

# DÁIL ÉIREANN

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## AN COMHCHOISTE UM SHLÁINTE

## JOINT COMMITTEE ON HEALTH

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*Dé Máirt, 17 Nollaig 2019*

*Tuesday, 17 December 2019*

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The Joint Committee met at 5 p.m.

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Comhaltaí a bhí i láthair/Members present:

Bernard J. Durkan,	Colm Burke.
Alan Kelly,	
Margaret Murphy O'Mahony,	
Kate O'Connell,	
Louise O'Reilly.	

I láthair/In attendance: Deputy Bríd Smith.

Teachta/Deputy Michael Harty sa Chathaoir/in the Chair.

## **Engagement with Patient Representatives on CervicalCheck and the Royal College of Obstetricians and Gynaecologists Review Process**

**Chairman:** The purpose of the meeting of the Joint Oireachtas Committee on Health this evening is to engage with patient representatives on CervicalCheck and the Royal College of Obstetricians and Gynaecologists review process. On behalf of the committee I welcome to the meeting Mr. Stephen Teap and Ms Lorraine Walsh, both of whom were patient representatives of the 221+ Patient Support Group. Stephen Teap remains the representative for this group. In advance of our meeting tomorrow with the RCOG assessors, the Department and the HSE, it is important that we hear from representatives of the women and families impacted where there was failure to prevent cervical cancer or a failure that led to a delayed diagnosis.

I wish to draw witnesses' attention to the fact that by virtue of section 17(2)(l) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if you are directed by the committee to cease giving evidence on a particular matter and you continue to do so, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, you should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any opening statements you have made to the committee can be published on the committee website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I call on Mr. Teap to make an opening statement.

**Mr. Stephen Teap:** First, I thank the joint committee for inviting Lorraine and I today as patient representatives on the CervicalCheck steering committee and as representatives of the 221+ Patient Support Group. I take this opportunity to highlight the importance of the cervical screening programme. Since the beginning of this debacle, I, along with Vicky, Lorraine and others, have spoken about the importance of women continuing to get their smears taken and continuing to participate in the screening programme. Screening saves lives and the CervicalCheck screening programme has saved many lives. The odds of the screening programme picking something up are in favour of the women who participate. This has been a difficult conclusion for me to overcome given how it completely, 100%, failed my late wife, Irene. However, the facts are evident and even CervicalCheck screening, a programme "doomed to fail", as described by Dr. Gabriel Scally, has saved lives. That being said, many lives have been lost as well. Many families have been torn apart and destroyed. Many women have beaten cervical cancer but have to live with the high price of beating such a disease with life-long complications, including infertility and psychosexuality.

When I went public in May 2018, it was to raise myself to a level where I could have a voice to get the answers for my family on what happened to Irene. It was also to influence those people to uncover the failures in our screening programme to ensure what happened to my family never happens to any other family. If the true meaning of failure is to highlight the mistakes of the past, learn from them and correct them to ensure they never happen again, then Dr. Gabriel Scally's recommendations are key to this and should remain the backbone in addressing these

failures. Of the 116 actions the HSE has identified in Dr. Scally's recommendations, a total of 95 are now complete. A little over 80% of the implementation plan has been completed. I acknowledge the hard work of many people in the HSE who have been working tirelessly in achieving this and the transparency they have provided to Lorraine and I over the past year in oversight of this plan. That being said, I have concerns about its fulfilment and reaching 100% completion. Oversight of the implementation plan will drive it to fulfilment. We need to continue to shine a light on the progression of the plan. The oversight needs to continue. We must ensure a plan is in place to review the ongoing actions that have been implemented, while following up to ensure they are still being worked on in future. Restoring trust in the screening programme will not be achieved simply by this plan. We must start listening to the voices on the ground especially those of doctors, consultants and nurses in clinics throughout the country as well as the staff within CervicalCheck.

Currently, in the colposcopy clinics throughout the country, the wait time for referrals to be seen within four weeks for high grade abnormalities is at 70% while for those waiting to be seen within eight weeks for low grade abnormalities the figure is at 57%. This, in addition to what we have heard about staffing issues, in particular the inability to retain staff due to the extraordinary stress levels they face daily, is of major concern. If we do not get this right, it will only continue to worsen as we see the introduction of human papillomavirus screening next year. While the HSE and the Department of Health will argue that additional funding has been put in place to address this, I am concerned that not enough is being done and that this will be another problem facing all of us next year.

I have spoken on several occasions about the importance of patient representatives and medical professionals working together with one voice to give a view from the ground up. We talk about the culture in our healthcare system that needs to be changed. We know this cannot be changed overnight but we can start to dilute that culture by voicing our concerns together on the back of our common goal, which is to improve healthcare for everyone, not only for those who rely on the system but for those who work within it as well. I have spoken to the Minister for Health and the Department of Health on a number of occasions about setting up a proper, structured, patient representative platform to help with this. Patient representatives who enter our healthcare system do so to make positive change but most, like Ms Walsh and I, do so coming from tragic backgrounds. There needs to be more of a structured platform to support us while proactively encouraging the patient voice to be involved in shaping our healthcare system, instead of exploiting those who enter on the back of a tragedy. It needs buy-in from the medical professionals, along with the colleges. They should be a part of shaping this platform also.

