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Under the Health and Disabilities Services Act 1993

*in the matter of* The Ministerial Inquiry into the Under-Reporting of Cervical  
Smear Abnormalities

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STATEMENT OF EVIDENCE OF SHARON RANUI REID

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Dated

2000

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## STATEMENT OF EVIDENCE OF SHARON RANUI REID

### **Background**

- 1 My full name is Sharon Ranui Reid. I am currently employed by Hutt Valley Health Corporation Limited in the Regional Public Health Unit. I am the co-ordinator of Well Women, Maori for the Breast and Cervical Screening Programmes. I started in this role on 1 March 1999. Prior to this I was employed by Tairawhiti Healthcare Limited (“THL”), working at Forrester House at Gisborne Hospital initially then at the Public Health Unit in Bright Street, from 11 March 1991 to 12 February 1999.

### **The regional programme**

- 2 My first job at THL was as a data entry operator/systems administrator/administrative assistant within the Tairawhiti area of the National Cervical Screening Programme (“NCSP”). This was initially for three months, and then consecutively for three or four month periods over the next 18 months. During this time I worked for Liane Penney (“Liane”), the manager of the regional programme. Liane had been there since approximately April 1990.
- 3 On my first day of work I was given an orientation to Gisborne Community Health Services and introduced to the staff. Over the next three days, I was trained on the National Cervical Screening Register (“NCSR”) by Department of Health information technology staff.
- 4 On 16 March 1992, Rose Stewart was appointed as an educator for promotion and education of the NCSP. She resigned in 30 April 1993. Missie Winiata was appointed educator to replace Rose, on the 27 September 1993.
- 5 Around July 1992, Liane resigned from her position and recommended to Brian Towersey (Service Manager, Community Health Services) that I be appointed systems administrator and interim co-ordinator of the regional programme until more suitable arrangements could be made. This was initially for three months but, because I was getting the job done, the arrangement continued on an informal basis.
- 6 My understanding of Liane’s role was that she was to implement the policy of the NCSP, using the NCSR as the main management tool, within the Tairawhiti area. Liane and I were involved in, amongst other things, actively enrolling women onto the NCSR. At the time, the enrolment process was “opt-on” which meant that women had to give signed consent to enrolment on the NCSR. We also emphasised the importance of cervical screening and the NCSP to local people, and provided general health promotion strategies. There was on-going communication with other regional co-ordinators and the

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NCSP National Co-ordinator at the Department of Health. The first NCSP National Co-ordinator at the Department was Gillian Grew, who was appointed on 5 June 1990.

- 7 When I became regional co-ordinator, I continued the communication with the other regional co-ordinators and managers and the national co-ordinator. There were approximately four national meetings per year attended by regional co-ordinators and managers for the purpose of discussing NCSP issues. I also had informal contact with the other regional co-ordinators and managers if I was unsure of anything.

#### **Reports for the NCSP**

- 8 I started writing reports to the NCSP managers meetings around 8 June 1994. The purpose of these reports was to give a snapshot of where the regions were at locally in terms of service delivery, including:
- what had and had not been achieved and how;
  - statistics such as the number of enrolments and number of smears;
  - any problems or concerns we identified and how they had been rectified; and
  - seeking assistance and ideas on how to resolve any problems.
- 9 The reports to the NCSP managers meetings have already been produced by Ms Judith Glackin.
- 10 Written reports were used to save time and could be referred to at a later date. Otherwise, much of the meeting time could be consumed by verbal feedback even though this was a very important part of the national meetings. The reports were useful when we wanted to adapt other regions' strategies in our own region. These meetings were very useful to me in terms of how we ran the NCSP locally.
- 11 I was also able to produce quality of smear (QOS) reports from the NCSR. These reports were prepared at the request of the national office of the NCSR. The QOS reports were generated on an irregular basis initially and then approximately every three months from July 1991. Separate QOS reports were generated for smear takers and laboratories and sent to both. The QOS reports contained information about the number and code description of smears taken during the relevant time period. I recall that the reports were also sent to the Department/Ministry of Health. I was not expected to interpret

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the QOS reports. To an extent the QOS reports would have been useless without comparable data.

