1 **MONDAY 18 SEPTEMBER 2000**
2 **THE HEARING RESUMED AT 2.15 PM**
3 CHAIR: I understand Counsel for the women affected are going to go first
4 in these submissions, is that correct?
5 MR GRIEVE: Yes Madam Chair.
6 CHAIR: Just pause please until we get the microphone Miss Bunkle, we
7 can't hear you and things are being recorded as well.
8 MS BUNKLE: Ma'am, I rise as a trustee of the Women's Health
9 Information Trust. Yesterday I visited Northland and found very
10 widespread anxiety following disclosure in the newspaper that Colleen
11 Poutsma had had a series of smears reported as normal. I request that in the
12 public interest and to alleviate the anxiety of the women in Northland, the
13 inquiry consider requiring disclosure of the names of the laboratories
14 regarded as problematic by the Health Funding Authority Du Rose study.
15 When that study came before the inquiry, it was on a confidential basis and
16 it wasn't necessary to know or to identify those laboratories. But it seems
17 that now we have some of the same symptoms emerging in other areas,
18 including Northland, where I also met two other women with the same
19 smear history yesterday. And it seems that while the Committee didn't
20 know if those laboratories would be included in the group that required
21 follow up, now it does seem that it would be useful to know if that
22 laboratory is involved in the follow up group, and because we need to know
23 that, there may be concerns in other areas. And if it turns out that the six
24 laboratories in the Du Rose study do not include Northland, then it may be
25 that in fact there is concerns about wider areas in the country. So I would
26 ask that the Committee might consider requesting the identification of those
27 other laboratories where they may be a risk.
28 CHAIR: Miss Bunkle, I would just like to raise a few matters with you.
29 Firstly, when the information was produced to the Committee, the
30 Committee was not aware of the identity of the laboratories. That

1 information remains with the Ministry of Health. For the purposes of the
2 terms of reference, there was no need for the Committee to be aware of the
3 identities of the laboratories and the Committee is set up to look into the
4 terms of reference, it is not here sitting in the public interest generally to
5 look at the competency of certain health services. At the same time, the
6 Committee is attempting through Professor Skegg to have an audit done of
7 other areas including Northland, that was chosen because it had a high
8 incidence of cervical cancer and at the moment, that study still is not off the
9 ground because of difficulties in gaining access to information and we
10 expect to know whether or not we will need to go to the High Court by
11 Monday of next week. So the audit that the Committee proposes is one way
12 of allaying fears about Northland if that audit is able to take place. As I see
13 it, what you are asking the Committee to do at the moment in respect of the
14 laboratories in the Du Rose study falls outside the terms of reference. Now
15 if you can point me to a term of reference where you can say that it would
16 be relevant for me to require the identity of those laboratories, then I will
17 consider the matter further but I'm struggling at the moment.
18 MS BUNKLE: I believe that it is relevant to term of reference 3. Ma'am,
19 although it may be that the information needed to answer terms of reference
20 3 is better and will be more fully answered by the audit that you are
21 requesting, so long as that audit goes ahead.
22 CHAIR: That's right.
23 MS BUNKLE: And the answers, the people in those areas can get some
24 degree of assurance from that.
25 CHAIR: Yes because it seemed to me that for the Du Rose study, there
26 was evidence as to how much the Du Rose study would be helpful to
27 determining whether or not there was a systemic issue and it seemed to me
28 that any assessment of how helpful the Du Rose study was didn't turn on
29 being able to identify the laboratories. Do you have anything to say to the
30 contrary?

1 MS BUNKLE: To the contrary Ma'am, it's that we've got, we've been in
2 this dilemma now for some months –
3 CHAIR: Yes.
4 MS BUNKLE: And I think that that was satisfactory, what has changed is
5 that there is now an awareness from information coming from outside the
6 inquiry in a specific area and it's that that has substantially changed the
7 nature of the public interest in this issue –
8 CHAIR: Yes.
9 MS BUNKLE: And I suppose the delays in the audit make that
10 particularly, both, almost inevitable, but also particularly unfortunate.
11 CHAIR: Mr Murray, I'll hear from you, but before I do, does anyone else
12 want to be heard? (Silence) Very well Mr Murray?
13 MR MURRAY: I don't need to be heard for any great length Madam
14 Chair. I think the way you have assessed it, if I may say so, is exactly right.
15 The inquiry doesn't actually have the information so you can't lift the
16 suppression order. The study was done with the co-operation of all the
17 laboratories, the key to getting that study done was actually to try and
18 persuade all the laboratories of the value of doing it and on that basis, it was
19 done confidentially and so that it's not the information Ms Bunkle requires
20 is not actually before the inquiry. If we were to revisit that whole area, I
21 expect we would have to set aside time for the argument that we might have
22 had but didn't have because the inquiry didn't actually need to have that
23 argument –
24 CHAIR: Yes.
25 MR MURRAY: So I don't think we can take it much further than that.
26 CHAIR: No.
27 MR MURRAY: But the points made about doing some of these studies, of
28 course, are well made.
29 CHAIR: One concern I do have is that the points Ms Bunkle has raised
30 concerning Northland, does make the audit that the Committee of Inquiry

1 does want carried out more pressing. And I would like you to take that into
2 account for Monday of next week when we deal with that issue.
3 MR MURRAY: Yes of course.
4 CHAIR: Ms Bunkle, you want to be heard? Mr Grieve.?
5 MR GRIEVE: Briefly, Madam Chair. I don't want to be heard on the
6 submissions made by Ms Bunkle because they extend beyond that of which
7 I was involved which was the Northland case. You may remember that that
8 arose on the Saturday morning when Mr Du Rose was giving his evidence –
9 CHAIR: Yes.
10 MR GRIEVE: And that it was in that context that the suppression order
11 was made. Now, since then of course, there has been significant publicity
12 given to the plight of that Whangarei woman, and from time to time I have
13 been approached by the media asking about the suppression order in relation
14 to the reference in evidence on that Saturday morning.
15 CHAIR: Yes.
16 MR GRIEVE: It seems to me that of course the Committee of Inquiry has
17 power and exercised that power in relation to evidence given before it, but
18 should there be circumstances arising where someone unconnected with the
19 inquiry but related to that same case, sees fit to publish the name of that
20 laboratory then this Committee's writ would not run that far.
21 CHAIR: I agree and if you are involved in the Northland case, information
22 that you know of outside this Committee of Inquiry if you want to publish it,
23 I can't see that there is any restriction on you from doing so.
24 MR GRIEVE: No, I'm not involved Madam Chair and I'm not speaking
25 on that basis. The reality is that there is now, in the public domain,
26 considerable information about that case and considerable public interest in
27 it, and pragmatically it seems to me that the continued suppression of name
28 albeit limited in the manner that I have mentioned, namely relating to
29 evidence before this Committee, is somewhat well unnecessary. And so
30 perhaps, and I don't know whether this would meet something towards what

1 Ms Bunkle is seeking, but perhaps consideration could be given to removing
2 that suppression order.
3 CHAIR: Yes, well I would have to have a look at it and hear from people
4 on that. That is a separate issue but certainly I am aware of the questions
5 which arose I think as a result of your cross examination of Mr Du Rose
6 about the laboratory. And it may well be if there is sufficient publicity now,
7 that any attempt at keeping that confidential is moot and we no longer need
8 to be concerned about it. But for the moment, I just want to deal with the
9 identities of the laboratories which we were in the Du Rose study and unless
10 anyone wants to be heard on that. Very well, Ms Bunkle, I'm not going to
11 order that the identities be made available, because that information is
12 simply not available to the Committee. It's with the Ministry of Health. In
13 order to do so, I would have to order the Ministry to make it available to the
14 Committee and I have already ordered that it was not necessary for that to
15 occur in order for the Committee to meet the terms of reference and I see no
16 change there. If you want access to the information because you see it now
17 as being of public interest, the Ministry of Health is susceptible to the
18 Official Information Act and you could of course make an application under
19 that Act and that might see the information being released. Now, as to the
20 other matter concerning the limited amount of evidence about a laboratory
21 that was given by Mr Du Rose when cross examined by Mr Grieve, Mr
22 Grieve, should I treat your submission as a formal application to revisit the
23 confidentiality order?
24 MR GRIEVE: Yes Madam Chair. I applied because it seemed appropriate
25 given the other orders to which you have just being referring.
26 CHAIR: Yes, very well. Could I have that order please Madam Registrar
27 and does anyone wish to be heard on that? Mr Murray?
28 MR MURRAY: No, I don't have instructions of course from the
29 laboratory.
30 CHAIR: Is Mr Collins here? Because he was acting.

1 MR MURRAY: No, no, he was for ACL you will recall. He didn't have
2 instructions for individual laboratories. It arose, as my friends indicated sort
3 of a bit of the cuff actually in terms of questioning. At that stage I indicated
4 confidentiality suppression would probably be appropriate because there had
5 been a complaint to the Health Funding Authority.
6 CHAIR: Yes.
7 MR MURRAY: And I can indicate that that complaint is still being
8 handled –
9 CHAIR: Yes.
10 MR MURRAY: Because as the inquiry knows, finding out whether
11 smears have been misread or not is not a straightforward matter and that's
12 still being investigated. The only point I would add, so I don't take a
13 position on lifting the suppression order, the only thing is that I understand
14 Mr Waalkens is acting for the laboratory and it's entirely for the inquiry or
15 either counsel whether he should be given an opportunity to be heard before
16 the present status quo is changed.
17 CHAIR: Right, I'll just wait until I see what the order is. Can anyone help
18 me, how many laboratories are there in Whangarei?
19 MS BUNKLE: Ma'am, there's the hospital laboratory and Northland
20 Laboratory is the community laboratory, the private laboratory.
21 CHAIR: So there's one community laboratory and one –
22 MS BUNKLE: Smears from Northland have been sent to a large number of
23 laboratories and are currently sent out of Northland to National Women's
24 Hospital into a laboratory in the South Island.
25 CHAIR: So really Ms Bunkle, in terms of the women that you know of
26 who've had smears, or they've had normal, they've had a pattern of normal
27 smear reading which might now appear unusual, there's no way of knowing
28 at the moment what laboratory read their smears?
29 MS BUNKLE: I think the assumption is that because of the period when
30 they took place, it was at a period when those smears were being sent to

1 Northland Laboratories or to mostly to the hospital. But there is no
2 definitive way of knowing where they were going. The current situation is
3 that that laboratory as recorded in the Du Rose study is no longer doing
4 cytology and they're being sent out to National Women's or to the South
5 Island.
6 CHAIR: My understanding was that no laboratory was identified in the Du
7 Rose study so we do know that there is a laboratory which is no longer
8 doing cytology.
9 MS BUNKLE: Ma'am, in the Du Rose Study there are two so we haven't
10 actually identified it.
11 CHAIR: Yes, right.
12 MR GRIEVE: I haven't seen the formal order Madam Chair, but the event
13 arose at page B2087 and 2088 of the transcript. B2087 and 2088. It's the
14 very last line on B2087 and 2088 Madam Chair.
15 CHAIR: Thank you Mr Grieve. Right thank you Mr Grieve, well it seems
16 that all the transcript shows that it was a laboratory in and then obviously
17 Whangarei, the word Whangarei would have been mentioned. We don't
18 know for sure if it's a hospital, a community laboratory. So this is your
19 questioning Mr Grieve, and you're actually saying Miss Fisher had brought
20 to attention another laboratory and that was a laboratory in Whangarei so the
21 actual laboratory in the area had been identified.
22 MR GRIEVE: I've certainly mentioned the locality Madam Chair, yes.
23 CHAIR: Mr Murray, have you looked at the transcript?
24 MR MURRAY: No, I'm just trying to find it actually but I do recall that
25 there was an exchange about the locality being relevant in itself because
26 there were so few laboratories in each region.
27 CHAIR: That's right, see my concern earlier was we may not know where
28 the smears had been read. If there was just a complaint about problems
29 concerning women living in Whangarei who had had smear tests who were
30 concerned until we knew the laboratories, it seemed to me that it would be