I want to acknowledge those who spoke out recently on the ongoing issues on the ground and commend them on their courage, in particular to those voicing their concerns around the staff in the clinics and CervicalCheck, whose voices are limited in what they can say. I want to thank them for speaking out. Working together will be the key stepping stone as we move forward to not only restore trust and confidence in our screening programme, but also rebuilding the confidence in the key relationships in our medical care, and also that of our GPs who we all rely on.

Now that RCOG has finally reached a conclusion our focus has been on those who have been impacted by this. I want to especially highlight the 159 women and families who, over the last three months, received discordant results from their participation in the CervicalCheck screening programme. These women and families like the 221 last year have come to learn of missed opportunities due to a delayed diagnosis on the back of slides that could have been read

differently first time round. Now all these families are left in the dark, like those of us in the 221 who received audit results last year. They now face the many questions we faced when receiving this news.

What does all this mean? For the last 17 months, Ms Walsh and I have been requesting that funding be put in place so those who wish to have independent reviews can have them in order to get to the truth of what went on. Many of the families cannot afford them. They are complicated and are not cheap. One gentleman who learned about the misreadings of his late wife's smear tests called to my house recently. He said that he owed it to his wife to find out the truth of what happened to her and that he also owed it to his family. This is what it is all about - the truth. To us the truth is all that matters. I never bought into the RCOG review from day one because I knew it would not give the women and families all the answers they required.

We are all fully aware of the limitations of screening and for some an independent review has highlighted this for them. Now these families can get closure. Others have not been so lucky and our journey continues in the adversarial system that is the only route available to us in getting to the truth of what went on in these reviews. The limitations of screening have been spoken about on a number of occasions. Some critics refer to these limitations as the only thing at play here. Without a properly defined explanation of these limitations, the conversation has gone askew. For many of us, it has been hurtful to listen to. Without a proper, recognised, published document we can all refer to, we have started to see this term being used as a blanket excuse to downplay what is going on here.

We must remember that screening is not perfect and that it comes with its limitations. However, we must also remember the labs that outsourced smear tests to other labs, behind the HSE's back and without approval and the lack of quality assurance that was in place and that none of the labs that were outsourced to was ever checked.

We must remember that Dr. Gabriel Scally only visited seven of the 16 labs, as the remainder either did not exist anymore or there was no point in visiting them. We must remember also that Dr. Scally could not comment on the quality of those labs back in the day as he physically could not go back in time to review this. He was clear that any opinion he had was based on whatever information was provided to him. For the most part that information was extremely difficult for him to obtain.

For all these reasons, it is so very important for us to find out the truth individually. It is why we have been asking for the support of the Government in helping us achieve this. Not supporting the women and families in determining the truth will be this Government's biggest failure in this debacle. Contracting our screening programme to labs in the United States, the systemic failures within CervicalCheck and the lack of quality assurance around the additional labs that the HSE was unaware of have all had a devastating impact on many lives.

We are years away from determining a final conclusion on all this as we are waiting to hear how many of these slides either fall within the limitations of screening or breached the duty of care of the women who participated in this programme.

For now, all we can do is focus on the women and prioritise on correcting the wrongs of the past. Screening will and should save lives. We need to continue to focus on implementing Dr. Scally's recommendations, so we can have the best possible screening programme, one that the women and families can rely on.

We also need to continue to build on the incredible legacy the amazing Laura Brennan left for us, and continue to move forward with the HPV vaccinations for girls and boys, which is being done. To get to the point of eradicating this dreadful disease, we need to look after women with the best cervical screening programme we can all trust and rely on while at the same time we must protect our future from HPV by educating and supporting parents on the importance of the HPV vaccination. I very strongly believe we can achieve this and prevent what happened to my wife and family from happening other families in the future.

**Chairman:** I thank Mr. Teap, and call on Ms Lorraine Walsh to make her opening statement.

**Ms Lorraine Walsh:** The last 18 months have been the most psychologically challenging in my life. No citizen of this country would seek this trauma out. Myself and the other women in the 221 group were told of a potential missed opportunity to detect our cancers at an earlier stage. This was compounded by the fact that this information was withheld from us. It threw us into a black hole. We all needed and wanted the truth. As patient advocates, this is what this journey for Ms Vicky Phelan, Mr. Teap, and myself is all about.

Why do we do what we do as patient advocates? We do it to try to restore trust in the system for ourselves, which in turn will help restore trust in it for others. We bore the pressure of that for the benefit of everyone. We did not want what happened to us, the needless pain, loss and suffering, to happen to anyone else. Advocacy has been a chance for us to rebuild hope and trust but it comes at a price. It has been cathartic, heartbreaking, emotionally draining and has had a huge impact on our everyday lives and work, relationships and mental health.

Dr. Scally's investigations and subsequent reports brought many answers but not every answer. Dr. Scally stated it was a system doomed to fail. He said the scoping inquiry concluded that on the basis of visits to laboratories and examinations of their records, there was no reason those laboratories currently providing screening for CervicalCheck could not continue to do so. He said it was not feasible to reach conclusions on how satisfactory, or otherwise, the operation of the laboratories which provided services to CervicalCheck in the early years of the screening programme was. Some of the labs no longer exist, some no longer conduct screening and, in any event, making such retrospective judgment was not feasible. The final report of the scoping inquiry recommended that audits should continue to be an important component of cervical screening. It is important that clear priority is given to clinical audit of contemporary screening services so that improvements can benefit women in the short term. Dr. Scally reported on huge deficiencies in oversight, procurement, quality assurance and auditing of the system. His findings gave insights into what went so wrong for so many of us. The real success of his report and recommendations can only be appreciated when it is fully implemented. This is paramount for the future success of screening.