- 12 Dr Bottrill would have received QOS reports pertaining to his laboratory and it would have been up to him to decide what use he made of it.
- 13 The first QOS report I generated was on 31 July 1991 for the period 12 April 1991 to 31 July 1991.
- 14 From 1996, the QOS reports for laboratories were called "Statistics for Cervical Smears by Individual Laboratories" ("SCSIL") reports and from 1997 they were called "Laboratory Statistics for Smears by Bethesda Codes" (LSSBC) reports.
- 15 I recorded QOS reports for individual smear takers from 1 July 1995 to 31 December 1998 and I regularly reported to Jane Smith (Medical Officer of Health).

### **Funding**

- 16 The regional programme was funded by the Department/Ministry of Health. The funding came to the area health board, which allocated funding for the regional programme. When Liane left, I became involved in the funding of the regional programme to a limited extent. I assisted with the drawing up of the business plan for the regional programme. Beyond that, funding was negotiated and dealt with by the managers of the Public Health Unit/Community Health Services. Right from the implementation of the programme, there was a perception that the programme was under-funded in terms of employment of staff, development of resources for promotion and so on. However, we coped with what we had and tried to get the most out of it by utilising resources already available within Community Health Services and the wider hospital. For example, the public health nurses were happy to be trained as non-medical smear takers so that we could provide alternative services. We would also use the rural health clinics which made the service more accessible to the women. Much of the operational and administrative costs were covered by the hospital and taken out of the NCSP budget as overheads.

### **Education information**

- 17 Information kits were provided by the Department of Health. There were general information kits, Maori-specific kits and Pacific Island-specific kits. The NCSP was promoted in Tairāwhiti as part of a national screening programme for well women. The "education audience" was anyone who wanted to know or were happy to have us talk to them. Our main message

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was “take care, have a smear”. We also encouraged people to take back responsibility for their own health and wellbeing and, in the context of the NCSP, to have regular smears which would reduce the risk of getting cervical cancer (squamous cell carcinoma). The biggest risk of getting this type of cancer was by not being screened at all. Prior to the establishment of the NCSP there was just opportunistic screening.

- 18 When I started in March 1991 I saw graphs showing that Maori women had one of the worst rates of cancer of the cervix in the world. Having enrolled in the NCSP, and having had a smear myself, I could understand why that might be so. I used myself as an example for education purposes. I had only become aware of this thing called a smear test in 1990. My doctor’s nurse kept ringing all the time for me to go in and have one done. The smear was a very undignified experience and I remember going away from that feeling very embarrassed, not only for me but for the doctor as well. It was a small community where we all knew one another.
- 19 From the beginning of my employment I knew this was going to be a very challenging journey. I realised that information about the programme was the most obvious thing that had been missing for me. As a result, I assumed that providing more information would be a good place to start with other women, people, whanau, and communities.
- 20 One of my first jobs in the early days was to try and get women enrolled on the NCSR. One strategy was to attend colposcopy clinics to talk to women about enrolling. The first time I went made me think it was more like the meat works than an outpatient’s clinic. I went back to my manager quite distressed. She encouraged me to do what I could to make that experience more comfortable and appropriate for women. Again, information was the key, about basic rights and expectations, as well as trying to change the very impersonal attitude that seemed the norm for a very personal thing. I realised that perhaps our services were not as appropriate and sensitive as they could be and that it was not just the women that needed information but also our own staff. I was quite happy to act as a go-between/translator of the medical jargon for both the women and staff, when that need was identified.
- 21 I am aware that there has been suggestion, in the evidence given by some of the women affected, that the NCSP promoted the message that screening would absolutely prevent women from getting cervical cancer. I am quite emphatic that neither I nor any of the staff that worked with me promoted that message. The message we promoted was that having regular smears would reduce the risk of getting cervical cancer.

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**Indications of cervical smear abnormalities in Gisborne and Dr Bottrill**

