

BRIEF OF EVIDENCE OF JANICE HOBBS

1. My full name is JANICE ANN HOBBS. My address is 7 U'ren Place, Gisborne. I am the Co-ordinator of the Gisborne East Coast Cancer Society, a position which I have held since July 1993. Initially I was employed in a part time capacity, I am now employed 30 hours per week.
2. My background is in Social Sciences. I am currently completing my certificate for Te Whakamana Te Tangata. I commenced my studies through University of Waikato Outreach Programme at Tairawhiti Polytech and am currently studying through Massey University with cross credits of the papers completed to date. My involvement also has been in community work including 4 years as Student Co-ordinator of American Field Service Scholarships for the local chapter.
3. My role as co-ordinator of the Gisborne East Coast Cancer Society is to support patients and their families through their diagnosis and treatment of cancer. This involves many different tasks and functions including the following:
 - 3.1 providing information including pamphlets and documentation published by the National Office of the Cancer Society,
 - 3.2 providing advice on available social services;
 - 3.3 networking for the patient and their family with the providers of those services to facilitate their access to them. For example, I arrange and co-ordinate individual patients' transport and accommodation necessary to enable them to undergo treatment.

On a personal level, through my contact with patients, I frequently become aware of their particular cancer and details of their treatment options and the personal, medical and social issues that arise for them in the context of their cancer. This may involve activities as basic as arranging for a house sitter while a patient is away having treatment,

driving and other transport services and sitting with patients.

- 3.4 Many of these tasks are carried out by volunteers and I am the Volunteer Co-Ordinator.
 - 3.5 I advocate for patients' access to medical services including diagnostic services, reports of diagnosis and access to treatment. This is a liaison function between the patients/families and the providers of the various services.
 - 3.6 I organise and co-ordinate support groups including co-ordinating their meetings and access to them; I co-ordinate services and programmes such as "Look Good, Feel Better" and a programme "Living with Cancer".
 - 3.7 I manage the administration of the Gisborne East Coast Cancer Society office. Until recently I also carried out health promotion work, but approximately 18 months ago a second officer was employed to carry out this aspect of the work.
 - 3.8 In the work that I do, I am required to be aware of legislative and policy changes in the provision of health care, especially oncology services, and their impact on our community.
4. The service which the Gisborne East Coast Cancer Society provides through me is a "self-referral" service. The patients and the families approach the Society by telephone or by coming in to our offices. Sometimes they are referred by their general practitioners or surgeons or other health providers.
 5. In my role as co-ordinator for Gisborne East Coast Cancer Society, I have been very well supported by health providers in the area. We have had a very good working relationship which optimises access to services for the benefit of patients and families.

6. My work requires me to establish relationships of trust within the community for the benefit of patients, that being always the primary focus.
7. In a small community such as Gisborne and districts, with a population of approximately 45,000, many of the patients and/or a family member are personally known to me and I am known to them. Because of this background of personal contact, I am often required to be available outside working hours. The boundary between the personal and the professional is not always clearly defined. The successful functioning of my role depends in part on an informal network built up through the community.
8. These informal networks form a background to the history of my involvement in the specific events under investigation in this Inquiry.

PATIENT NUMBER 1

9. I exhibit as **JAH/CS/0001** two pages of extracts from diary notes and memoranda regarding my dealings with this patient, which I refer to in the following paragraphs. These diary notes and others later exhibited to this brief are an occasional and partial record only of some of the events to which they refer. Where I have no notes, I am speaking from my own recollection.
10. In April 1996, "R", the mother of Patient No.1 came to my office to discuss Patient No.1's cervical smears. R worked in the same organisation as one of my former rural neighbours.
11. R said that her daughter Patient No.1 had discovered that four of her cervical smears over the period of 1990 to 1994 had been misreported by Gisborne pathologist Dr Michael Bottrill. R said that Patient No.1 now had invasive cancer.
12. I refer to diary entry of 30 October 1996 (JAH/CS/0001p.1) recording that R telephoned me to say that the "private court case (was) due for hearing 11 November" and that she would "ring me with outcome." I cannot recall the

details of the private court case, although I do recall that Patient No.1 was applying for ACC and had reported Dr Bottrill to the Medical Council for disciplinary proceedings against him.