The Royal College of Obstetricians Gynaecologists was commissioned to compile a report into individual cases to see if there were missed opportunities, and if so their implications for women. RCOG found an array of missed opportunities in relation to screening, together with some colposcopy management concerns. The HSE worked on the communication and disclosure of this information and put much effort into working with clinicians to ensure that the women and families were treated with sensitivity, respect and compassion, and given the appropriate support they needed to process what was for many heart-scalding information. I want to thank each and every person involved in this process, as by and large the feedback from women and families was very positive in relation to the disclosure.

However, my own experience has not been positive or reassuring in seeking the truth in

relation to RCOG. I had worked closely with the HSE over the last year on the planning of RCOG and giving the patient's voice in this. The reports finally started to filter through in late August-early September. From an early stage, it was clear there were various issues in relation to accuracy of the information in reports, which were continuously returned to RCOG by the HSE. Examples of these included incorrect smear dates, incorrect diagnosis dates and incorrect staging of the cancer. On one call to discuss the issues it was suggested that there were cutting and pasting issues arising that may have been contributing to the inaccuracy of the reports. On 2 October, I was contacted by the HSE and informed that following the return of the slides from RCOG to the laboratories that a mislabelling issue with regard to the slides of three women had been identified. The labels had been removed and replaced on the incorrect slides. Two of the three women involved in this mislabelling were Vicky Phelan and me.

On 3 October, I attended a CervicalCheck steering committee in Department of Health, where I voiced my concerns about the verification of reports and the quality assurance process involved in the checking of reports before releasing. I had been appointed to this committee in June 2018 by the Minister for Health to give a voice to the women involved in the Cervical-Check debacle. Meanwhile, women were feeding back to me that the reports they were receiving still contained inaccurate information. I was placated and informed there was no need for any concern and was also informed that people did not like my tone. I knew what that meant so I retreated to a position of silence.

Finding the reply at the CervicalCheck steering committee unsatisfactory, I raised the matter with the 221+ board group. We wrote to Department of Health on 9 October reiterating our concerns. It replied on 11 October. I have copies of this correspondence for the committee.

People often forget what is said, but we do not forget how we are treated. Eventually, I had enough of being treated as though I was not worthy and did not matter so I removed myself completely. My resilience could no longer sustain the pressure. A culmination of feeling irrelevant, the inaccuracies in the RCOG reports of which I was aware from the HSE, women contacting me directly regarding inaccuracies, and the amount of time I felt I was wasting not being listened to, forced me to resign, an act I did not take lightly but had to for my conscience. I wrote to Minister for Health on 31 October advising him of my resignation. I did not include my concerns in my resignation letter as I did not have any proof at that stage, but I did tell him exactly the reasons I was resigning when he called me that day.

On 15 November, I receive RCOG's first report, which outlined that my one and only slide prior to diagnosis from June 2011 was unavailable. By the report's classification, this slide was in the concordant group. On the same day, my solicitor received a three page letter from HSE outlining the movements from June 2011 of my slide, which was deemed "unavailable" by RCOG. Ironically, the first and last paragraph refer to the fact that the errors would have no impact on my RCOG review. At approximately 6 p.m. on that day, the HSE called to say that RCOG had produced its second report and that it would be hand delivered to Galway.

On the following day, 16 November, two very kind and compassionate ladies from the HSE, with whom I had worked closely through my advocacy, hand delivered the second report to my home. My husband was so angry that he could not even stay in the house and had to leave. He was angry but, I think, more hurt that I was so upset. For the record, I have the utmost respect for the HSE employees who have worked with us. They have always treated us with absolute respect. RCOG's second report showed that the missing slide had been found and my report was now classified as a discordant result. I became the victim of my own concerns. I voiced my concerns to the most senior people in the health system but it would seem that women are

still not being listened to.

It is important from our experience to caveat the RCOG aggregate report findings with the following points. A little over half of the approximately 1,850 women invited to participate, who had screening prior to diagnosis through the CervicalCheck programme, did so. A total of 1,038 participated, which is a 56% participation rate, so we are not looking at the full picture. While not questioning the clinical assessment of each case, from our experience the accuracy of the administration of these reports and how the information was processed has not been accurate in some cases. A statement signed on 18 April 2019 by RCOG and three other organisations working in the UK's cervical screening programme stated there was an urgent need to address the outdated IT systems that support UK screening. It also stated the UK programme's IT infrastructure was deemed not fit for purpose in 2011 and that since then, little progress has been made. This raises concerns about the integrity of RCOG's statistical reporting capabilities. RCOG's success is based on percentages of discordant versus concordant but the percentage of concordant would seem skewed and non-intuitive. Cases involving missing slides were classified in some cases as concordant when they should intuitively have been classified as inconclusive.

Further concerns about the integrity of the processing of the information were raised by the mislabelling incident. The circumstances surrounding the removal of labels, which were then incorrectly replaced on a different woman's slide were not adequately explained. Where a system produces incorrect reports subsequently spotted by the women concerned, the reliability and the accuracy of all reports cannot be trusted.

I cannot face another year of negativity and anguish, leaving myself and other women feeling distraught, hopeless, powerless and burnt out. It is not good enough that we are still going around in circles seeking the unpalatable answers to allow us to try to regain our peace of mind and the ability to sleep at night.