1 very unfair to a laboratory in Northland when any misreading, if it had
2 occurred, may well have been done in the laboratory outside that area.
3 MR MURRAY: Yes.
4 CHAIR: But if there is a specific complaint about a laboratory in a locality
5 and the way the transcript reads, it says. What I'll do is that I'll have it
6 handed to you rather than read it out. Mr Corkill's giving it to you.
7 MR MURRAY: Yes I think that my intervention was really out of
8 abundant caution because we didn't want to jeopardise the investigation of
9 the complaint.
10 CHAIR: That's right, yes, you were acting for the Health Funding
11 Authority who had received a complaint.
12 MR MURRAY: And I should have just, excuse me for interrupting, but
13 the complaint is actually being handled by the Health Funding Authority not
14 the Ministry and I did ask about this position, this complaint, prior to
15 coming up here and it's still being investigated. It's quite difficult now
16 apparently to set up a protocol. I think the Health Funding Authority might
17 know where the slides were read because they have to get the slides, go back
18 to the laboratory and then set up a protocol. I don't have that information
19 myself –
20 CHAIR: Right.
21 MR MURRAY: But I think at the end of the day it comes down to the
22 laboratory's interest, not now –
23 CHAIR: Yes, rather than.
24 MR MURRAY: The Health Funding Authority can carry on with it's
25 investigation.
26 CHAIR: Yes. Thank you. Ms Bunkle, can you help me please, what has
27 the publicity been, I'm not aware of the publicity myself.
28 MS BUNKLE: Ma'am, I have a number of -
29 CHAIR: Could you show it to me please?
30 MS BUNKLE: The newspapers, a number of cuttings, I've got a piece

1 from the New Zealand Women's Weekly detailing one of these cases in
2 Whangarei from an earlier period and the other mentions have been from the
3 Herald and from local newspapers. And I do have quite a series of these
4 cuttings with me. They were given to me yesterday by some of the women
5 who were asking questions about it, including the woman whose story is
6 here who had four apparently clear smears, and invasive cancer, and I felt
7 constrained in answering them because I was concerned that I didn't want to
8 violate the suppression order or the confidentiality agreement.
9 CHAIR: Well, if I could see them because it has an impact on whether
10 there's any point in having a confidentiality order if there's already been so
11 much publicity about laboratories in Northland, and it's also helpful to the
12 Committee when it comes to better assessing how important it is to have this
13 audit done and whether or not there is a need to go to the High Court.
14 MS BUNKLE: Ma'am, I may just need to go through and select them, if
15 that's alright, it'll take me –
16 CHAIR: Alright.
17 MS BUNKLE: If I can give you this one from the Women's Weekly
18 which I know, and the Herald, and I'll go through the rest.
19 CHAIR: Well if you go through them and I could perhaps hear from Mr
20 Grieve and by that, we should be getting close to the afternoon tea break by
21 then, and if you could give them to me then, and I'll rule on this by the end
22 of the day.
23 MS BUNKLE: Thank you.
24 MR HINDLE: Ma'am, if we're leaving that subject, I just thought that I
25 should indicate that I've discussed the question of order generally with my
26 friends and it might help if I could indicate that –
27 CHAIR: Certainly.
28 MR HINDLE: Subject to reservations that I am sure my friends, Mr
29 Grieve and Mr Corkill will explain to you, they are happy to go first,
30 representing women affected. It's hoped that Ms Kapua representing the

1 interests of Maori Women may be able to go tomorrow morning. She has
2 yet to file a submission but I understand that it will be received and that it's
3 not very lengthy so that might be appropriate. It's then proposed that
4 submission be presented on behalf of the Women's Health Information
5 Resource Trust represented by Ms Bunkle and Mr Kirton and although I
6 confess I haven't discussed this with Ms Coney, who wanted to present her
7 submission on behalf of the Women's Health Action Trust, we'll see if we
8 can arrange for her to come in after that. I do know that she has some
9 availability difficulties this week but we'll just have to work around those.
10 CHAIR: Well the way things would stand, would she be on tomorrow
11 would she?
12 MR HINDLE: Either that or Wednesday morning, but likely tomorrow.
13 I'll shall just have to make contact with her. I have the feeling that she may
14 not be available until next week in which case, she may have to consider
15 about her position as to whether or not she needs to present them at all,
16 certainly she's filed a full written submission which explains her position,
17 the position of her Trust. It then follows the suggestion that the Cancer
18 Society should gives it submission and then followed by the Ethics
19 Committees and in no particular order that would be both, I assume the
20 Tairawhiti Regional Ethics Committee and the National Committee
21 represented by Mr Parker and again, I actually have to get news of that to
22 them so they can make travel plans. Tairawhiti Health Care would go next,
23 followed by the Royal College of Pathologists, the Ministry of Health and
24 the Health Funding Authority and finally, Dr Bottrill and if the Committee
25 wants to hear from counsel assisting after, we will of course be ready to
26 assist but you would have heard an awful lot by then. And we have filed a
27 submission we certainly will be ready to address you on anything that you
28 are concerned about. So that really represents the tentative order at this
29 stage.
30 CHAIR: Thank you Mr Hindle. Mr Grieve, are you going to go next?

1 MR GRIEVE: Yes Madam Chair, could I just mention the reservations
2 that both Mr Corkill and I have signaled –
3 CHAIR: Yes.
4 MR GRIEVE: As far as Mr Corkill is concerned, as you know, the
5 submissions for the Ministry of Health and the Health Funding Authority
6 were received on Friday, I make no comment about, I make no criticism of
7 that but that's the fact of it. Now –
8 CHAIR: Also, they're not complete.
9 MR GRIEVE: And they are complete. Now, and of course, as far as Mr
10 Corkill is concerned, they deal essentially with matters with which he has
11 been involved, the complex and detailed systemic matters. He is happy to
12 proceed as I am but asks that leave be reserved to permit him to respond by
13 way of reply, should it be necessary, either orally depending on time or in
14 writing, if time constraints mean that it can't be orally. So that's the first
15 reservation, the only other reservation is mine and it is of less significance,
16 but it's this: Were this a civil trial in the High Court, then there are some
17 rules of practice which would govern the order of addresses, generally being
18 that the party that leads off during the course of evidence and in cross
19 examination during the trial, by going first has their case commented on by
20 parties that follow and normally the order of addresses is therefore reversed.
21 So that we could, were those rules applicable expect to come rather towards
22 the end. I mean there are other rules that apply such as parties that are being
23 criticised, having the right to hear those criticisms so they can respond. I
24 simply ask that depending on how matters develop, should the submissions
25 or response from the College and Dr Bottrill on our oral submissions,
26 require reply then I would ask that at least consideration be given to giving
27 me leave to reply, because of course they've had the opportunity of
28 commenting, criticising, whatever on our case throughout. So, those are the
29 reservations I just signal at this stage.
30 CHAIR: Have you received submissions from the Royal College and Dr

1 Bottrill?
2 MR GRIEVE: Yes.
3 CHAIR: If you want in the course of your oral submissions, what I have
4 done, I made the order that submissions be filed in writing in advance so
5 that everyone would be aware of what others were saying. I understand
6 your predicament in respect of the Ministry of Health, Health Funding
7 Authority submissions but particularly Mr Corkill's predicament because he
8 deals with the systemic issue and subsequent terms of reference and we're
9 all waiting to hear what the Ministry has to say about that. But in terms of
10 what the Royal College and Dr Bottrill has said in their submissions, you
11 can use this time now to comment on that.
12 MR GRIEVE: Of course, and I will be doing that but briefly, and I
13 wouldn't expect any further opportunity to do that, it's rather what might
14 emerge by way of oral submission only.
15 CHAIR: Yes.
16 MR GRIEVE: I should've made it clear, that's limited to that.
17 CHAIR: Yes, because what I anticipated is that today people would speak
18 to their submissions, emphasising the important parts or anything they want
19 to embellish on or anything that they want to comment on arising from other
20 submissions, and also be subject to questions from the Commission of
21 Inquiry.
22 MR GRIEVE: Yes. So I take it then Madam Chair or should I, can I take
23 it that subject to those limitations that I may have the right to respond to the
24 oral submissions should that be necessary.
25 CHAIR: I don't see there is any need for me to say anything about that at
26 the moment, you're obviously free to make an application should the need
27 arise and I'll deal with it then because I'll have something concrete to
28 consider, but feel free to make the application.
29 MR GRIEVE: Thank you Madam Chair. Now, can I just have a moment
30 to grab (inaudible).

1 CHAIR: Yes.
2 MR GRIEVE: Madam Chair, as with the opening submissions, and for
3 obvious reasons, both Mr Corkill and I will address you. I don't propose to
4 do so at great length, I will refer to the introduction and then just briefly
5 highlight one or two matters that have been dealt with in rather greater
6 length in the written submission that is being served on all the parties. I was
7 contemplating whether I should just read the introduction because, but I
8 think that rather than read it, it's probably best to follow, or set the example
9 that I think everybody is anticipating will be the way in which we proceed
10 and that is that we simply don't read our submission and we just deal with it
11 orally by way of summary without taking a great deal of time. The
12 introduction of course deals with the fact that you've heard from a number
13 of women, the fact that there are lessons to be learned from what has
14 happened here in Gisborne. I refer to the fact that in clause 1.4 that the
15 underreporting is now established and that the factors or relations, causes of
16 it go beyond Dr Bottrill's, what I say is now established and obvious
17 incompetence. I make trenchant criticism of him in paragraph 1.5 and I'll
18 be developing that, or it is developed later in the submission, but I do submit
19 that that the determined cavalier attitude to the health and safety of the
20 patients he served, exhibited by his persistent refusal to take the necessary
21 steps to achieve things like accreditation to participate in quality assurance,
22 or any significant continuing education. Section 2 makes some comments
23 about the women affected and the important role that they have played not
24 only in providing important evidence in terms of the details of their
25 individual cases but also really in terms of bringing attention to this whole
26 situation in Gisborne which has resulted in this Committee of Inquiry.
27 CHAIR: If we could just pause there. My recall of the evidence was that
28 patient one's legal costs were in the vicinity of $200,000, is that right?
29 MR GRIEVE: She submitted a schedule –
30 CHAIR: Yes.