- 22 The QOS reports that were sent to Dr Bottrill's laboratory could not, on their own, have been able to show that Dr Bottrill was under-reporting or not reporting cervical smears adequately. These reports, without comparative national data, would have been useless in that respect. In fact, as time went on, we were not concerned about the number of normal smears being reported, rather we did become concerned about the number of high-grades (HGIL) being reported in the Gisborne region. At the time, I thought we were picking up so many high-grade abnormalities because health providers were managing to screen women who had not been screened before or who had not been screened for a very long time (more than 5 years). Also, my thoughts were that if women were going to begin screening then we would most likely pick up more abnormalities initially anyway. It was my understanding that an organised screening programme would do this.
- 23 When I started with the programme, Dr Bottrill was very supportive and helpful to me and the NCSP. He often commented that the workload created by the establishment of the NCSP was a huge concern to him, and he was not sure how he was going to cope. He was always so very helpful and obliging and I thoroughly enjoyed the working relationship I had with him and his staff. In fact from an NCSP perspective the service he provided, in terms of reporting times, was exemplary not only from a local viewpoint but from a national one as well. The NCSR also produced "Smear Turnaround Time" reports. These reports were forwarded on to the appropriate laboratories. They reported such things as:
- number of smears reported during any given period;
  - time from the smear date to the arrival of that smear test in the laboratory;
  - time from arrival in the laboratory to obtaining a result;
  - time from obtaining a result to arriving at the NCSR;
  - time from obtaining a result to recording on the NCSR.
- 24 Dr Bottrill's laboratory had an average turnaround time from smear date to recording on the NCSR of about 10 days or less. Because we believed we were getting a superior service with him, we also had smear tests go there from our Well Women's Clinic and did not change to Gisborne Hospital Laboratory until I was directed to. The reason I was directed to use the hospital laboratory was that we needed to be supporting our own services within the hospital and the hospital was competing for the same services as Dr

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Bottrill. A summary of the "Smear Turnaround Time" reports for Dr Bottrill's laboratory is produced as **SRR/THL/001**.

- 25 I was always very grateful for Dr Bottrill's support. Another example of this was when he gave me his own software to use to get smear results in an electronic format from the Gisborne Hospital Laboratory.
- 26 I did not have any concerns about him.
- 27 The first time I became aware that some people might have concerns about Dr Bottrill was in June 1997 when I had a very informal conversation with Janice Hobbs.
- 28 I knew Janice reasonably well because of my involvement with the Gisborne East Coast Cancer Society (GECCS). I was a member of the GECCS Trust, a member of the volunteers group of the GECCS and one of a few people responsible for forming a support group with a specific Maori focus for the Tairāwhiti area.
- 29 We had a very informal discussion, about a patient who had her cervical smears misread, on either the night of 3 or 10 June 1997 after a GECCS meeting. Janice did not divulge any names.
- 30 However, either that week or the week before, the outpatients' department had telephoned me to discuss our processes to ensure that no patients fell through the gaps for colposcopy and treatment. The outpatients' department was aware of a patient who had taken Dr Bottrill to the Medical Council. The outpatients' department staff member, who spoke to me, named the patient as patient 1.
- 31 It seemed too coincidental not to be the same person Janice Hobbs spoke to me about and yet, to this day, I am still not sure if it was. Janice and I never spoke about the patient's identity.
- 32 By this stage, Dr Bottrill had retired. I had no previous concerns about Dr Bottrill. Janice only mentioned one person. With the benefit of hindsight, one might say that this was the first warning of a potentially larger issue. But at the time, I felt that the particular case was being dealt with and that there was nothing further that I could or should have done.
- 33 The next thing I heard about this issue was a report in the media of the court case against Dr Bottrill. Shortly after that, I heard that the HFA had begun an

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investigation. By this time I had resigned from THL, on 12 February 1998, to take up my present position with Hutt Valley Health.

**Involvement with Kaitiaki**

- 34 I have been involved with the National Kaitiaki Group (NKG) from its inception. I participated in National Maori NCSP hui around the country from 1992. There was a concern that Maori needed to have their own NCSR so that they could be sure that Maori statistics would be looked after and not used in a negative way. This was a common perception about Maori statistics at that time; that Maori always appeared to be at the bottom of the heap and the services never reflected any improvement for Maori. At least with the establishment of an NCSR for Maori, kaimahi believed that they would have more control and positive protection of such sensitive personal data. This was not supported by the Ministry of Health or the Minister of Health, I think, because they thought it would cost too much. However they were happy to compromise with the establishment of the NKG which was eventually established in April 1995. The legislation provided that, in order to get Maori statistical data from the NCSR, you would have to apply in writing to the NKG and agree to meet all the criteria set out before approval to release the information could be made. This did not affect individual women obtaining details about themselves.
- 35 During my employment at THL, I applied for aggregated Maori statistics many times as this was useful to justify some of the strategies I decided to take.
- 36 I am a current member of the NKG with five others, and we receive administrative assistance and advice from the Ministry of Health. My current term of office is for 3 years from November 1998.

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Sharon Ranui Reid

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Date