Last week, I met my consultant for the first time since this broke in April 2018. I was feeling apprehensive, hurt and broken. I had trusted with my life this doctor, who has always treated me with the utmost respect. We had an honest and frank discussion airing our views, concerns and criticisms, with both of us desiring the same outcome, which is a screening system in which women can have faith. I am asked all the time by Irish women whether they can trust the results of their smears. We need to encourage the uptake of HPV vaccinations for girls and boys in order to reduce the incidence of cervical cancer but this takes time and faith on behalf of parents to vaccinate their children. In the meantime, every day women are being diagnosed with cervical cancer and are battling the disease through treatment. We have a huge survivorship that desperately needs care in dealing with and living with the after-effects of this cruel disease. No Government should condone substandard care for its citizens and all of the patients suffering as a result of cervical cancer should have access to adequate post-treatment care and support. I had to go to the UK to get a definitive diagnosis of lymphedema last year, which is another horrible aftereffect of cervical cancer that I must live with.

We need to focus a number of supports, including a psycho-oncology service and oncology social workers. Onco-fertility should be available in the public system. At present, the Government funds this through a private clinic so the pathway is not direct. Psychosexual support is also required, as are dieticians to help with gastroenterology and post-radiation bowel toxicity, pre-clinical lymphedema assessment and early diagnosis, management and physiotherapy for pelvic floor and lymphedema.

We must recognise and acknowledge that clinicians feel unsupported, isolated and undervalued. All involved have felt the strain but in different ways. As patients, we must value the concerns of the clinicians on whom we absolutely rely. Healthcare professionals, such as colposcopists, nurses and smear takers, are essential to the provision and promotion of good healthcare and healing and they deserve respect.

Screening is so important and helps save lives. It is hoped that any impasse can be lifted by constructive dialogue, such as that from Dr. Nóirín Russell and Professor Donal Brennan. We all have a vested interest in preserving life, health and good relationships. We say this today in a place of neutrality in the Houses of our Oireachtas and invite doctors to work with us and come together for mutual benefit. We need them. We must heal any divisions and emerge united and strong.

Perhaps we have established as much of the truth as is possible and the time has come for us to come out of the trenches and focus on better futures and outcomes for women and their families. For Vicky, Stephen and I there is no going back or undoing the past. We must all live with the consequences of these failures and in doing so we should not forget but should strive for a stronger voice for the patient and to build better communication channels and synergies with all working in our health system.

Advocacy has been a heavy burden at times and I want to thank the health committee for the invitation to come here today and give us a voice instead of the usual talking about us. The references often made to us sound like we are an army of people but generally it is just Stephen and myself. We are far from perfect but we have always been honest and we have done our absolute best.

**Chairman:** I thank Ms Walsh for her presentation and for having spoken with such eloquence and clarity on the issues this evening. It must have been very difficult for her to come in to speak here at the committee. I will ask members to comment and I call first Deputy Stephen Donnelly.

**Deputy Stephen Donnelly:** I thank both witnesses for their statements just now. It is never easy to speak in public. To speak about matters that are so personal and have caused so much hurt and distress is particularly difficult. We volunteer to be in the public eye but neither of our guests is here by choice. I acknowledge the extraordinary work they have both done in patient advocacy. Listening to both of their statements, these have come at a cost. They have done their country a great service. I want to acknowledge that service and the price they have paid to stand up for other people and I thank them both for that.

I will start by asking Ms Walsh about the CervicalCheck steering committee, which is chaired by the Department of Health. She has given testimony to us this evening that suggests not much has changed and that women and patient representatives are being talked to. The language she used was very upsetting to hear, which essentially was that she was being handled and made feel irrelevant and unworthy. At no time is that acceptable. In the context of the CervicalCheck scandal, it is beyond comprehension that that could have happened. Does the CervicalCheck steering committee have the governance in place it needs? Do the patients on that committee have the support, voice and influence they must have? Is the steering committee sufficiently independent to act on behalf of patients and in doing so, to hold the State to account?

**Ms Lorraine Walsh:** I thank Deputy Donnelly for his comments.

As I said earlier, I was appointed as one of the patient representatives to the CervicalCheck steering committee. It did not come with a set of guidelines but I thought it was to give the women and families involved in this a voice. What happened in October, was that I voiced my concerns to the committee. I had not received my Royal College of Obstetricians and Gynaecologists, RCOG, report at that stage but had worked very closely with the HSE and was privy to the ongoing problems within it. I brought those concerns to the committee and to the Minister. When one tells the most senior people in the country of one's concerns and one is not listened to, what else does one do? My only option at that stage was to resign as I felt that the committee was not listening to me. What is the point in having a patient representative voicing concerns when they are not being listened to? One issue raised by the Deputy was that the oversight of this has been chaired by the Department of Health. Perhaps it should have been or should be chaired by an independent person or body, that is, somebody who was outside of this issue, which may be better. One thing that has come up a lot over the past 18 months is that women have not been listened to. This has happened multiple times over that period and prior to that. It seems that this is still not happening in my experience.

**Deputy Stephen Donnelly:** When Ms Walsh raised these concerns with the steering group, with officials and with the Minister, did anybody say to her what might be done to change the committee to make it a place where she might be listened to?

**Ms Lorraine Walsh:** No. Even at the time, somebody could have said to me that they would investigate this further, get clarity on it and ensure my concerns were addressed. I was told at the time that there was a verification process in the HSE that would take up all of these issues. I did not realise at the time that I was going to become the victim of my actual concerns a number of weeks later, which is exactly what happened.