1 MR GRIEVE: Which, and I have been unable to find the exhibit reference
2 number and I'm not even sure that it got one, I looked in the transcript and
3 couldn't find it, despite some significant electronic technology.
4 CHAIR: Well I think there was a schedule of a series of her expenses that
5 went in with the first exhibit, I'll just get the exhibit number. It comes to
6 $182,000. The reason I just raised that is I can't recall what amount the
7 exemplary damages were that she was seeking.
8 MR GRIEVE: That's a good question, I should know the answer but I
9 think it was, and I may be wrong, I think it was of the order of $200,000.
10 CHAIR: Right.
11 MR GRIEVE: I could find that relatively easily but not while I'm on my
12 feet.
13 CHAIR: No, no that's right. It seemed to me the point she makes that
14 spotlight really came on Gisborne after the High Court litigation brought by
15 Patient One was done at considerable financial risk for her in the sense that
16 she incurred $182,000 worth of legal costs and it's problematic whether she
17 would ever get exemplary damages of a very high amount.
18 MR GRIEVE: True.
19 CHAIR: Not the same as compensationary damages.
20 MR GRIEVE: Just to make sure you have it accurately Madam Chair, she
21 was legally aided but she had to, and I think it's right that her property is
22 subject to a charge.
23 CHAIR: Yes, that's standard for Legal Aid today so even though she has
24 had the benefit of legal aid, she may well have to repay that money.
25 MR GRIEVE: Yes. That's so. And I think that schedule, the figure in the
26 schedule of course is something like $400,000. That included her
27 assessment of income lost and other expenses as well.
28 CHAIR: You have, I know I'm jumping here, but I think that there is a
29 connection in the sense between this transparency created by the High Court
30 litigation? You make it 2.3, as I see it there is a connection between that

1 and the point you make at the very end of your submission when you deal
2 with compensation, because it seemed to me that we work in an
3 environment where we have the Accident Compensation Legislation which
4 has it's no fault principle. Which in turn means that there are no negligence
5 actions for compensatory damages and therefore you do not get this
6 spotlighting effect that a High Court trial can have when there has been an
7 error. Do you have any comment on that?
8 MR GRIEVE: Well Madam Chair, I have very strong views about the
9 relevance and appropriateness of the Accident Compensation regime in
10 today's environment. The fact is that had Patient One lived in Australia, she
11 would have been compensated I would estimate to the extent of at least
12 $1m, maybe $2m, and I say that because in the O'Shea case, Ms O'Shea, in
13 relation to one smear I think, received awards totaling something like
14 $750,000. Now some of that, that was not all pain and suffering, some of it
15 was loss of earnings and so forth. But it gives an indication of the sort of
16 awards that used to be made in this country and are no longer. And of
17 course, there are other impacts that one has, that have been adverted to
18 during the course of the Inquiry as to whether or not the fact of the threat of
19 litigation imposes on people generally, let alone medical practitioners better
20 standards of care, the awareness that if one falls down negligently, one can
21 be liable to civil suit. In my view, that is a significant sanction against
22 people, particularly medical practitioners, because that is the context we are
23 in at the moment so –
24 CHAIR: I recall asking Ms Glackin: that question in terms of the Ministry,
25 would it have made any difference as to how they managed the programme
26 if they could have been sued for compensatory damages and she said, no it
27 wouldn't. Do you have any comment to make on that.
28 MR GRIEVE: Well, with respect to Ms Glackin, I think that is an
29 unreasonable approach. I suspect that not just in the medical field but in all
30 fields of endeavour, if one realises that one can be called to account

1 financially for one's carelessness or sins of omission or sins of commission
2 then one assumes a greater practical level of responsibility. So I'm sorry, I
3 know she is here but I wouldn't accept that answer for a moment as being
4 correct.
5 CHAIR: So is it your point, at point 2.3, if it were not for the availability
6 of an exemplary damages action in New Zealand given that you can't sue
7 for compensatory damages, the difficulties that have occurred in Gisborne,
8 may not have come to light and they did.
9 MR GRIEVE: I think that is so Madam Chair, although being candid
10 about it, I didn't have that exactly in mind when I made the point. The point
11 was simply that had Patient One not had the tenacity to pursue the matter,
12 then that would, that is the result. It wouldn't have come to light.
13 CHAIR: Yes, we've said without the High Court trial and subsequent
14 publicity, there would've been no re-reading exercise and that is your point.
15 It did strike me that whereas you can expect persons to be tenacious in an
16 environment where they can sue for large compensatory damages, given the
17 environment in which we work where there is simply exemplary damages
18 and the Court of Appeal has indicated the awards are not going to be high.
19 It's expecting a lot of persons at the end of the chain who suffer any medical
20 error to expect them to then commence litigation which is going to bring it
21 to the public view.
22 MR GRIEVE: That is absolutely so Madam Chair. It requires a certain
23 special person to decide that they have been so wronged that they are going
24 to exhaust all remedies available whether they win or lose and –
25 CHAIR: And whether the property is encumbered with a lien of $182,000
26 or not.
27 MR GRIEVE: Exactly, exactly. The fact is that Patient One felt and still
28 feels terribly wronged by what happened and her life, her health, and I made
29 the point, I haven't read it and it's the same for all the other women and
30 various, I mean we heard from the young woman who can't have children. I

1 was having my hair cut the other day and the young woman who cut my hair
2 says "that poor young woman, she's not able to have any children", that's
3 how it affects people, and it's important Madam Chair in my submission
4 that those sort of very human reactions, and that wasn't someone concerned,
5 that was someone observing from a distance, those very human reactions are
6 not lost sight of and I think it took tremendous courage for all the women to
7 come forward and tell their stories. Some of them have come through it
8 better than others, some of them as we know have died and well, I know that
9 that's an appeal to the emotions but in this sort of area, while one must look
10 at the facts unemotionally, the fact is that behind all that for those women
11 and there are a lot of others in addition to them, anonymous ones who
12 haven't come forward, this tragedy has wrecked their lives.
13 CHAIR: Well, it's not only an emotional issue because what it does is
14 demonstrate what the ultimate consequences are if something is badly done.
15 It could happen anyway, but if a programme is badly managed, you are
16 going to get people dying.
17 MR GRIEVE: That's right, and sadly that has happened.
18 CHAIR: That of course is not to say that this programme has been badly
19 managed, I'm not saying that at the moment, but you have to accept that I
20 only say that in the sense that I think it goes beyond being just an emotional
21 issue.
22 MR GRIEVE: Yes, but coming back to the point, while I don't think
23 Patient One would claim entire credit for this inquiry becoming a reality,
24 nevertheless it was certainly the catalyst and once that had occurred, there
25 were a variety of things that happened. There was the letter that I wrote that
26 was followed up by Ms Bunkle's question in parliament –
27 CHAIR: Yes.
28 MR GRIEVE: All those things and to her credit, without those two latter
29 things, the Health Funding Authority as a result of the publicity in the High
30 Court was embarking on it's own inquiry.

1 CHAIR: Yes but I noted from your submissions the way you present the
2 evidence as you say that there was a resistance to the need for a re-reading
3 exercise initially by the Royal College and we don't know, we can only
4 speculate, but it may be that had it not been for the High Court trial and the
5 evidence that come out at that trial, simply letters of concern and complaint
6 about the performance of a pathologist may not have produced the pressure
7 which lead to a re-read exercise being carried out.
8 MR GRIEVE: I think that's absolutely right and if I recall correctly
9 Madam Chair, in the evidence somewhere I think it might have been from
10 Dr Tie, but somewhere there is evidence that the thing that moved the
11 College to support was the publicity rather than the scientific proof of
12 necessity so that it was the publicity no doubt that resulted in the re-reading
13 exercise being undertaken.
14 CHAIR: Given the impact that publicity has had, could you assist me here.
15 We all know that court cases are carried out in public and one of the benefits
16 of the legal process is that it is a public process. Given that you cannot sue
17 for compensatory damages in this country, can you think of any other
18 processes which are going to put concerns, such as the concern that has
19 happened in Gisborne, under the spotlight and in a way similar to a court
20 case?
21 MR GRIEVE: Well I know that already the legislation is being changed so
22 that the hearings before the medical practitioner's disciplinary tribunal are
23 now, as a general rule, public rather than the reverse. I think the problem
24 with that though being of the forum is the, well it's certainly been in the
25 past, the difficulty in getting there promptly. That may improve now
26 because I think there have been certain administrative changes put in place
27 that may mean that there is a faster reaction time but having said that, it is
28 the thrust of our submissions really that the lessons from Cartwright have
29 not been learned and we move on in the submissions to deal with the issue
30 of lack of internal morality, the question of whether as a result of what was

1 said in Cartwright and Justice Cartwright in that report referred to the fact
2 that she was not confident that the medical profession would be sufficiently
3 open in terms of it's imposition of disciplinary processes on it's own
4 members that it could be left safely to them. Now it is the theme of part of
5 this submission that that lesson has not been learned. And I know that in the
6 submission from the Women's Health Information and Resource Trust,
7 similar themes are developed, so I don't have confidence that things are in
8 place that will prevent this happening again –
9 CHAIR: Yes.
10 MR GRIEVE: And here we have another case in Whangarei, now I'm not
11 involved in that but the history of it from what I've seen is that for a lengthy
12 period, a number of years, this particular doctor has been the subject of a
13 number of complaints, being through the official channels, and he is still
14 there practising until Friday a week ago when he was stopped, suspended by
15 the Tribunal. Northland Health still comes out and defends him.
16 CHAIR: Yes, well we don't have evidence before us on that point but it
17 does seem that one of the arguments that is always made against name
18 suppression is that if concerns about the performance or the conduct of a
19 particular person are made public, it can often had a flushing out effect so
20 that you have other people who come forward and certainly that happens in
21 criminal matters where an offender's name is published. It can happen in,
22 say for example, medical negligence matters, it's in a sense happened here
23 because a result of Patient One's court case we have learnt about other
24 women that the publicity has generated others coming forward. What I'm
25 really trying to explore with you is, its seems to me that given the high cost
26 involved in litigation for a small return with exemplary damages, you're not
27 going to get everyone affected bringing an exemplary damages claim.
28 Therefore, is there any other equivalent which is going to get concerns about
29 the performance of someone out in the public arena so that if others are
30 affected, it will have a flushing out effect.

1 MR GRIEVE: Well, off the top of my head, the Medical Injuries
2 Compensation Tribunal –
3 CHAIR: Who are they?
4 MR GRIEVE: Well, they're a figment of my imagination –
5 CHAIR: Oh I see.
6 MR GRIEVE: Right at the moment but there are, there is in the UK for
7 example, the Criminal Injuries Compensation Board.
8 CHAIR: Yes, ACC hearings are private aren't they?
9 MR GRIEVE: Yes they are.
10 CHAIR: And the appeals, are they private too? When you have the
11 appeals to the District Court, I don't know.
12 MR GRIEVE: They're in public.
13 CHAIR: They're in public, right. You're really stuck then if, with a
14 situation where the ACC have denied a claim and then it's gone on appeal
15 so that if you're getting a series of claims coming forward in respect of a
16 performance of a particular medical practitioner and they're being upheld,
17 it's all going to be done privately, no on else is going to know about it.
18 MR GRIEVE: That's right. So short of repealing the Accident
19 Compensation Legislation going back to the, dare I say it, the good old days
20 of common law litigation, it's going to need specific legislation to, because
21 of course I think we're now about to reinstate some sort of lump sum
22 compensation, but that may have some effect, but it doesn't answer the point
23 that you were making Madam Chair.
24 CHAIR: No. It may mean that someone who suffers injury does get some
25 compensation because some of these injuries for a start, the women may not
26 have been working so they wouldn't be liable for earnings related
27 compensation but it doesn't really address the flushing out effect, so you can
28 find out whether or not what is occurring is a one off mistake or whether
29 there is a pattern of mistakes.
30 MR GRIEVE: Quite.