13. Throughout 1996 and 1997 I was in intermittent contact with R, partly through occasions when she telephoned me, and partly through occasions when we met in the street or in her work environment. From time to time she also visited the Centre where I worked.
14. At some point I became aware that ACC had found that there was medical misadventure and that all four slides were incorrect.
15. In June 1997 I had a telephone call from R to say that the Medical Tribunal had found Dr Bottrill guilty of conduct unbecoming.
16. R said that Patient No.1 was now asking to have all Dr Bottrill's work reviewed. She was also due to meet with lawyers to draft a press release.
17. Following my receipt of this information I rang Betsy Marshall, Health Promotion Policy Advisor in the National office of the Cancer Society, for advice. I understood that if the matter was released in the press, there would be many calls to my office, and I required reassurance the information to be given in response to expected calls was consistent with Cancer Society policy and the National Cervical Screening Programme.
18. Betsy Marshall advised me to contact Sharon Reed, Manager of the Tairawhiti Cervical Screening Programme.
19. Betsy Marshall also said that she would contact someone in the programme. She subsequently sent me a fax recording advice from Di Best, the National Programme Co-ordinator and Dr Brian Cox, and adviser to the Cancer Society, refer to exhibit **BC/CS/OO42**
20. In the meantime I did contact Sharon Reed. I have not recorded any notes of

my discussion. I do however recall that we spoke at length. To the best of my recollection we were both aware of the case and of the names of the parties involved and spoke openly on this basis. We discussed the coincidence of one woman having four slides misread over a period of four years, with the possibility of other women also having had one or more misread slides by the same doctor.

21. I recall that in the event, Patient No.1 did not go public at this point. I recall a discussion with her mother R, in which R informed me that Patient No.1 had been advised not to go public pending a legal case.
22. R faxed to me a copy of the report of the Medical Practitioners Disciplinary Committee into the misreading of the smears by Dr Bottrill.
23. It was my very clear impression as at 10 June 1997 that the National Co-ordinator of the Cervical Screening Programme and shortly after, the Manager of the Tairawhiti Cervical Screening Programme were both aware that Dr Bottrill had been found guilty of conduct unbecoming in respect of four misread cervical smears taken from a patient in Tairawhiti District.
24. Common sense told me if there was one patient in this situation there may well have been others. I recall absolutely clearly that I raised these concerns in my discussions with Sharon Reed and with Betsy Marshall.
25. Throughout the rest of 1997, and throughout 1998, although R kept me informed of events involving her daughter, I felt there were no further steps I could take. In the first place, my information from R was obviously confidential. In the second place, I felt that I had alerted those with responsibility to inquire further. In the third place, I knew that the Medical Council was aware of the circumstances. I was aware also that the patient had the benefit of legal advice and assistance. Therefore, although I was deeply concerned, I was unsure what more I could do.
26. It was not until March 1999 that I knew that Patient No.1's case had actually

been heard in Court. I was alerted to this by a television report on 19 or 20 March.

27. I was deeply concerned to hear both that she had lost her case in Court and, more importantly, that the Court had granted name suppression of the pathologist, extending to the identification of the region in which he worked. This seemed to me contrary to the interests of the community involved.