**Deputy Stephen Donnelly:** Essentially, by raising a flag and saying as a patient representative that there was a problem here, she was not listened to. Rather than anyone taking her seriously, making any changes or asking for her opinion on how it might be made better, she was essentially shut out of the process.

**Ms Lorraine Walsh:** Yes.

**Deputy Stephen Donnelly:** That is infuriating.

**Ms Lorraine Walsh:** Yes, it is.

**Deputy Stephen Donnelly:** I am very sorry to hear that and it is outrageous that she has been put through that.

**Ms Lorraine Walsh:** I am sorry that I have to tell the women and families in Ireland this, but that is the truth.

**Deputy Stephen Donnelly:** I thank Ms Walsh for sharing that with our committee but that is just outrageous.

Mr. Teap raised some concerns about the implementation of the Scally report. Many of the recommendations have been implemented, which is obviously welcome. He raised concerns, however, about the ongoing implementation. Are there aspects of this that are particularly important, that he would like to see happen and that he believes are not being implemented?

**Mr. Stephen Teap:** The biggest issue I have is the longevity of the oversight of the plan and

that it remains in place. We have seen earlier this year, around February, an attempt to wind down the CervicalCheck steering committee. Right now, I am not confident that it will stay running for the next couple of months either. For me, the biggest reason it has been so successful in its implementation to date, with over 80% of the recommendations implemented, is the fact that there has been so much oversight of it. The unfortunate thing about this is it is because of the media spotlight also. That aids its progression as well, in that people are interested in seeing this report fulfilled but we should not need the media interest to move this along. It needs commitment from the Department of Health to ensure that it continues. This oversight makes the job easier for the people mainly involved with this within the HSE to continue with this process.

Another issue I have is that it is one thing to tick a box and fulfil an action but it is also necessary to follow up on that action to ensure that in years to come, it is still continuing and that some sort of review process is in place for it, which currently does not exist. Right now, with 116 actions, it is a tick-box to ensure that it is done but there is nothing to follow that up in a few years' time to see that it is still running or working. We need to ensure the continuity of this aspect of it because many of these recommendations are in respect of governance, employment, staff quality assurance, as well as auditing and tendering. There are many important elements that impact not just CervicalCheck but the healthcare system as a whole. Open disclosure and many other important items should not just be isolated to CervicalCheck but are matters that will impact the whole healthcare system. It is important that proper oversight of this remains in place.

**Deputy Stephen Donnelly:** I thank Mr. Teap.

I wish to ask both of our witnesses about mandatory open disclosure, about which they have talked. The related Bill was before the Dáil last week on Second Stage. One point I made to the Minister on Second Stage was that it is all well and good telling clinicians through legislation that they have to disclose, which is correct. I imagine the single biggest cause, however, of clinical error is overworked, overwhelmed, understaffed and under-resourced clinicians. It is a bit rich for the Government to be legislating for mandatory open disclosure of clinical errors when it is failures in the public health system that are putting our clinicians in an impossible position. I note the witnesses - without putting words in their mouths - have said something and have referenced this. In both of their opinions, where they obviously are engaging with clinicians a lot, are our clinicians working in a safe environment and in a position where they can do the job safely?

**Mr. Stephen Teap:** I would honestly say they are not working in a safe environment. The stress levels they are all going through are public knowledge. We read about it every day. We have heard a great deal about people involved in clinics around the country and within CervicalCheck and that the support just is not there for them. That, of course, creates risk for them but also for the patients and the people who rely on the system. Mandatory open disclosure is important. If it is not done, how will we ever get to the bottom of the problems that exist? An error, for example, may take place due to being overworked, tired, or understaffed. Those issues need to come to light so they are addressed. If an error of some description is inflicted on patients due to staff being overworked, tired or understaffed then they need to be made aware of that also.

In terms of medical professions having a voice, they are very limited in what they can say. When we say patient representatives and medical professions work together, it is in our interests, your interests and everybody's interests in this country that these issues are highlighted at a very early stage. If medical professions are coming out and giving a view from the ground up,

they are not listened to. If patient representatives are doing it without the backing of the media then they will not be listened to either. This is why a combination of both voices is the key, in my opinion, to addressing these issues. Unfortunately, we live in a world where we still work to a very Victorian style system where everything seems to be dictated to from the top down and very little attention is given to the voices from the ground up. Probably the biggest failure in our healthcare system is not listening to the voices on the ground. I mean the people who have to walk into medical centres and rely on our healthcare system but also the people who have to work within the healthcare system - the doctors, nurses and administrators. I mean everyone. It is quietening those voices that really is the backbone to a lot of our problems. We really need to start looking at those voices.

**Deputy Stephen Donnelly:** Ms Walsh listed this evening, and I have heard her talk publicly about it, numerous and really worrying inaccuracies in the RCOG process. If I understood her correctly, she was given a report that said there was no discordance and no miss and then another report saying that there was. Also, her slide seems to have travelled all over the place.

Ms Walsh said something very important about whether the women who received these results should have confidence in their results. There have been some deeply upsetting results for the 159 women, many of whom the witnesses, the members of this committee and I have met. Should these women who have these results have confidence in them or should they now opt for an independent review?

In terms of supports for the women and their families, we have the 221+ group whose members have engaged with the system for some time and we have the new 159 women and families from the RCOG review. At this point are all of the women and their families getting the support that they need?