1 CHAIR: Thank you Mr Grieve.
2 MR GRIEVE: Now, I deal then in section 3 with what I've called
3 preliminary legal issues. I don't, I suppose the, and I'm not asking Madam
4 Chair that this be re-argued or re-litigated but I do submit there that with
5 respect you adopted a somewhat, shall we say, cautious approach to
6 admissibility and I deal with, I really just reiterate the arguments that were
7 put forward from time to time during the hearings –
8 CHAIR: Yes.
9 MR GRIEVE: That's really at paragraphs 3.6 through to 3.11 –
10 CHAIR: Yes, well if you could just pause there, firstly with your 3.5, it
11 seemed to me here it really was an issue about what was meant by blame.
12 Mr Corkill has dealt with it in his submission and I can't quite put my hand
13 on it just now but it seemed to me that everything really turned on whether
14 or not the Committee made findings as to what were factors which may lead
15 to underreporting, you know, who would be and in the course of doing that,
16 it may be that you identify who was responsible for those factors. Now
17 from that it seemed to me one could infer blame so it seemed that there was
18 nothing wrong with coming out with findings which might implicitly within
19 them have blame but it was not the role of the Committee to make explicit
20 findings saying that someone is, or should be blamed for doing something in
21 the way that you might find them legally responsible and Mr Corkill, he
22 might be able to help quickly, I don't know. He's referred to a –
23 MR CORKILL: It's page 40 Ma'am.
24 CHAIR: Page 40, yes the Transport Accident Investigating Commission,
25 that starts at page 39 and, over at page 40, there is a reference to the
26 Whalewatch and Transport Accident Investigation Commission where it
27 said there that inferences of blame can sometimes not be avoided. And it
28 talks later about blame being implicit and then it goes on to say that the role
29 of the Commission is not to ascribe blame but to lay a sufficient foundation
30 for their conclusions as to the cause of the accident. In some ways it

1 becomes, it seemed to me, a semantical exercise and it was really a matter of
2 how you framed the writing of the report but certainly as I see it, it is
3 necessary for the Committee to identify factors which have lead to under-
4 reporting and if in identifying those causes, blame can implicitly be laid at
5 someone's door, so be it, if the Committee has no control over what
6 inferences people draw from its findings. But I still think, open to what you
7 may have to say, that it is not the role of the Committee to then ascribe
8 blame in a legal sense.
9 MR GRIEVE: Yes I think Madam Chair it may well be a semantic issue.
10 Take by way of example, and I'm not wanting to urge this on as a specific
11 submission now, I do it later, but deal with it in the context of this inquiry.
12 The various actions of Dr Bottrill, either omission or commission, and I
13 could probably perhaps leave it as broadly as that, there are as we have
14 submitted acts of commission and omission in his case. Now, I'm not
15 submitting that you need to, assuming one finds that they existed, I'm not
16 submitting that you need to go on and say well, in this regard, he is
17 responsible to this degree. But in my submission, it is important that the
18 fact of responsibility be sheeted home to whoever you find to be
19 responsible. Now the way I see it, that connotes blame and yes, it's a
20 semantic approach to the thing I suppose, but in my submission, that's what
21 you are asked to do by the terms of reference, identify areas of responsibility
22 and I accept immediately that you are not required nor perhaps even
23 permitted to make statements which could be taken as specific findings of
24 either tortious acts, certainly not criminal acts, so I don't whether that
25 clarifies it.
26 CHAIR: Yes.
27 MR GRIEVE: Somehow, I don't think it does.
28 CHAIR: Well no I just wanted to tease that out with you. I have no
29 difficulty, because certainly it seemed to me terms of reference 2 talks about
30 identifying factors likely to have lead to underreporting and if for example,

1 one of those factors is the failure to have the laboratory Telarc accredited or
2 participate in External Quality Assurance, that should be set.
3 MR GRIEVE: Yes, exactly.
4 CHAIR: Then moving then through your submission, the next thing in
5 terms of the admissibility point, one of the things that struck me about this,
6 it seemed to me that firstly the issue correctly pointed out section 4B of the
7 Commissions of Inquiry Act really sets the scene by giving the discretion to
8 receive any evidence. The reference to the Erebus case I had more difficulty
9 with just because it seemed to me that the whole thrust of that case was
10 really about breaches of natural justice and whether or not the no evidence
11 rule which is making findings not supported by evidence amounted to a
12 breach of natural justice and the Privy Council was saying they're, well, yes
13 it does if there is no evidence but when it comes to determining whether or
14 not there is any evidence to support the finding, it doesn't have to be just
15 evidence that would be admissible in a Court of Law. Evidence which tends
16 to logically support the existence of the facts will be sufficient and that is
17 fine when you're making an assessment after the event when the report is
18 written and you're looking to see is there any evidence of any sort, be it
19 admissible or inadmissible, say hearsay, to support this finding when you're
20 trying to make a decision as to whether or not you'll admit evidence, you've
21 no idea at that point what your findings will be. So it seemed to me that the
22 real test was to fall back on section 4B and look at whether or not under 4B
23 the evidence was going to be of assistance because 4B says the Commission
24 may receive as evidence any statement document information that in it's
25 opinion may assist it to deal effectively with the subject to the inquiry
26 whether or not it would be admissible in a Court of Law.
27 MR GRIEVE: yes.
28 CHAIR: And so it seemed to me in terms of assessing whether or not
29 something is going to allow the Committee to deal effectively with the
30 subject matter, if something seems to be of little relevance or of little

1 weight, it's really of no assistance.
2 MR GRIEVE: Well I accept that of course, and Erebus, the dicta from
3 Erebus support that, that the weight is entirely for the Committee of Inquiry
4 and I suppose it's a question of, I mean we do get mixed up in areas of
5 natural justice here because until the Committee hears all the evidence, then
6 it is not in a position in my submission to make an informed decision about
7 weight. So I know that the argument becomes circular to a point, but
8 nevertheless if a line of inquiry pursued by Counsel is stopped at an early
9 stage, then the decision is to wait is going to be made only on a basis of part
10 of the facts. So it's a matter in my submission and this would become a
11 natural justice argument, it's a matter of taking a broad approach to what
12 material is going to be received and waiting until the end and then making a
13 decision about weight rather than the other way around.
14 CHAIR: It's not so much weight though, because weight is something that
15 is applied to the evidence that is received and deciding whether or not to
16 receive evidence in the first place. Under section 4B there is a discretion to
17 decide whether or not, in the Committee's opinion, the evidence will assist it
18 to deal effectively with the subject to the inquiry. And whereas some
19 evidence is going to be obviously of assistance, other evidence obviously
20 not of assistance, and that is going to be the grey area, where it may be of
21 assistance, it may not.
22 MR GRIEVE: Well, yes, I'm not arguing. In the end it's for the
23 Committee to decide whether it's going to be assisted, now I've made these
24 submissions in the context of being stopped from time to time over various
25 matters on the basis of primarily not relevant to the terms of reference and in
26 particular, we were dealing with matters of what could broadly be talked
27 about as professional practices and at one stage, it was on the basis, well yes
28 it might be a professional practice under terms of reference 4, 5 or 6 because
29 you can broadly link those three terms together, but then they were linked to
30 the period of time designated at the end of preamble to the terms of

1 reference, namely prior to March 1996.
2 CHAIR: Where did that happen because I noted what you said there in
3 paragraph 3.15 and that wasn't how I was interpreting those terms of
4 reference. I didn't see them as being tied to March 1996 before that period,
5 so I'm just curious to know what evidence was it that you say you were not
6 allowed to introduce because of this approach.
7 MR GRIEVE: Well, really it was during the cross examination of Dr
8 Teague and it concerned acts and omissions to be alleged in relation to him
9 at a time about the, well during the period of preparation for the High Court
10 trial, that was adverted to him at his brief the receipt of the information
11 about the second patient and –
12 CHAIR: Which I found was subject to litigation privilege.
13 MR GRIEVE: Well, yes but there were matters in relation to that could
14 have been explored. Now I agree Madam Chair that terms of reference 4, 5
15 and 6 are not temporally linked to terms of reference 1 or 2, they're not
16 linked to that period and indeed at one point, you acceded to an argument of
17 mind that a subsequent fact might be relevant to prove a state of mind and so
18 on. So it's in that context that I'm making these submissions that there was
19 material in that regard in respect of which I felt constrained –
20 CHAIR: Yes.
21 MR GRIEVE: And so –
22 CHAIR: Well where does it get us now? Are you saying there has been a
23 breach of natural justice by the Committee or not?
24 MR GRIEVE: I suppose Madam Chair I am.
25 CHAIR: You are.
26 MR GRIEVE: Yes. Now where does it get us now? Well we certainly
27 can't go and revisit it –
28 CHAIR: You're not asking me to do that? To cure this breach, by
29 revisiting it?
30 MR GRIEVE: Well in not asking you to do so Madam Chair, I'm

1 recognizing, as we were all required to recognise not only now but during
2 the course of the hearing, the pragmatic realities of the situation and so I
3 make the point but I accept that nothing can be done about it now for that
4 reason. But I just, by way of completing this point about admissibility,
5 perhaps refer you to the cases that I found through the Crown Law Office
6 opinion –
7 CHAIR: Yes, if you're going to refer me to Douglas and Pindling, I've
8 read
9 MR GRIEVE: There's that one and Costigan.
10 CHAIR: Yes, because Pindling refers to Costigan, you've got a copy of
11 Costigan, yes well Costigan would've seen us be here for a good year,
12 wouldn't it?
13 MR GRIEVE: Yes Madam Chair, it might've seen us here for a little
14 longer but that's the pragmatic problem we all faced because if one took
15 Justice Ellicott's dicta as stating the position correctly, I suspect that the net
16 could have been cast significantly wider and in that regard, could I just also
17 make reference to the fact that no doubt through time constraints, term of
18 reference 7 has largely been overlooked. I don't say that in a critical way,
19 but it's just a fact that we haven't, nobody sought to call in aid to any great
20 extent term of reference 7 but in terms of receiving relevant material,
21 unrestricted by the terms of the specific terms of reference, term of reference
22 7 gave you a pretty broad mandate with respect.
23 CHAIR: Depending on whether you've read it as if the eustem generis rule
24 applied and it was to be read in the context of all the other terms of
25 reference or you saw it standing alone, it would be unusual I would think.
26 MR GRIEVE: I'm not suggesting it needed to be construed as standing
27 alone because that would be tantamount to submitting that you had a licence
28 to do what Justice Ellicott said you can't do, which is go off on a frolic on
29 your own.
30 CHAIR: Yes.