MY ROLE IN INVESTIGATION OF OTHER CASES

28. I became anxious that this would not be investigated further by those with the authority to do so. I wished to satisfy my own conscience. I therefore began, within the limitations of my obligations of professional confidentiality, to gather information with a view either to confirming or dispelling my concerns.
29. I had contacted Besty Marshall again. She told me that she was to meet with the Health Funding Authority. My notes refer to the names of Jane MacIntyre as National Co-ordinator and Dr Julie Peters as acting Manager of Prevention Programmes. My notes of March 1999 (JAH/CS/0001p.2) tell that "Betsy will meet with HFA, will ring back with action." I exhibit later diary notes and memoranda referring to discussions with Betsy from April 1999 as **JAH/CS/0002**.
30. >From about 20 March I began to gather information, not as a personal crusade on behalf of our or any other women, but in order to establish whether there was a wider problem or issue which I should bring to the attention of the HFA or to whoever might have the ability to investigate further. Among my clients were three whom I knew to have had cervical cancer in the preceding five years and I began to discuss with those people the question whether they had had cervical smears, and if so, what the results of those smears had been.

PATIENT NUMBER 10

31. The first client I inquired about was Patient No.10. She had died in February 1999. I had been in contact with her in my professional capacity during her treatment for cervical cancer. I exhibit as **JAH/CS/0003** my diary notes and memoranda regarding this patient.
32. Prior to March 1999, the mother of Patient No.1 had told me that she had been in contact with Patient No.10's husband, "RH" regarding the misreading of Patient No.1's smear results.
33. On the strength of this information, I telephoned RH. We arranged to meet at his home to discuss further the issues of his late wife's cervical smear history .
34. I visited RH on 24 March 1999. During our discussion RH said that although he had nothing personal to gain from pursuing the question of his own deceased wife's smears, he did have a concern of possible consequences for other women. He therefore wrote a signed legal authority requesting that I collect data on his late wife's smear history.
35. I went in the same day to the Public Health Unit in Gisborne, this being the location of the office of the Cervical Screening Register. I handed to Jan Ewart, Co-ordinator of Personal Health in the Public Health Unit, the letter and request from RH. She declined to release the records to me in accordance with that letter and request. She told me she would need to obtain legal advice. I left a copy of RH's letter with her.
36. In accordance with the letter that RH had given me, I then made an appointment with Dr Smale, the GP for his deceased wife. This took place on 26 March 1999. Dr Smale gave me the results that she had on record. These consisted of three smear reports from Dr Bottrill, dated 1988, 1991 and 1993, and a copy of a re-read of a smear taken on 17 September 1996.

37. Dr Smale told me, during that appointment, that Patient No.10 had in about October 1998 requested a review of her slides. Dr Smale further told me that she had actioned this request. I understood that was how she had received the review of the test from 17 September 1996. At that time Dr Smale did not have a written report of the 1991 and 1993 rereads.
38. I went back again to the Public Health Unit on 1 April 1999, this time accompanied by RH. At that point Jan Ewart released RH's deceased wife's cervical smear history.
39. Subsequently, I either phoned or visited (I cannot recall which) Janet Wilson, manager of Medlab Gisborne. With the permission of RH, I requested information on the re-reading and location of the deceased's slides.
40. My diary notes record that over the next 10 days or so I approached both Medlab Gisborne and Dr Smale in accordance with my authority from RH to trace the progress of requests for re-reading of the smear tests. I collected the reports of the re-reading of the 1991 and 1993 smears from Dr Smale at 5.45 pm on 9 April 1999.
41. Over the next week I advised RH that I had received the report from his deceased wife's GP. I did not however disclose the contents and suggested that he talk to the GP. I believe that he did this.
42. On 21 April 1999 I received a phone call from Dr Smale. As a result of our discussion, I requested that she ring Dr Duncan of the Public Health Unit.

PATIENT NUMBER 9

43. Patient No. 9 was another patient whom I knew as a friend. I annex as exhibit **JAH/CS/0004** my diary records regarding steps I took in connection with her case. I telephoned her on 25 March 1999 expressing my concerns over cervical reporting.