**Ms Lorraine Walsh:** My experience of the RCOG review has been catastrophic so I could not have any faith in it whatsoever. I got report No. 1 that said my slide was missing. On the same day, I got a letter from the HSE explaining that the same slide had been mislabelled so, in fact, it was not missing. My question here is not about the clinical reading of these slides but more about the reporting of them.

On page 20 of the RCOG report, they allude to the process of the generating of letters in saying that it required a recheck of both the CervicalCheck database, the National Cancer Registry database and their own master RCOG database. That is three databases they were supposed to be rechecking before issuing each individual letter. How could it possibly be that they issued a letter to me telling me that my slide was missing when, in fact, they had it, they had reviewed it and produced another report that evening to say they had reviewed it? To me, it would seem that when they were compiling the individual reports they were not checking them individually even though their report states that they had a three-step check. On top of that the HSE had a verification process, that they were trying to pick up on any inaccuracies as well. If both of their processes were that good and that accurate then how did I, who happened to be just the one patient representative that was involved in this, get an inaccurate report on top of them taking my slide, mislabelling it and putting Vicky Phelan's label on my slide? I cannot say I have faith in the review.

To me, if any women and families are involved in this, regardless of what result they have got through RCOG, my advice to them would be to get an independent review to get the truth. Let us remember that is all people want - the truth. People only want to know what happened. We were all brought in and told there was a potential miss in our cases but people were not sure

if it fell within the limitations of screening or whether there was negligence in the case. One cannot undo that. One cannot just say, “Fair enough, I will take that” and walk away and get on with one’s life. One must find out the truth. It would seem that this review is not going to give those answers.

In terms of supports, there are two layers to this. There are supports from the 221+ perspective and the supports for women who are living with and past cervical cancer. Last week, I met my clinician and he said to me: “My big problem is not cervical cancer. My big problem is women coming in here living with the aftereffects of cervical cancer and I do not have the supports to help them.”

Last year, when I started getting symptoms of lymphoedema, I was sent around in a circle because there is no clinic in Ireland at the moment to treat people with lymphedema, to get early intervention and early diagnosis, which is critical in the management of lymphoedema. Lymphoedema is a horrible sideeffect of cervical cancer and one can get it from other cancers as well. We have got to start looking after these women. There are a lot of young women who are surviving with lots of problems post-cervical cancer. That is something that the Government needs to start looking at. It must improve the quality of life for women who are living with and after this disease.

**Chairman:** I thank Ms Walsh.

**Deputy Stephen Donnelly:** I asked about supports for the 221+ group and the 159 women. I ask about them because I speak to women from both groups. Maybe the 221+ group is more advanced but certainly, the women in the 159 group do not appear to be getting the administrative, psychological, clinical and financial supports that seem to be needed at this point.

**Mr. Stephen Teap:** I will take that. In May of this year, we asked the Minister for Health to replicate the supports that were in place for the 221+ group for those who were going to be impacted by RCOG and, thankfully, that was done. So anything that was available to the original cohort of people is also available for those who have been added on as a result of RCOG except the *ex gratia* payment of €2,000 that was recommended by Dr. Gabriel Scally in June of last year. Over two weeks ago we wrote to the Minister for Health. Bar reading a couple of headlines there still has been no confirmation on this.

What triggered the discovery that the *ex gratia* was not being paid is that somebody contacted the support group who, due to having cancer, had to finish up work on sick leave and it was going to take three or four weeks to process illness payment. I do not need to go into detail on the financial impact of cancer on the individuals and families affected because the Irish Cancer Society recently compiled a fantastic report that highlighted the real cost of cancer. What was apparent when it was highlighted to us that the *ex gratia* payment was not included in the supports, even though the Minister for Health did say he would essentially copy and paste the supports, was when last Wednesday, I think, the Taoiseach said he supported it being paid. I raised the matter with the steering committee on Thursday but it was not in a position to commit to it and we still have no confirmation of that. The *ex gratia* payment is the only support that is not available and everything else is like for like.

A fantastic team of liaison officers around the country are contacting the women and families who are affected, as the report highlighted. I am not too sure about the status of that. I do not know whether everybody has been contacted or whether some people may be waiting to be contacted. All of the supports that are available to us are available to the RCOG group and the

people implicated by that, except for the *ex gratia* payment.

**Chairman:** I thank Mr. Teap.

**Deputy Louise O'Reilly:** I thank our two witnesses most sincerely, not just for their evidence this evening, but for everything they have done. They have spent a large amount of time away from their families working on behalf of women like me, my daughter and people who use the service and want, need and deserve to have confidence in it. We can say "Thanks" for everything the witnesses have done, but that is clearly not enough. They are here doing that work, so they are clearly not at home with their families. For that, they are to be commended.

I had not intended to ask this question, but the matter has been raised. Despite the assurances given by the Taoiseach and the Minister, has the €2,000 *ex gratia* payment been paid yet?

**Mr. Stephen Teap:** No. It has not even been confirmed officially that it will be paid. I will set out the timeline of events for the payment. On meeting a number of the women and families, Dr. Gabriel Scally last June identified a financial need from a lot of the suffering that he had seen. I have explained the financial impact of a cancer diagnosis. That is where the payment came from. We raised the matter two weeks ago and wrote to the Minister for Health, but there is still no official confirmation that it will be paid. From what we saw of the Taoiseach last week, the word is that he is trying to move this along, but unless "It is going to be paid" is in writing, the HSE is not in a position to pay it. The answer to the question is that the payment does not exist right now for the people impacted.