1 MR GRIEVE: So that's subject to any other questions you might have of
2 me, that's the preliminary legal issues. Can I move on to deal with term of
3 reference 1.
4 CHAIR: Yes, we're at 3.30 which is the time for a break. We'll stop for
5 15 minutes, also I did want to go over Douglas and Pindling, but really in
6 the context of the audit that the Committee wants to carry out and I can do
7 that at the end of your submissions since you've read the decision and are
8 familiar with it or I can do it now as it's before you. I am happy to do
9 either, it's in your hands there.
10 MR GRIEVE: Now, I haven't read Douglas and Pindling, I've read Justice
11 Ellicott and the Court of Appeal so –
12 CHAIR: Well
13 MR GRIEVE: I've got it though.
14 CHAIR: That may be enough and you can look at Douglas and Pindling
15 over the afternoon break and we'll come back at 3.45, you really only need
16 to look at Douglas and Pindling from page 901 to 904.
17 MR GRIEVE: Thank you Madam Chair.
18 CHAIR: And you don't have to do it straight after, it can be at the end of
19 your submissions, I don't want to interrupt the flow so I'll leave that to you.
20 MR GRIEVE: Thank you.
21
22 INQUIRY ADJOURNS UNTIL 3.45
23
24

1 3.45 PM INQUIRY RESUMES
2
3 MR GRIEVE: Now Madam Chair I've done myself a minor injustice
4 because I had started to read and I remember Douglas and Pindling, I've
5 now read it I think and hope sufficiently to volunteer for an oral
6 examination.
7 CHAIR: Right. Well really just in terms of the audit that the Committee
8 of Inquiry wants to conduct and the difficulty it has getting the information
9 and seemed to me on my reading of Douglas and Pindling and I'm interested
10 in hearing from you on this point because you act for Counsel for the
11 women. There is a point, at page 904 lines b to d,
12 MR GRIEVE: Yes, I've got that Madam Chair.
13 CHAIR: Yes, in this point where it says, refers to the discussion earlier
14 and then says if there is material before the Commission which induces in
15 the members of it a bonafide belief that such records may cast light on
16 matters falling within the terms of reference then it is the duty of the
17 Commission to issue the summonses. It's not necessary the Commission
18 should believe the records will in fact have such a result, the Commission
19 can do no more than pursue lines of inquiry that appear promising. It
20 seemed to me that applying Douglas and Pindling, it wasn't really just a
21 matter of having a duty to issue the summons but equally if the material was
22 not forthcoming, if there was a way in which it could be determined whether
23 or not the material should be made available and by that, I mean section 10
24 of the Commissions of Inquiry Act which allows the Committee to refer
25 disputed points of law to the High Court for resolution, that the Committee
26 had a duty to exercise that power, in other, words that it should pursue the
27 issue to the full extent of the powers available to it, if it believed that the
28 information may be of assistance and here the Committee believes the
29 information would be of assistance in terms of terms of reference 3 deciding
30 whether or not there was a systemic issue and also terms of reference 4, 5, 6

1 and 8 because in terms of being able to answer 4, 5, 6 and 8, it seems that
2 the Committee needs to be clear about what are the legal impediments to
3 gaining the information which is necessary for the monitoring and
4 evaluation exercises to be carried out.
5 MR GRIEVE: Well Madam Chair, my response to that would be that the
6 phrase or clauses the duty of the Commission to issue the summonses, it
7 would be an obiter remark in the context of both Douglas and Pindling but
8 of authoritative value obviously, indeed binding insofar as obiter remarks
9 can be binding. I think it provides support for the view that if there is a
10 legal remedy which is required to be pursued to enable the Committee of
11 Inquiry to exercise it's duty, then that should be undertaken.
12 CHAIR: Yes, because if the Committee at this point decided having said it
13 wanted to issue a subpoena to get information which would allow an audit
14 which it considers important to be carried out, if it then decided that given
15 the position of the Ministry of Health as expressed in the Crown Law
16 opinion, that the information cannot be made available. If it decided to
17 leave the matter there, short of being fully persuaded by the Crown Law
18 opinion that that was correct, would you say it would be remiss of the
19 Committee to not pursue it?
20 MR GRIEVE: Well, I would go back to first principles on this, aided in
21 part by Douglas and Pindling but only in part.
22 CHAIR: Yes.
23 MR GRIEVE: But the first principles are that the Committee of Inquiry
24 has a duty and it has a duty to take all reasonable steps and undertake all
25 proper inquiry to enable it to answer the terms of reference. That's the duty
26 that you have, now Douglas and Pindling is an expression of that and the
27 way that duty operates albeit in a somewhat more limited sphere, namely it's
28 in the context of the duty to inquire which will be largely met by issuing a
29 subpoena and getting the evidence for it. So, I don't think that Douglas
30 against Pindling can be advanced as on all fours and going through the full

1 legal gamut but I don't know that it is necessary to have authority in any
2 event. It's helpful and perhaps provides a level of comfort, my own view
3 would be Madam Chair that, and this is just an obiter comment of my own,
4 because I'm not dealing in any depth with terms of reference 3 but it seems
5 to me from what I do know about the evidence relating to it and the
6 submissions relating to it, that at the moment you are in a position of being
7 unable to answer term of reference 3 with, certainly with the certainty that
8 the scientists would like. By the scientists, I mean with reliance upon
9 statistical material that is regarded as sound or, forgotten the word that was
10 used,
11 CHAIR: Robust?
12 MR GRIEVE: Robust, yes, robust. So –
13 CHAIR: So do you think in those circumstances it's good enough to leave
14 it and report on the basis that of the evidence being uncertain, or should the
15 Committee exercise powers that are legally available to it which it may see
16 it get better evidence?
17 MR GRIEVE: The latter. That's how I see it. I just want to check with
18 Mr Corkill that I'm not treading on
19 CHAIR: No right, thank you. And also, and I'm interested in your views,
20 and I don't want to shut out Mr Corkill from saying this either, but term of
21 reference 8 says to make recommendations consistent with section 4A of the
22 Health & Disability Services Act. Now do you have a copy of section 4A?
23 MR GRIEVE: Yes I do, thanks to Mr Corkill, Madam Chair.
24 CHAIR: As you'll see, it's says to secure for the people of New Zealand
25 best health, best care or support for those in need of those services that is
26 reasonably achievable within the amount of funding provided and then see
27 achieve appropriate, no it's actually 4A so we're just looking at 4A. So best
28 health and best care or support that is reasonably achievable. Now, it
29 seemed to me that in order to make recommendations on term of reference
30 8, in terms of best health, best care, to be able to say something meaningful

1 about monitoring and evaluation of the programme, whether it was up to the
2 mark or not, whether it should be better. Putting aside practical issues of
3 resources, there is the legal situation of what impediment is section 74A of
4 the Health Act to using the Screening Register as a monitoring evaluation
5 device and also access to the Cancer Register. So it seemed to me that in
6 order to be able to make recommendations under term of reference 8,
7 Committee really needed to know where it stood on the law in relation to
8 gaining access to the type of information that would allow a meaningful
9 exercise on a regular basis to be carried out. What comment do you have on
10 that?
11 MR GRIEVE: Well with respect Madam Chair, I would agree with that
12 suggestion. The other comment that I would make just reading it as I stand
13 here, having regard to the requirement in term of reference 8 to make
14 recommendations consistent with section 4A and relating that back to term
15 of reference 3, well if as matters stand you are unable to make a
16 determination as to whether or not there has been an unacceptable level of
17 under-reporting or a systemic problem for the programme, then that plainly
18 may well affect a significant number of people in New Zealand and
19 obviously affect whether or not steps are being taken to secure for them best
20 health, best care and support and so forth.
21 CHAIR: Yes you're quite right and also, term of reference 6 to consider
22 all relevant proposals that could ameliorate any risk of under-reporting and
23 whether these are covered by 4 or 5, whether further changes are needed.
24 Regular monitoring and evaluation would be one way of picking up under-
25 reporting and therefore it would ameliorate the risk of under-reporting and
26 in order to be able to say whether it can occur whether a further change is
27 needed, you may need to know what the position actually is at the moment
28 in terms of legally being able to access the information you would use for
29 the purposes of monitoring and evaluation.
30 MR GRIEVE: Yes Madam Chair, I would accept that that's the situation.

1 CHAIR: Thank you. I was interested in your comments on that because of
2 course as representing women affected in a sense you represent the
3 consumer interest on this point.
4 MR GRIEVE: Well could I say immediately that it may be that Mr Corkill
5 wants to add to what I have said –
6 CHAIR: Certainly
7 MR GRIEVE: In a little more detail. Now Madam Chair does that
8 complete my oral on Douglas against Pindling.
9 CHAIR: It does, yes.
10 MR GRIEVE: Now Madam Chair, term of reference 1, I don't propose to
11 say anything more about that without wanting to pre-empt any of my
12 learned friends, it seems that there is by and large a degree of unanimity that
13 term of reference 1 has been established.
14 CHAIR: What does Ms Gibson say to that because she represents Dr
15 Bottrill and that's the most important person on that point.
16 MR GRIEVE: I don't know whether that's an invitation to her to make
17 statements now. I think perhaps I have
18 CHAIR: Yes.
19 MR GRIEVE: I'm not intending to overstate it as far as she is concerned.
20 There are some reservations expressed in her submissions. I don't place any
21 great store by the fact that Dr Bottrill acknowledged the proposition that was
22 put to him but there is a substantial other body of evidence that in my
23 submission, particularly bearing in mind the standard of proof that is
24 required and I know that Madam Chair you have reservations about the
25 Erebus case, but –
26 CHAIR: We haven't actually touched on what the standard of proof is so I
27 would be interested in hearing from you on that.
28 MR GRIEVE: Right. Well, in that regard, and I haven't done anything in
29 writing on this but in my submission, it is certainly no higher than on
30 balance of probabilities –

1 CHAIR: Do you think it's lower than balance of probabilities?
2 MR GRIEVE: I think it's lower –
3 CHAIR: Yes.
4 MR GRIEVE: In fact, I would be submitting that it's lower than on
5 balance of probabilities. We're talking here what is required to,
6 immediately one gets into difficulty when you talk about, to prove the terms
7 of reference; they're not consonant with an indictment.
8 CHAIR: No.
9 MR GRIEVE: So it's more correctly perhaps to be considered in terms of
10 what is the standard of proof required for the facts upon which we can as a
11 Committee of Inquiry then move forward to make a conclusion.
12 CHAIR: Yes.
13 MR GRIEVE: On the terms of reference. So I would submit that that is
14 the correct approach. What standard do we need to adopt to find a fact
15 established to our satisfaction?
16 CHAIR: Well the Erebus quote is –
17 MR GRIEVE: And this is where the Erebus quote that I have set out
18 Madam Chair on page 8 is in my submission, relevant –
19 CHAIR: Yes.
20 MR GRIEVE: What is required by first rule that is making a finding based
21 upon evidence that have some probative value in the sense described below.
22 What is required by that rule the finding must be based upon some material
23 that tends logically to show the existence of facts consistent with the finding
24 and that the reasoning support of the finding, if it be disclosed, is not
25 logically self-contradictory.
26 CHAIR: So you would say that notion of some material that tends
27 logically to show the existence of facts consistent with the finding really
28 could be a test lower than balance of probabilities?
29 MR GRIEVE: Yes, there has to be some probative material that
30 withstands logical analysis and testing. Now how far below tipping the