44. I met with her later the same day at the Public Health Unit. There, she uplifted her cervical screening history up to the date when she first registered in 1993. She wished to go back further through her records, as she was diagnosed with cancer of the cervix in 1993. I advised her to contact her GP.
45. On 31 March 1999 I visited her in her home. My notes record that she was unwell and had a barium meal that day. She had collected the results of her previous slides and gave me copies. She gave me a signed authority which I took to the Gisborne laboratory to uplift her slides. The manager Janet Wilson told me that she would first need to contact the laboratory owner Dr Lineham for permission.
46. On 1 April 1999 I collected Patient No.9's slides from Medlab, Gisborne.
47. In a discussion later that day with Patient No.1 about her own case, we discussed the question of where other women's slides might be re-read. She said that she would contact her lawyer Mr Stuart Grieve, to see if Dr Hitchcock, an Auckland pathologist who had supported her through her case, would be available to re-read the slides.
48. Following further advice from Patient No.1, on 6 April 1999 I posted Patient No.9's slides and information to Dr Hitchcock in Auckland.
49. On 8 April 1999 I telephoned Dr Hitchcock. He confirmed that he had received the slides; he said they were "not A1" and that the 1992 slide was "under-reported". He said that he would write a report and send this with the slides back to me to forward on to Patient No. 9.
50. On 23 April I received by fax a copy of Dr Hitchcock's report. I delivered this to Patient No.10 on that day. The slides were not returned to me.
51. I have continued my professional support of Patient No.9 over this past year.

PATIENT NUMBER 8

52. Patient No. 8 was another of my clients whom I considered a friend. I annex as **JAH/CS/0005** my notes and records in respect of her case.
53. I telephoned Patient No.8 at her home on 18 April 1999. I explained my concerns with cervical smear reading in Gisborne. We arranged to meet the following day, and she said that meanwhile she would collect a copy of her smear results from her GP.
54. The next day I met with her. I received a copy of her smear result dated 26 August 1994. I then telephoned her gynaecologist, Dr Dianne van de Mark. I requested on behalf of Patient No.8 that the smear of 26 August 1994 be re-read. This was to be done through Medlab, Gisborne.
55. On 21 April 1999 I attended a meeting with Dr Bruce Duncan, Bronwen Laurenson of Central Districts Cancer Society and Dr van De Mark. I set out in more detail the background to that meeting elsewhere in this brief of evidence. At this meeting, Dr van de Mark confirmed that Patient No.8's cervical smear had been misread. The original reading showed "normal" while the re-reading showed "high grade abnormal cells".
56. I was involved in supporting Patient No.8 as publicity unfolded over the Gisborne misreadings.

PATIENTS REFERRED TO ME BY PATIENT NUMBER 1

57. Although I had spoken by telephone with Patient No.1 on many occasions, I did not meet her in person until Friday 16 April 1999 when she came to the Gisborne Centre.
58. At that meeting she told me that she had a list of people whom she "was to follow up on". I do not know how she became aware of the names on this list. On Monday 19 April however she came to me with several letters of signed

consent for me to follow up.

59. I did not know all of the people on the list. I therefore insisted that they contact me themselves, rather than making the first contact myself.
60. Patient No.1's lawyer, Mr Stuart Grieve, had telephoned me at home on 31 March 1999. On the same date, he faxed me forms of authority for release of patients' records.
61. Mr Grieve and I had various discussions throughout April. I recall that on 22 April 1999 I repeated to him what I had said to Patient No.1 that I required women to contact me personally before I went ahead and uplifted any information on their behalf. I stressed I was not comfortable to proceed until they had done this and recall explaining to him my reasons why. I needed to be reassured that the women still wished to proceed. I needed to know if they were aware of the "wider issues" outside of supporting Patient No.1 with her case. I needed to be able to offer support throughout the process.
62. During the month of May 1999 I believe I faxed in total 9 copies of signed authorities to Mr Grieve. These were all authorities from women and their families who had made direct contact with me. As a result of their making contact with me, I helped them with the process of collecting their cervical history from the Register, advising on how to find original reports of the smears and what information was required in locating their smears.

