and the right treatment, especially for those who are potentially at risk, aren’t
28 they?
29 A: Yes.

1 Q: and in order to ensure that those objectives were achieved, you
2 developed a criteria for selection of the laboratory that would do the re-
3 reading work; that's right, isn't it?
4 A: yes.
5 Q: And in fact if we go to tab 27, we see that at an earlier time than the
6 investigation brief on the 26 May 1999 the criteria for laboratory selection
7 are set out there at the bottom of the first page of that exhibit are they not?
8 A: Yes.
9 Q: And they require full accreditation by IANZ or NATA, the Australian
10 accreditation organization?
11 A: Yes.
12 Q: Performing an adequate volume of smears/year.
13 A: Yes.
14 Q: Use of qualified pathologists in cytology?
15 A: Yes.
16 Q: And a senior technologist to do the re-reading?
17 A: Uh huh.
18 Q: and then the next step of the journey was to ensure that those criteria
19 were actually achieved, you obtained information from laboratories or at
20 least from the Sydney laboratory, which is set out at tab 28?
21 A: Yes.
22 Q: And what you got there at p2, you got the information that Sonic
23 HealthCare, the owner of the Douglas Hanley Moir Pathology laboratory is
24 one of Australia's largest private pathology providers, and if you go to p9 it
25 confirms that all of the laboratories were accredited by NATA.
26 A: Yes.
27 Q: At p10 they showed you how many smears they did each year, and in
28 their case they are well ahead of anyone else listed there – 160,000
29 smears/year?

1 A: 160,000 by Douglas Hanley Moir Pathology and I believe that the other
2 laboratories listed there are the other laboratories, some of which were
3 actually used in the re-reading and under the direction of Dr Farnsworth.
4 Q: You are quite right, in fact we should be adding those numbers up for
5 their collective experience shouldn't we?
6 A: Yes.
7 Q: And then if we look at pp11 to 15, they set out the qualifications of
8 people who were going to do the re-reading, be responsible for it.
9 CHAIR: Ms Mellor, at p10 we have got the laboratories and the number of
10 PAP smears/year - the minimum seems to be about 25,000 PAP
11 smears/year. From the examination you did of laboratories in Australia
12 which you may have used to do the re-reading, from your experience were
13 the PAP smears in such high numbers, in terms of readings/annum.
14 A: As high as 160,000 or?
15 Q: Or 25,000? Are these all the laboratories you looked at, or were there
16 others?
17 A: These are the laboratories which come under the direction of Sonic
18 HealthCare, and our contract was actually with Sonic, so it was
19 predominantly done by Douglas Hanley Moir Pathology, which is where Dr
20 Farnsworth works, but some of the slides were actually re-read at some of
21 these different sites which, under her direction, using the same protocols that
22 had been established for the whole contract, so these are Sonic laboratories
23 in Australia.
24 Q: When you chose Sonic, did you look at other laboratories as well before
25 you made your choice?
26 A: there were some approaches made to one, or maybe two other
27 laboratories who indicated that they were not able to take on that volume of
28 work in that timeframe, and therefore we focused very quickly onto Sonic
29 and Douglas Hanley Moir.

1 Q: Looking at the laboratories on p10 and the number of PAP smears/year
2 that each of them carry out, from your knowledge of laboratories in
3 Australia are you able to say whether or not this amount of PAP smears/year
4 being read is characteristic of the number of PAP smears most Australian
5 laboratories would be reading?
6 A: No, I'm sorry, that's not something that I should answer.
7 Q: Has the Health Funding Authority made any investigations into looking
8 at whether or not laboratories that do a large amount of smear reading can
9 perform a better service?
10 A: Again, this is not something that I should answer. I think Dr Peters will
11 be giving evidence about the establishment of the standards policy for the
12 laboratories here and I think should be better placed to talk about that.
13 Q: Did the fact that the Sonic laboratories do so much re-reading of PAP
14 smears/year influence the Health Funding Authority's decision in choosing
15 sonic?
16 A: It was certainly an advantage on the basis that we required what we
17 thought at that time could have been up to 30,000 slides to be re-read within
18 a 6 month period. Clearly, that would not be possible for a laboratory that
19 only read 20 or 30,000 slides in an average year, so we had to look for a big
20 laboratory that would have the capacity to put that volume through.
21 Q: and did you take into account the likelihood that a big laboratory, doing
22 a lot of smear reading, might be in a better position to read smears accurately
23 than a laboratory doing a small amount of smear-reading. Was that a factor?
24 A: No, not a judgement as to whether they would be more or less accurate.
25 We knew that Dr Farnsworth had a very good reputation and that the
26 laboratory was potentially big enough to take the volume.
27 MR HINDLE: But I would just refer you to the next few pages of this
28 document where the qualifications of those who would be undertaking the
29 work is set out and in order to meet your criteria for laboratory selection we

1 see some very impressive qualifications for not only the pathologists but also
2 the site screeners and everyone who is going to be involved.
3 MS MELLOR: Yes.
4 MR HINDLE: And in fact if we go to the interim report back at tab 85
5 on page 15 of that document where the Sydney laboratory is actually
6 reporting what it did … do you have the page, page 16 …. And under the
7 heading reports they explain that first the slide must be screened and that is
8 usually carried out by a specially trained scientist or technician.
9 MS MELLOR: Yes.
10 MR HINDLE: And then in the next paragraph the second part of the
11 process is the classification whether there is any deviation from normal the
12 slide is then re-screened by another senior scientist.
13 MS MELLOR: Yes.
14 MR HINDLE: And if it is still considered abnormal the slide is then
15 examined by a cyto pathologist so that in the case of a slide containing
16 abnormalities there are going to be at least three people who look at it is that
17 right?
18 MS MELLOR: Yes.
19 MR HINDLE: And even if there are no abnormalities we see from two
20 paragraphs down that rapid re-screening was not performed but targeted re-
21 screening was used as per the routine protocols.
22 MS MELLOR: Yes.
23 MR HINDLE: And all of those things were done in order to meet that
24 objective which was about ensuring that women at risk were identified and
25 that their health outcomes were improved as much as could be possible.
26 MS MELLOR: All of those things were done because that's a good
27 quality process for screening slides. The reason why we did the process at
28 all was to make sure that we had protected the health and wellbeing of the

1 women and had some information in order to assess the extent to which Dr
2 Bottrill may have under-reported slides.
3 CHAIR: Mr Hindle its 5 o'clock so if you would pick a convenient
4 time.
5 MR HINDLE: I was aware of that ma'am, just to finish this little part
6 and then …. I am conscious that what we are going to look at tomorrow
7 morning first thing is the second part of the investigations objective which
8 was to determine the extent of the problem regarding the pathologist
9 concerned but for the moment what I wanted you to reflect on is that these
10 procedures, the qualifications of the people, the size of the laboratory, all of
11 these were things that you looked for in order to meet that objective which
12 was to ensure that women received appropriate treatment for their health and
13 wellbeing is that right.
14 MS MELLOR: Yes.
15 MR HINDLE: I'll leave it at that.
16 CHAIR: Right we will adjourn until 9:30 tomorrow morning.
17
18
19 THE HEARING ADJOURNED AT 5.03
20 TO RESUME AT 9.30 AM
21 TUESDAY 4 JULY 2000