1 scales that might be is probably impossible to quantify. Maybe it's a bit like
2 the elephant? you'll know it when you see it or you'll know when you're
3 there so that unsubstantiated guess work or rumour and there's none of that
4 that I can think of anyway, well I suppose there is, so laid back –
5 CHAIR: Yes, so laid back that he was almost falling over. That could be
6 example of something.
7 MR GRIEVE: That's an example which probably would be unsafe to rely
8 upon to say well that impacts badly on Dr Bottrill.
9 CHAIR: Yes.
10 MR GRIEVE: Yes, if that was all that there was, it might be that that's
11 part of a wider picture so that that we're in the sort of notions behind
12 drawing inferences and
13 CHAIR: Strands of rope.
14 MR GRIEVE: Strands of rope, yes. So standard of proof in my
15 submission, something less than on balance of probabilities, but I suppose if
16 I'm going to try and articulate it, not greatly so.
17 CHAIR: I wanted to ask you about paragraph 4.7 which if you're ready to
18 move off your part 4, I'll ask you about that now because you're saying
19 there that in a commonsense basis it's open to the Inquiry to conclude that
20 the very obvious abnormalities which I would infer, to me, the slides that
21 look like the classic Papanicalaou slides –
22 MR GRIEVE: Yes.
23 CHAIR: Had been misread by Dr Bottrill and of course there was no
24 evidence from Dr Farnsworth –
25 MR GRIEVE: No quantitative evidence.
26 CHAIR: Yes, as to whether these were ones that Dr Bottrill had
27 recognised as well as being abnormal or whether he failed to do so.
28 MR GRIEVE: Yes.
29 CHAIR: So it seemed to me on that basis in the absence of evidence where
30 it could be either or, it was a matter of speculation as to which it was, which

1 is something the Inquiry shouldn't be doing.
2 MR GRIEVE: Well, where I am coming from Madam Chair is that is this
3 and I have set out some of the references but I won't go to them now
4 because I don't think they cover what I'm about to say, but I don't think
5 there's any doubt that what Dr Farnsworth said was broadly along these
6 lines. She got a significant proportion of the high grades and the
7 photographs that she took represented I think it was 20% or was it more, it
8 was representational of the total number that she saw. She just picked them
9 at random in the sense that they were the ones that were sitting on her desk
10 on that particular day and she photographed that lot. There was the issue of
11 how many of the total high grades did she see and of course, one can't be
12 precise about the relationship between that and the total body of high grade
13 because in terms of linking the gross abnormalities that she saw, I think she
14 said about other people who saw them well, they all reported to me similar
15 experience. Now that's unquantified. But of the ones that she
16 photographed, there was a percentage that had these obvious abnormalities
17 and all I am saying there and it will be a matter for the Committee to decide
18 is that one applies that percentage to the total number of abnormalities that
19 Sydney saw and compares that to the total number of abnormalities out of
20 the same group that Dr Bottrill, now wait a minute, it's the ones that were
21 there to be seen but didn't see because he only reported a very low
22 percentage then one can say that well it is likely that there were obvious
23 abnormalities that he missed.
24 CHAIR: It seems to me that if, for example, he had reported 10%
25 abnormalities and Dr Farnsworth said these classic Papanicalaou type slides
26 represented 20% of the re-reading exercise. At that point, you could say
27 well he must have seen some of these and failed to recognise them. But
28 unless you've got percentages like that from which you can fairly safely
29 conclude that these Papanicalaou slides exceeded the percentages of high
30 grade abnormals read by Dr Bottrill, it's a rather dangerous exercise to

1 embark on.
2 MR GRIEVE: Well I don't want to make any concessions about that
3 Madam Chair.
4 CHAIR: Well the next question I was going to ask you is on the basis of
5 the evidence that the Committee has, do we need to go this far? As there is
6 no point in going too far if we don't need to.
7 MR GRIEVE: No, you don't. I accept that, in order to determine term of
8 reference 1, you don't need to go that far, no.
9 CHAIR: That deals with that point, thank you. Unless you want to say
10 anything more about it.
11 MR GRIEVE: No Madam Chair I don't. Term of reference 2, the fact that
12 it lead to this under-reporting, well again, I've summarised them there. I
13 suppose I should emphasise that it is my submission, it's our submission that
14 in fact Dr Bottrill had no formal training that appropriately qualified him to
15 examine cytology and perhaps I should qualify it to this extent by saying to
16 the extent that he did in the period in question.
17 CHAIR: By that, do you mean doing the primary screening?
18 MR GRIEVE: I meant temporally during the period 1990 to 1996 and of
19 course, he was then doing the primary screening, that's an added factor but I
20 added that qualification because I am mindful of the point made on his
21 behalf which is correct that he did not infringe any legal requirements. In
22 other words, he had the qualifications which gave him the right to carry out
23 this work –
24 CHAIR: And what's more, I would assume that the majority of
25 pathologists of his generation would be the same. I think the evidence was
26 that training in cyto-pathology did not come into it's own until about the
27 70's or later.
28 MR GRIEVE: Well that is so Madam Chair and of course there was the
29 evidence that the Royal College had this focused qualification about 1973 so
30 that my point in this regard is that as time progressed and I'm paraphrasing

1 what's in this submission, as time progressed, pathologists generally became
2 aware of the need for additional qualifications in training for cyto-
3 pathology, that over the period through his participation such as it was in
4 collegial activities, meetings and that sort of thing, his involvement in the
5 Association of Community Laboratories and so forth, it's apparent that Dr
6 Bottrill became aware of these advances and so that it's put on the basis that
7 certainly by the relevant period, that is the 1990's, he must have known that
8 neither his training, certainly his qualifications and his subsequent
9 endeavors, because they didn't amount in my submission to continuing
10 education at all. He must've known that he was not fitted to do this task.
11 CHAIR: Well it seemed to me while I was reading your submission that
12 given that other pathologists who trained at a particular period of time also
13 would lack training in cyto-pathology, you couldn't be critical of that on its
14 own but you might say, well a reasonable pathologist he or she hadn't been
15 trained in cyto-pathology because of the time when the training was carried
16 out, would therefore be more alert to the need to upgrade skills or to
17 participate in continuing legal education and to participate in quality
18 assurance programmes. More so than say someone who'd had the latest up
19 to date training in cyto-pathology.
20 MR GRIEVE: And that Madam Chair was what I took out of Professor
21 McGoogan, perhaps not quite with the same emphasis as Dr Farnsworth but
22 certainly against, it's Dr McGoogan isn't it?
23 CHAIR: And Professor.
24 MR GRIEVE: And Dr Medley as well.
25 CHAIR: Yes. So is it your point that it's because he had no training in
26 cyto-pathology it was more imperative that he participate in accreditation,
27 quality control, external quality assurance continuing education or do you go
28 further than that and say just lack of cyto-pathology training here meant he
29 shouldn't have carried out cyto-pathology in Gisborne.
30 MR GRIEVE: No Madam Chair I think it's got to be the latter. I mean it's

1 not his fault that at the time that he did his formal qualifications, this was a
2 developing science.
3 CHAIR: Yes, so you mean that the former I think rather than the latter?
4 MR GRIEVE: Oh well, what I'm meaning is that his failure was failure to
5 update himself at a point when he knew that things had developed beyond
6 his field of qualification.
7 CHAIR: Right.
8 MR GRIEVE: Now I then go on and deal with, I mentioned very briefly
9 lack of, and this is probably a subsequent-plot of the first, the lack of
10 knowledge of appropriate screening method. That wasn't explicitly said but
11 there are some passages that I have referred to in Dr Farnsworth's evidence
12 and that there is a more detailed passage given in one of the other
13 submissions. I think it might be in my learned friend Mr Murray's
14 submission. Dr Farnsworth referred to the lack of methodical process –
15 CHAIR: Yes.
16 MR GRIEVE: And referred to the Cos text book and putting it bluntly, I
17 took from it that she was saying that she didn't think Dr Bottrill knew how
18 to read slides properly and I asked him about that and he agreed to the
19 possibility that he may have as a result of his method, missed cellular
20 material.
21 CHAIR: Right.
22 MR GRIEVE: Now, whether that is significant in the scheme of, well
23 depending on what view one takes about obvious abnormalities, we're all in
24 the same area but I do make the point that it may well be that his training
25 was such that he did not know how to screen slides properly. Then I refer to
26 failure to review patient's smears, no accreditation etc., I'm on page 14 and
27 I come on to then refer to, well I suppose before I leave that, I have to say
28 Madam Chair that I don't regard those failures as benignly as some would
29 submit according to the submissions that I have read. I know that my
30 comments and paragraph 5.8 are relatively strong, but it's my submission

1 that from time to time, strangely enough it began when Dr Bottrill was
2 giving his evidence in chief, he let drop one or two interesting phrases that
3 gave the lie to how he viewed certain things like the reference to quality
4 control measures as being draconian and in my submission –
5 CHAIR: I think that was said though in the context that he was saying, and
6 this of course, is open to how you accept his evidence, but he was saying he
7 didn't want to impose what he described as draconian quality measures –
8 MR GRIEVE: On his colleagues, when he was retiring.
9 CHAIR: Yes, when he retired, so that was his concern. So he wasn't
10 saying I think quality control measures are draconian, but rather the
11 measures I wanted to leave it open so whoever came in, would be subject to,
12 would their own measures or whatever measures were there to impose,
13 rather than him imposing them.
14 MR GRIEVE: With respect Madam Chair, I submit that's being overly
15 generous to him because one takes that word with the reference that was put
16 from time to time in the High Court to modern fad, that puts a different
17 complexion on his view of these measures.
18 CHAIR: Tell me this. Just two points here, the first one is to do with his
19 evidence, you said here that despite the attempt of his brief to retract the
20 acknowledgement in the High Court that he regarded these matters as a
21 modern fad, his evidence in the Inquiry confirmed that he held such
22 opinions. I recall you putting to him the transcript from the High Court, do
23 you recall what comment he said in his cross examination?
24 MR GRIEVE: I don't think I put modern fad to him Madam Chair.
25 CHAIR: Well if you didn't, how can we have it in the evidence?
26 MR GRIEVE: It was put to someone else and he, that's right, he referred
27 to it in his brief and said, well I better find it I suppose.
28 CHAIR: Yes, because I would just like to know how we can treat the
29 phrase.
30 MR GRIEVE: It's paragraph 44 Madam Chair.