MY CONTACTS WITH TAIRAWHITI HEALTHCARE LIMITED

63. When I visited the Public Health Unit on the evening of Friday 16 April 1999, I was approached by Dr Bruce Duncan, Medical Officer for Tairawhiti Health. Dr Duncan called me into his office. We had a lengthy discussion regarding my concerns of the quality of cytology reading and the results of the information I had gathered up to that date. Notes from my diary referring to this conversation and other communications with Tairawhiti Healthcare are exhibited in **JAH/CS/0006**.

64. On 19 April 1999 I telephoned Dr Duncan and requested a meeting with him, together with Dr Dianne van de Mark, and Bronwen Laurensen the CEO of Central Districts Division of the Cancer Society. We arranged a meeting for Wednesday 21 April.
65. I met with Dr Duncan, Dr van de Mark and Bronwen Laurensen in the morning of 21 April 1999 at the Public Health Unit. Dr Duncan informed us that on the strength of my enquires, he had made contact with Tracy Mellor of the HFA and also Robyn Stent, the Health & Disability Commissioner. He reported that he had also informed Sheryl Smail, CEO of Tairawhiti Healthcare.
66. It was also at this meeting that Dr van de Mark reported on the result from the re-read I had requested, of Patient No.8's 1994 smear.
67. We spoke at length regarding a plan of action, for example an 0800 number and a local person to co-ordinate concerns. The meeting agreed that this should be led by the HFA. A further meeting was planned for Monday 24 April, but this meeting never took place.
68. In the afternoon of 21 April 1999 Dr Duncan phoned me. I recall that he said that he had contacted the HFA and a local project co-ordinator had been appointed. I recall that he had said that he requested that Tracy Mellor visit Gisborne. He requested also that he sight the records in my possession of persons whose smears had been misread. At that stage I had three cervical smears and one histology report. I suggested that Dr Duncan obtain directly from Patient No.9's GP a copy of Patient No.9's original and re-read smear results. I then rang Dr Smale, Patient No9's GP and requested that she telephone Dr Duncan.
69. On 23 April 1999 Dr Duncan telephoned to advise that Tracy Mellor was coming to Gisborne Monday 26 April, and asked me to supply a copy of "evidence" by then.

70. On 26 April 1999 I visited the Public Health Unit. I spoke with Dr Duncan briefly and passed on copies of the information he requested. He reported to me that Tracy Mellor was to arrive at 10 am, but I was not invited to meet with her that day. I did not meet again with Dr Duncan directly over this issue
71. I believe that I spoke to Dr Duncan again by telephone on 27 April and then 29 or 30 April inquiring as to discussions or progress.

OTHER ACTIVITIES CONCERNING THE EVENTS BEFORE THIS INQUIRY

72. >From about the last week of April 1999 I stopped looking for “proof” or otherwise of a problem. I directed my energies and attention to advocating for services for women identified as having a mis-read. To this end I met with Ms Mellor and others from HFA, attended public meetings and met with the other local agencies.
73. I also contacted Alison Moore, chairperson of the Gisborne East Coast Cancer Trust. I annex as **JAH/CS/0007** copy of a letter I sent to her in May 1999.
74. On 26 April 1999 I met with Phillida Bunkle when she visited Gisborne. I passed on to her general information regarding the mis-readings. I did not give her the names or identities of the women involved. I understand that someone else gave her the name of Patient No. 8 and that they subsequently met with each other.
75. By May 1999 however I heard via the media that HFA planned to reread all cervical smear slides read by Dr Bottrill for the period 1991 to 1996.
76. Several women concerned made contact with me, inquiring how to proceed to have their smears re-read. These women were supported through this process. I also helped set up a cervical cancer support group.
77. I am also a member of the Provider Group. This group has representatives from the various community groups and providers involved with women who

have had a mis-read smear. We are continuing to meet once a month. I annex as **JAH/CS/0008** the minutes of the Provider Group.

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Janice Hobbs

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Date