**Deputy Louise O'Reilly:** That is very disappointing in light of where we have come from. What has characterised this situation from the beginning up to the present is an unsubstantiated media report followed by repeated questioning by people like the witnesses, us and journalists and evidence then emerging. The hope is that the payment will be made, but people in the HSE cannot action it until they get a piece of paper. Of course they cannot.

**Mr. Stephen Teap:** Correct.

**Deputy Louise O'Reilly:** They would not have the wherewithal to do it. We will collectively try to do as much as we can. I read the Irish Cancer Society's report, but I would have known the situation anyway. If someone has to go off work at the time of the initial diagnosis, having to face additional charges is regrettable. I hope that we will be in a position to follow up on that.

We will have an opportunity to ask questions tomorrow. We have heard of some of the difficulties experienced by women engaging with RCOG. Are there other examples that pursuing tomorrow morning might be worthwhile? Much of this is anecdotal evidence. Some of it I already have, as people have contacted me. People have also contacted other committee members. Are there examples of what we should be honing in on tomorrow?

**Ms Lorraine Walsh:** There are a number of issues, one of which has to do with eligibility for inclusion in the review. I refer to page 14 of the report, No. 3 on which reads: "All slides missing i.e. not retrievable, or slides not available for review having been obtained by a third party at the woman's request." By "All slides missing", is RCOG referring to all slides prior to diagnosis or all slides in general, including the one at the time of diagnosis? A number of women have come to me with concerns regarding their one and only slide prior to diagnosis being unavailable even though their results were classified as being concordant. How could that be possible?

**Deputy Louise O'Reilly:** Yes.

**Ms Lorraine Walsh:** The whole idea of the RCOG review was to look back at slides taken prior to diagnosis. We see that there was a 30% discordance and a 70% concordance. If there were a number of women's slides missing that were deemed concordant, though, then that does not seem right. When I got an answer to that previously, I was told that many of those were called "partial reviews". I have contacted a number of women whose one and only slide prior to their diagnoses were missing about this issue. They said that "partial review" was not mentioned, only that the review was in agreement.

**Deputy Louise O'Reilly:** Were all such slides concordant?

**Ms Lorraine Walsh:** Not necessarily.

**Deputy Louise O'Reilly:** But there was no finding of inconsistency. When Ms Walsh asked questions, it became a "partial review". Before then, it was simply advised that the slides were concordant.

**Ms Lorraine Walsh:** Exactly. That was one of the issues. I referred to another in my opening statement relating to a report in the UK about RCOG's IT system and how it raised questions about how RCOG was managing the data for this review.

The 2018-19 cervical screening programme quality statement in England, which was published in November, reads: "There is generally no accepted or expected level of false negatives in the NHS Cervical Screening Programme." Despite this, RCOG expects us to accept a 30% false negative rate. That is what RCOG wrote. I wonder why it is telling us that this is an acceptable rate when it says that there is no acceptable rate. That is a question.

**Deputy Louise O'Reilly:** That is something that I raised at this committee during our first session. For reasons that I will not go into now, I am someone who has had occasion to engage on a regular basis with the service. I know the limitations, because I asked my doctor and my doctor knew. Dr. Peter McKenna did not know, though. The first time I asked him, he gave an assessment of 10%. According to the literature that was distributed, no screening test is ever perfect. It is good that there has been a discussion so that everyone understands, but women who asked their doctors could have found that out. It is unfortunate that information was not available in this room on that day when we asked the question. It is readily available to everyone now, which is probably a good thing. Anyone who would have had occasion to ask would have been told by her doctor something that the head of the women and infants programme did not know. He put the figure at 10%. There is a great deal of information in the public domain now, which is a good thing because women in particular are able to ask questions. Judging from Ms Walsh's submission in particular, though, it seems that women can keep asking questions but will still not be listened to. That is regrettable and has to change. We cannot continue in this vein.

Mr. Teap referred to "a proper, structured, patient representative platform". Clearly, it does not exist at the minute, but what would that forum look like, who would be on it and, more importantly, how would it be resourced? I am conscious that much of the work that has been done was done in the witnesses' own time and at their own expense. People have to be free to participate and they must be supported. Will Mr. Teap give us an idea of what "a proper, structured, patient representative platform" would and should look like?

**Mr. Stephen Teap:** Certainly. It is important to highlight that Ms Walsh and I never applied

for this job. No one advertised it. Ms Walsh and I both come from tragic backgrounds. All of a sudden, we were given the title of “patient advocate” or “patient representative”. After a month of going public, I saw myself being referred to with different titles. It was not just “widower” anymore. Now, I was a “patient advocate” or “patient representative”. The main problem is that, when one comes from a tragic background, one is reacting to something that has happened. There are other areas of the HSE where people are required on a more proactive basis, but when people come from tragic backgrounds like ours, they could be anyone. Instead, who we are looking for are people who have time and money to fill these roles. Ms Walsh and I do not have these either. Dr. Scally or someone else used the word “exploitation”. There is no support whatsoever for us. There was no induction pack or explanation as to where the Department of Health, the HSE and its staff fall. There is no psychological help or any assistance like that at all. There is nothing whatsoever.