1 CHAIR: Yes.
2 MR GRIEVE: In the High Court, it's the last sentence but one, in the High
3 Court, this is under a heading Quality Assurance. He refers to the Royal
4 College Programme and the fact that –
5 CHAIR: I see, I've got it now. It says in the High Court I accepted a
6 description of it as a modern fad. I wish to withdraw that. I did not regard it
7 in that light.
8 MR GRIEVE: Yes.
9 CHAIR: We've got it in evidence that he said that in the High Court and
10 now says he doesn't.
11 MR GRIEVE: And so he wants to withdraw that acknowledgement in
12 front of this Committee, it'll be for the Committee to assess what it makes of
13 that, I've submitted that taken with the word draconian, it in fact indicates
14 that is his real attitude, it hasn't changed.
15 CHAIR: Tell me this, we know that there was no accreditation, no quality
16 control or external quality assurance. Do we need to go the step further and
17 comment on why these weren't in place in the sense that we have to make a
18 finding about his attitude to them? The fact that he didn't have them would
19 maybe factors which have lead to under-reporting. Do we have to go the
20 extra step and say, well his attitude to these factors has itself lead to under-
21 reporting?
22 MR GRIEVE: Well as a matter of law, I suppose I would be bound to
23 concede that you don't have to go that far. That doesn't mean that in an
24 appropriate situation you ought not to go that far if that is the situation.
25 CHAIR: See, it came to me as well in 5.11 with his health, where you've
26 said we shouldn't accept his health, well again it seemed to me that do we
27 need to bother about what excuses he might make. In other words, if we
28 decide that his performance was inadequate and incompetent, that's enough.
29 MR GRIEVE: Yes, I accept that Madam Chair.
30 CHAIR: And as to why it was, his motivation, his intention, those reasons

1 are, they're extra and we may not need to go into that.
2 MR GRIEVE: Well I suppose, yes my learned friend Mr Corkill reminds
3 me that it might be a basis upon which one uses to support a finding and the
4 same could be said of the submission made in 5.9 about the financial aspect
5 of not embarking on accreditation. You could equally say to me Mr Grieve,
6 well do we need to worry about that, the fact is he didn't get accredited.
7 CHAIR: This is where this whole issue of blame comes in, because if our
8 role was to apportion blame, you might then want to be looking at not only
9 the acts or omissions but in a sense the mens rea, to use that word, the
10 mental element. Well what was motivating him, did it just happen or did he
11 really have a real mind set against these matters which in a sense, might
12 make him seem more blameworthy but I don't see that as our role, I think
13 we have to look at what factors caused under-reporting and identify those
14 and it may be that having identified someone reading the report, would infer
15 certain things about Dr Bottrill and whether he should be held to blame or
16 not. But to go the extra step and say well he didn't have quality assurance
17 because it's clear to us he didn't like the whole concept, he thought it was a
18 modern fad, and was draconian, seems to me to be going an extra step that's
19 unnecessary.
20 MR GRIEVE: Well, Madam Chair I can only repeat that I think I am
21 bound to accept that legally it's not necessary, but that is not necessarily a
22 complete answer, it's a question of whether the material before you warrants
23 it and I've made strong submissions about Dr Bottrill's attitude to all these
24 matters. I've called him arrogant, I've said that he had a misplaced
25 confidence in his own ability because in my submission, the evidence shows
26 that he simply, it wasn't just a case of not realising but he was someone who
27 simply turned his face against modern developments that he knew were
28 taking place and it's not as though it's a plumber who doesn't use PVC
29 piping but just wants to use the old stainless steel with lagging. He has an
30 ethical obligation to keep himself up-skilled for obvious reasons. Now, in

1 my submission it warrants trenchant comment but that is for the Committee
2 and really I can't take it any further.
3 PROFESSOR DUGGAN: Good afternoon.
4 MR GRIEVE: Welcome back Professor.
5 PROFESSOR DUGGAN: Thank you. I have several questions of my own
6 to ask you because the language is totally different to me, however in 5.2
7 where you make the comments about his training and experience, are you
8 including in cytology training in laboratory management and quality
9 assurance practices, or are you keeping those separate?
10 MR GRIEVE: I don't think I turned my mind to it, I think I was keeping
11 those separate. What I had in mind was more a temporal thing that back in
12 the 50's, he simply underwent no training in cytology beyond what he
13 described as the opportunity to look at some smears. Does that answer your
14 question?
15 PROFESSOR DUGGAN: So you don't consider that maintenance of
16 knowledge and skill in the discipline of cyto-pathology, which is an ongoing
17 event, includes quality assurance and laboratory management?
18 MR GRIEVE: I know to the contrary, I think now it does and at what
19 point of time in the development of the discipline it became relevant, I don't
20 know. You would be in a better position to know that than I, I suspect some
21 time in the, may have been earlier, but certainly in the 80's. Those facets
22 were part and parcel in appropriate training in cytology. I would doubt
23 whether they were back in the 50's.
24 PROFESSOR DUGGAN: Okay, I understand. Thanks.
25 CHAIR: Just getting back to this, try to finish it off but it seems to me that
26 his description of quality control is draconian and is a modern fad would be
27 very relevant if we'd heard evidence that he was carrying the measures out
28 but you were submitting that he wasn't doing it adequately because he really
29 thought it was just a modern fad and it was draconian, he didn't really need
30 to do it. So in other words, his mental attitude would be relevant if this was

1 a situation where there was evidence that there was something in place, but
2 it wasn't being properly carried out, it wasn't effective. But here we know
3 there was nothing place and given that we know there was nothing in place,
4 the reason why nothing was put in place, you've said that's not legally
5 relevant for us so I'm struggling to see why we should embark upon it,
6 given that it will mean that we will be criticising Dr Bottrill in a way which
7 could expose the Committee of Inquiry's report to challenge.
8 MR GRIEVE: Madam Chair, those submissions are made in the context of
9 the evidence establishing that he knew that ought to have been put in place,
10 he knew that they should have been but –
11 CHAIR: We know that he knew others were doing it, but on what basis
12 can we say that he knew he should have been doing it at the time but
13 decided not to do it?
14 MR GRIEVE: I would rely on the fact that he knew others were doing it
15 and so I criticise because knowing what his colleagues were doing, he
16 turned his face against it.
17 CHAIR: Right.
18 MR GRIEVE: Now I'm about to move on Madam Chair.
19 CHAIR: Yes, that's fine thank you.
20 MR GRIEVE: Section 6. Again, I'm not going to go through this in
21 detail. We say that one of the problems here is that while the false negative
22 smear is a undeniable statistical fact in any screening, well it's certainly in a
23 screening programme such as this, in other screening situations, you will get
24 false negatives as well. Nevertheless, that should not provide a simple 'well
25 everything is alright' and you will remember that I asked various witnesses
26 questions about the qualitative assessment of the error and I think although I
27 didn't realise at the time, that was what Professor McGoogan was referring
28 to when she talked about positive predictive values. As I understand it,
29 that's a statistical means of embarking on some sort of qualitative
30 assessment of, and I'm not sure whether it's error actually, is that right

1 Professor?
2 PROFESSOR DUGGAN: It was a test to determine accuracy of your
3 abnormal result, so it's a confirmation
4 MR GRIEVE: Of a correct abnormal result? Yes.
5 PROFESSOR DUGGAN: It's a confirmation of the prediction.
6 MR GRIEVE: Yes.
7 CHAIR: It seemed to me here the point you were making where really in
8 the first place all dependent on robust statistical information being available
9 and one of the difficulties with the programme it seems is that the
10 information hasn't been available.
11 MR GRIEVE: Yes and one of the shortcomings that I'm sure will be
12 discussed in detail is the problem of the cytology histology correlation
13 because that's inherent as I understand it in positive predictive value. What
14 I'm talking about here is that where you get a situation where say a woman
15 develops invasive cancer in one reviews the smears and finds that there were
16 false negatives, then obviously it is not enough to simply say, oh well you're
17 going to get them in a screening regime, that's okay.
18 CHAIR: So what you're saying is that if the omission has been a classic
19 Papanicalaou type smear, you'd say well you just should never had missed
20 that, whereas if it's one that most people would miss that's marginal, it's
21 more understandable. Is that what you mean by qualitative.
22 MR GRIEVE: Yes, exactly. So that I go on to say that where you have
23 and Dr Wain referred to them numbers of women with multiple mysteries,
24 then one should be, and if some of those, well they are false negatives, so
25 there should be a system in place whereby those smears are qualitatively
26 assessed because that will tell you something about appropriate behaviour
27 by the pathologist who read them.
28 CHAIR: The evidence that we have heard in relation to the review by the
29 Royal College pathologists, when they did their review of Patient One's
30 slides, did they make any qualitative assessment of the slides as to whether

1 or not they were slides which would have been difficult to read?
2 MR GRIEVE: You mean the cytology review panel?
3 CHAIR: Yes.
4 MR GRIEVE: The one organised by Dr Teague.
5 CHAIR: Yes.
6 MR GRIEVE: Well could I take you Madam Chair to the exhibits and if
7 one looks at CAT/RCPA/16 which is the letter that by way of which Dr
8 Teague reported to Dr Bottrill
9 CHAIR: Yes.
10 MR GRIEVE: And this was the subject of quite lengthy cross examination
11 of Dr Teague about the qualitative assessment of error. Now I'm just not
12 sure where I've put the references, there's a reference to it at paragraph 6.6.
13 what I should do is find the references to the lengthy cross examination with
14 Dr Teague about qualitative assessment of error –
15 CHAIR: Yes.
16 MR GRIEVE: And I can give you those, I won't do it now.
17 CHAIR: Yes I would appreciate that, if you could tomorrow morning
18 because that would be helpful to know what the evidence is on that.
19 MR GRIEVE: They may be there but I cannot frankly remember whether
20 those references that are given are those particular references but now
21 Madam Chair, your question was did that review involve qualitative
22 assessment of error, and my short answer to that is no.
23 CHAIR: I see from this letter to Dr Bottrill for slides C, there is a sort of
24 comment which says the fact that one laboratory reported the smear as
25 normal, and one reported it as atypical but suspicious, the high grade
26 probably reflects that there is some difficulty in the interpretation of this
27 smear.
28 MR GRIEVE: Yes.
29 CHAIR: So that's said in respect of slide C but nothing is said like that in
30 respect of the other two or the other three slides.

