

**THE INDEPENDENT INQUIRY INTO HISTOPATHOLOGY SERVICES AT
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

Statement from Jane Mishcon, Chair of the Independent Inquiry Panel

Introduction

On behalf of the whole Panel I would like to begin by expressing our sympathy to those patients and their families who may have suffered an adverse outcome as a result of misdiagnosis by the UHBT histopathology service. We also sympathise with those patients who may have been worried about their diagnosis, but subsequent investigations have shown such concerns to be unwarranted.

The Independent Inquiry was set up to enquire into all matters which led to the concerns raised since 2004 about possible misinterpretation and/or misdiagnosis of histopathology specimens and to establish what action was taken by the Trust to address any such concerns and to draw conclusions as to whether such response was appropriate, timely and sufficient. We were also asked to consider the results of an independent review of 3,500 histopathological specimens and to draw conclusions from those results.

We have carefully considered extensive oral and documentary evidence over the last 12 months and have set out our detailed findings in our Report. We have made Recommendations under 12 separate headings, the main recommendation being that a unified Histopathology Service should be established for Bristol.

Background

In August 2004 a letter was written by five respiratory physicians from North Bristol NHS Trust to a thoracic surgeon at the Bristol Royal Infirmary (and copied to 14 other individuals) expressing concern about the reporting of surgical lung biopsy and resection specimens from NBT patients which had been sent to the histopathology service at UHBT. The letter mentioned two recent cases which, according to the NBT physicians, had serious adverse clinical effects for their patients.

No-one at UHBT pursued identification of those two cases and therefore the allegations were not investigated, however neither were the allegations of misdiagnosis pursued at that time.

One further alleged misdiagnosis was reported by one of the NBT respiratory physicians to the medical director of NBT in March 2005, but it seems that information about this case was not passed on to UHBT.

In 2007 further concerns were reported to Dr Jonathan Sheffield, the medical director of UHBT, which included details of 11 cases (four breast cases, three skin cases and four lung cases) in which alleged errors of diagnosis had been made by the histopathologists at UHBT. This was the first time that evidence of specific cases was provided to anyone at UHBT. However, even when these 11 cases were identified in 2007, no investigation of those cases was carried out by anyone at UHBT. Also in 2007 concerns were raised about the reporting of several gynaecological cases.

In 2008 there was an escalation of concern which led to the medical directors of both Bristol trusts attempting an appropriate response by making an application for a review by the Royal College of Pathologists, but they gave the College mixed messages and did not pursue the further joint application that the College advised them to make.

It was not until the publication of an article in *Private Eye* in June 2009 that any kind of independent investigation into the concerns which had been raised over the years was actually instigated.

By the time that this Inquiry was commissioned, 26 cases of alleged misdiagnosis during the period 2000 to 2008 had been identified. The original slides and reports of those 26 cases were reviewed both by Source Bioscience and by the Royal College of Pathologists and we prepared our own overview of these reviews.

In addition to the 26 cases, an independent review was commissioned by the Trust of 3,500 cases taken randomly from all specialties reported during 2007. We were concerned that such a broad approach was likely to dilute the effectiveness of assessing competency in the four specific specialist areas of concern. We therefore invited Professor Peter Furness, President of the Royal College of Pathologists, to evaluate the evidence which was available to us and to give his professional judgement on it.

Findings

- Overall, we have seen no evidence which would lead us to believe that the histopathology department at UHBT provides anything other than a safe service, although undoubtedly there is room and need for considerable improvement in some aspects.
- Diagnostic mistakes have been made by the histopathologists at UHBT. However, although every single error should be taken extremely seriously, review by the Royal College of Pathologists shows that only very few have been serious diagnostic errors with a serious adverse outcome for the patients concerned. Most errors were of lesser significance and are of a type that could have been — and frequently are — made by any histopathologist.
- Any competent pathologist can make a serious error on rare occasions. The frequency of such errors therefore has to be considered. The number and frequency of the serious errors in the 26 cases identified for the purposes of this Inquiry do not in isolation justify serious concern about the overall competence of the pathologists in the histopathology department at UHBT.
- Professor Peter Furness, President of the Royal College of Pathologists, concluded that there was no systematic pattern of error in the sample audit of 3,500 cases, although he did identify areas of concern in the working practices of the department, particularly in relation to the sharing of difficult cases, the incorporation of second opinions into reports and the checking of particularly significant or unexpected diagnoses
- The main area of our concern relates to culture and attitude, both in the histopathology department itself and between the two trusts. It is vital that there is an open and learning culture in which pathologists seek the advice of colleagues from within and outside their own department and in which mistakes are acknowledged and lessons learned. There is no place for arrogance or excessive confidence. The culture in the histopathology department at UHBT veers towards the opposite of what is required.
- As for the culture and attitude between the two trusts: Professional competition is healthy. Professional rivalry which damages the sane and rational distribution of services is not.
- The inappropriate and arguably unprofessional way of making serious allegations in 2004 about the competence of colleagues (in a letter copied to 14 separate individuals) in many ways set the tone for any subsequent response to and investigation of those allegations. UHBT's medical director, Dr Jonathan Sheffield, told us that he had always felt that the

allegations were vexatious in nature and it is clear that this belief coloured his approach to dealing with them and with subsequent allegations.

- The concerns raised in 2004 and subsequently were not taken sufficiently seriously and were not properly investigated. Dr Sheffield's failure to take immediate and appropriate action gave scope for the histopathologists to respond defensively and aggressively to the original 2004 letter of complaint. No attempt was made to meet the consultant physicians who raised the concerns. There was no follow up of any request for evidence to support the allegations. The escalation of concern in 2008 was fuelled by a lack of appropriate response by management. Neither of the two medical directors at UHBT and NBT appears to have been galvanised into action until 2008, by which time it was too late to deal with the issues 'in-house'.

Conclusions

An Inquiry of this nature, scope and cost would never have been necessary or probably even contemplated had concerns been thoroughly and promptly investigated when and whenever they were raised and the results of those investigations made clear to those who had made the allegations.

The failure to carry out a thorough and prompt investigation of the concerns when raised meant that matters escalated out of all proportion and the already strained relationship between the histopathology services in the two Bristol Trusts became even more deeply entrenched.

It was the cumulative effect of repeated allegations being allowed to linger or be unsatisfactorily answered which led to the perceived necessity to 'blow the whistle' by going to *Private Eye*.

As we have already said, overall we have seen no evidence which would lead us to believe that the histopathology department at UHBT provides anything other than a safe service.

What has happened is that there has been a breakdown of people's confidence in UHBT's histopathology department rather than a breakdown of the competence of the histopathologists in the department.

Working practices at UHBT should be improved. In particular second opinions should be sought more frequently and there should be further moves towards specialisation.

Our main recommendation is that a unified histopathology service should be established in Bristol. This should ensure more specialisation and double reporting and should have the potential to make it one of the leading service and academic centres in the country.

It is essential that lessons are learned as a result of our Inquiry by both Trusts, and, most importantly, are acted upon in a spirit of co-operation and with the determination to take any necessary steps towards achieving workable and cohesive solutions to the concerns highlighted in the Report.