1 MR GRIEVE: Therein lies the problem because in the heading to this
2 section, I've talked about a mindset that such errors are justifiable and do
3 not raise competence issues. I've referred to this exhibit in the submission.
4 CHAIR: Yes.
5 MR GRIEVE: But what I'm there complaining about is, or referring to is,
6 the sort of reference that is in the penultimate paragraph on page, in fact it's
7 the second paragraph on page 1, where they're dealing with slide A, this is
8 where it first appears. The fact that one of the reviewing laboratories did not
9 detect any abnormality is consistent with the known and false negative
10 screening cervical smears. Now slide A was one where the difference was
11 only in one degree, it was high grade reported as low grade so that's not
12 regarded as a false negative, that's regarded as an acceptable. Well it's an
13 error but not false negative because it's not the two grade difference. Then
14 the next one though was a high grade reported as normal, so it's, shall we
15 say, "true" false negative and we get the sentence again. It may well
16 represent the false negative screening rate associated with cervical cytology.
17 CHAIR: Yes, even though the earlier sentence is said that to regard it as
18 normal would be unsatisfactory in generally quality assurance terms.
19 MR GRIEVE: So then there's Slide C where as you correctly said it and
20 again, this was a true false negative because it was in fact high grade but
21 read as normal but difficult to read because it was in the Mitchell Medley
22 type false negative, few cells etc.
23 CHAIR: Right.
24 MR GRIEVE: Now, and then again in relation to slide C over the page on
25 the second page, it says in overall quality assurance terms diagnosis will be
26 regarded as unsatisfactory but then we have it again, it may represent the
27 false negative rate associated with the cervical screening techniques. Now,
28 the point I am making about this is that here we had four errors of varying
29 degrees I accept in the same patient. Dr Teague's response is that "but you
30 must examine each slide, or you must treat each slide as a separate entity

1 and the fact that it's from one patient, it's not statistically significant".
2 CHAIR: Yes, that doesn't fit with, I know for example, I pursued this line
3 of questioning with Dr Duncan the second time he came back to talk to him
4 about red flags, what alerted him and he said that more than one false
5 negative for patient alerted him that reminded him of the Scottish, the
6 Inverclyde situation. And there is an article by a writer Sigurdsson, where
7 he gets a particular definition of a false negative as being more than one
8 falsely read smear, I'll just get that, it's in the Cox exhibits. It's in page 733
9 of his article and it's in a, you've got to reverse the statement because he
10 says when you're looking at the sensitivity of the test, you exclude the false
11 negative cases which he says are those with only one negative smear prior to
12 diagnosis so I read the corollary of that being, well if you've got more than
13 one negative smear prior to diagnosis, you may be treated as something
14 different than a false negative case. And the reason I say that is because
15 with patient one, you've got four misread smears.
16 MR GRIEVE: Well, yes. I suppose the difference is whether you call on a
17 patient by patient basis false negative case as opposed to on a slide by slide
18 basis calling it a false negative slide and the fact, my point is Madam Chair
19 that this letter along with other things tends to illustrate that, well, Dr
20 Teague was taking refuge maybe subconsciously and there is other evidence
21 of it in terms of other pathologists as well. I don't know specifically but
22 generally, taking refuge behind this fact of there being false negatives which
23 enabled or prevented them from looking at the issue of query competence
24 and the situation in relation to Patient One and Dr Teague's approach to it
25 because as we know, he knew in August 1995 that there were four errors in
26 the one patient, varying degrees – sure, two false negatives in that properly
27 defined, one of which was difficult to read, an invasion which was read as
28 high grade and a high grade that was read as low grade. He said "well the
29 fact that it's the same patient doesn't matter, you're going to get false
30 negatives, it's a fact of life, each slide comes through at difference time

1 periods, bad luck that it's the four in the same patient". Now Dr Wain took
2 a totally different approach to that, he said words to the effect "well, quite
3 more than once and you're getting to be quite unlucky" -
4 CHAIR: Yes.
5 MR GRIEVE: 3 to 6 and so on.
6 CHAIR: Where does it say that in your submission because I've read it, is
7 it in Mr Corkill's submission?
8 MR GRIEVE: No, it's in my Madam Chair, it's further on.
9 CHAIR: Well it seems to me when I read this section that firstly putting
10 aside, I think there is a danger in personalising it by talking about the
11 pathologists having a mindset, but putting that to the side, it did seem to me
12 that there is an issue about false negatives in the fact that they can be
13 misleading, perhaps innocently misleading, because it creates the sense, well
14 from time to time there are false negatives. Therefore, if you looked at
15 every slide before you discreetly and it turned out it had been misread, you
16 could well say "oh but this is just an example of a false negative" in so what
17 was needed to be recognised as putting medical practitioners on the alert to
18 think that perhaps this is more than the false negative situation which can
19 occur from time to time and that it's a matter of determining what is that red
20 flag?
21 MR GRIEVE: And the red flag will vary for example, you could get a red
22 flag where you've got a false negative unknown to the general practitioner
23 but associated with clinical systems and requiring the receiving general
24 practitioner to say but hang on, I'm seeing symptoms here which should
25 cause me to question this negative smear.
26 CHAIR: Yes, see even if you have one example of a smear being misread,
27 if that smear is a classic Papanicalaou smear, does it seem reasonable that it
28 could be misread and be a false negative if it is so obvious?
29 MR GRIEVE: You then get into the area of shall we say grading of the
30 degree of error. In the O'Shea case, I'm not sure of the extent of the error,

1 but there was only one smear. I accept as it must be accepted that there will
2 be false negatives which reflect in no way adversely on the maybe the
3 primary screener and the cytologists who reviewed that and confirmed the
4 finding because it's going to happen and we know that many smears are
5 difficult to read. There will be borderline cases, there will be cases where
6 the appearances are obvious and should've been seen. I simply don't know,
7 it's very difficult to define when there's got to be a system in place whereby
8 when something happens which ought to be regarded as a warning that a
9 qualitative assessment is made. Now I say that in terms of Patient One with
10 the four errors, that was a warning sign which should've prompted someone
11 to say well hang on four errors, one patient, two false negatives, let's just
12 have a closer look at this.
13 CHAIR: Would you expect to, and this of course is dependent on the
14 information being gathered and analysed but would you expect those
15 managing a screening programme to see as a red flag a circumstance where
16 there is an incidence of cancer recorded and in the past five years, there has
17 been a pattern of normal smears?
18 MR GRIEVE: Yes I would.
19 CHAIR: And would you expect a screening programme to be set up in
20 such a way that red flag could be easily obtainable? In other words, you'd
21 expect that analysis to happen?
22 MR GRIEVE: Absolutely.
23 CHAIR: And what would your view be if it wasn't? What would you
24 submit?
25 MR GRIEVE: Well I would submit that steps ought to be put in place to
26 enable that it was, otherwise, well the particular woman or women are going
27 to remain at risk.
28 CHAIR: Would it be the case that because there is this concept of false
29 negatives and because they could, I read in your submission, be falsely
30 reassuring. In other words, it creates a view that if there has been a

1 misreading it's an excusable mistake, it's a false negative, that the fact that
2 this occurs in cytopathology, is a stronger reason for ensuring as part of a
3 screening programme that there is regular monitoring and evaluation of the
4 performance of the laboratories doing the cyto screening?
5 MR GRIEVE: That follows Madam Chair, yes.
6 PROFESSOR DUGGAN: The cytology review panel, this was set up to
7 provide a service to the pathology community in terms of the review of
8 individual slides.
9 MR GRIEVE: It was set up yes, Professor, I think it was set up where a
10 slide reading was questioned in some context or other, and I think there was
11 some evidence about whether or not the laboratory doing the original
12 reading accept that there was an error or not.
13 PROFESSOR DUGGAN: And this slide review panel deals with cases
14 that are usually are going to some kind of arbitration, it's not an external
15 proficiency programme.
16 MR GRIEVE: No, that's true.
17 PROFESSOR DUGGAN: So that why then would you expect the
18 pathologists involved in this slide review panel to make some decision about
19 how significant their result is in terms of raising flags?
20 MR GRIEVE: Well ..
21 PROFESSOR DUGGAN: The way I read it, it's not an external
22 proficiency testing programme, it's just a vehicle for slides to be reviewed in
23 a context of fairness. I believe there are other slides sent with the index
24 slides –
25 MR GRIEVE: Yes.
26 PROFESSOR DUGGAN: Some are trying to recapitulate those American
27 society cytopathology guidelines with regard to the …
28 MR GRIEVE: Yes, it's a, shall we say a blind review, in this case there
29 were 10 smears sent.
30 PROFESSOR DUGGAN: So if that's the context, why would you expect

1 that the slide review group to refer this case on somewhere else.
2 MR GRIEVE: I wouldn't have expected the, and I may have
3 misunderstood you here, I would not have expected the laboratories doing
4 the re-reading to make any comment because they do not know what the
5 original reading was but I would have expected the progress to be that where
6 the person who co-ordinated the results received them all where those
7 results raised a red flag that then something would be done to explore the
8 situation so that in this case, it happens to be Dr Teague who was doing the
9 coordinating so he has all the information whereas the reviewing
10 laboratories don't, they just have the original smears. He knows the first
11 result and the re-read result and my point is simply in this case, there were
12 four errors. Now it may be in that in another case and in fact I think at the
13 very end towards the end of the hearing we produced the reports that were
14 undertaken as it happened for Patient One but from Dr Linehan's laboratory.
15 Now there the results came back, the cytology review panel results, and I
16 accept that on the face of those results, there was nothing in them to raise a
17 warning flag so that someone in Dr Teague's position wouldn't be expected
18 to say that well there's anything unusual about this, don't need to worry
19 about a qualitative assessment. It's a different situation in my submission
20 for Patient One where he had all the information.
21 PROFESSOR DUGGAN: Can you remind me about the timing of this,
22 was there a case before, why did Dr Bottrill send those slides to be
23 reviewed?
24 MR GRIEVE: He sent those slides to be reviewed because he had received
25 a letter from solicitors saying that, alleging that he had negligently read
26 them or misread them and at some point around this time, I'm just not
27 absolutely sure whether it was before or shortly afterwards but at some
28 point, certainly in 1995 because he approached Dr Teague in July 1995 and
29 the results came through per that letter in August 1995. Sometime in 1995,
30 the Patient One to the Accident Compensation Corporation so that they were

1 conducting their investigation to determine whether there had been medical
2 error or not.
3 MS GIBSON: It was sent away as part of the ACC response.
4 CHAIR: One thing I would like to know, it seems to me that the points
5 you are making here is one, there was no qualitative assessment and you're
6 then saying, well there ought to be. Next point is that the concepts of false
7 negatives can be falsely reassuring so that there is a need to identify some
8 form of red flag which will make you look at a misread slide in greater
9 detail to satisfy yourself, is this an acceptable false negative or not.
10 Following on from all of this, the next point is well, we now go to Dr
11 Teague, and I'm conscious we're now moving more into part 7 of your
12 submission. In terms of any obligation on him to go further and to inform
13 the Medical Council, was there at the time any ethical requirement on him to
14 do so and if not, has there been a change so that there is such a requirement
15 now?
16 MR GRIEVE: Well whether there was an ethical requirement on him to do
17 so, depends upon his state of knowledge.
18 CHAIR: Well not exactly because I'm aware for example that with
19 barristers and solicitors, our ethical rules in fact have a, I think it's Rule 603
20 requires to report misconduct and something else when you, defalcations,
21 when they come to your knowledge. If you're working in a law firm even
22 as an employee and you suddenly realise that one of the partners is fiddling
23 the trust account, you have an ethical obligation under our rules to report it
24 to the Law Society. Now, what I'm first of all interested in before we get
25 into a general discussion of what's moral and what isn't, is do the ethical
26 rules on medical practitioners which the Medical Council imposes on them
27 or any other body that they belong to, expressly require them to report
28 instances of concern, professional competency etc.?
29 MR GRIEVE: I'm not sure about that expressly. I'm not sure whether
30 there is an express ethical obligation but …

1 MR KIRTON: Madam Chair?
2 CHAIR: Yes, Mr Kirton.
3 MR KIRTON: There is a specific, I'll give it to, once I find it.
4 CHAIR: It's 10 past 5 so we'll stop now, I had it in mind that we'd have
5 sufficient time this session to resume at 10 o'clock in the morning. Is
6 everyone happy with resuming at 10? We'll do that for tomorrow and the
7 next day and if it looks as if we're starting to run out of time, we'll have to
8 go back to longer hours, but for the meantime, we'll keep it at 10, we'll
9 adjourn until 10am tomorrow.
10
11 INQUIRY RETIRES UNTIL 10.00 AM
12 TUESDAY 19 SEPTEMBER 2000.
13