The issues raised in the conversations I have had with the Minister and the Department were first raised on the back of something Dr. Scally said to me but also because of something said by a friend of mine who works in the HSE in Cork and who attended a conference. The conference was led by someone from the United Kingdom, which already has a system in place for patient representatives. In the United Kingdom, there is a proper, structured platform for patient representatives, who are supported in every way. When Ms Walsh and I sit at a table, it is not about money but about respect and coming from an area of respect. The patient representative system does reimburse one for one’s time but it also puts the associated supports in place. It is also to get away from having people who come from the backgrounds Ms Walsh and I come from. There will always be a scandal and something will always go wrong, and people will step up to the plate, but when they do they should be supported.

Other issues arise in the HSE, and within CervicalCheck, concerning the marketing and putting the programmes and information packs together. Many people have volunteered their time to do this but we need to get the right people to volunteer. They must be of the right age profile and gender. The volunteers should be relevant to what exactly is going on in the health-care system. It is about ensuring that we can attract those individuals and have the supports in place. Those in their 30s, male or female, are probably going through a very expensive time in their lives, particularly if they have a small family and big mortgage. How can people of that age profile be asked to volunteer a day per week or per month in the HSE to improve it? That cannot be expected. The majority who volunteer, while they are needed to represent their own age profile, are retired, because of their age and the time they have available. It is not ideal that they would be representing people our age. Obviously they are important to represent themselves but we would be lost without them. It is about having the relevant people on this platform. This is what we have been discussing with the Department of Health. It has examined the UK model. Right now, it is only a conversation. Everyone’s support is needed to try to drive it on and put the arrangement in place. When I talk about diluting the culture of patient representatives and medical professionals working together, I am suggesting that the platform is what gives patient representatives respect. The platform obviously has to have buy-in from the medical profession and also the colleges if it is to be put together. It is important to try to have something in place for-----

**Deputy Louise O’Reilly:** That is a good point well made, particularly if we are to move towards a shift in culture in terms of open disclosure. We had to move in the Dáil towards that culture. As Mr. Teap will know, open disclosure was voted down but now enjoys full support. It is good that people are coming to this conclusion but there will have to be a massive cultural shift in the HSE. That will mean all the health professionals will have to be supported and-or

represented, as required, because, ultimately, we are also asking them to take a leap. To be fair to everyone concerned, that will have to happen. This will require a certain amount of leadership.

It is welcome that there is a conversation being had on the representative forum but, as Mr. Teap says, we probably need to work collectively to give it a wee shove.

**Mr. Stephen Teap:** Absolutely.

**Deputy Louise O'Reilly:** Have I time for one more question?

**Chairman:** Yes.

**Deputy Louise O'Reilly:** How many people are currently looking for an independent review? I fully respect the fact that the delegates may not know. I understand from talking to people involved that it is expensive and complicated to get the independent review done. Perhaps they could do with a bit of a hand in this regard. Have the delegates any idea of the number involved? There will be those who may not want the review. The majority probably will. As stated, the gentleman who called to the Mr. Teap's home feels he owes it to his wife. Many people would feel like that. Could the delegates give me an estimate of the numbers seeking a review?

**Ms Lorraine Walsh:** We have experience of the people who have come to us through 221 Plus. Its membership has increased significantly since the RCOG disclosure. It would seem, however, that the number who have parked this, put it behind them and do not want to know any more is quite small. I would say there are quite a number-----

**Deputy Louise O'Reilly:** The majority.

**Ms Lorraine Walsh:** The vast majority are probably considering an independent review. One must remember that many of the people involved do not have the money to go the independent route. They were hoping the RCOG review would give them those answers. I am very conscious that I am saying to these people that they cannot trust this report despite the fact that this is their only avenue to get some form of the truth. I do not say it lightly. Many are now wondering where they will get the money to find out the truth. These independent reviews can cost anything from €2,000 to €5,000.

**Mr. Stephen Teap:** I wish to add to what Ms Walsh has just said and explain exactly what we mean by an independent review. To get the truth about what happened with the smear tests, there is a need to find an independent medical professional, a cytologist, to read the slides and write up a report on them. I do not know any cytologists. We do not know these people. The protocol in place in the HSE is that, in order for the slides to be released, the name and address of a cytologist to whom they are to be shipped are needed beforehand. I can speak only about myself. The only people I know in this country who have any experience of carrying out reviews of medical files or anything like that are solicitors who practice in the area of medical negligence or such a field. Those are the people one has to approach because there is no other way to do it oneself. There is no body or individual one can refer to in order to get this done.

With regard to Irene, she had two slides. It cost up to €2,000 to have them read. There was also the cost of a solicitor to co-ordinate it all for me. I was brave enough to go into the solicitor's office and ask for this to be done but I realise people fear going to the solicitor's office, and this is preventing them from getting to the truth. They fear it because of the litigation process,

which we all witnessed in the case of Ruth Morrissey during the summer. People fear that they are going to be dragged straight to the High Court and that their name will be all over every newspaper in the country. Unfortunately, that has happened very many people. I know one woman who passed away without knowing the truth. The reason she did not contact a solicitor beforehand was because she was afraid she would be the next Ruth Morrissey. I was trying to explain to her husband that all he was doing was contacting a solicitor to get access to her slides, which would in turn be sent on to someone to review them. Ms Walsh has got this done and I gave got Irene's slides done. We both know now what is on the slides. In order for us to take it further, unfortunately, the system is such that we have to go to the High Court. As my solicitor's firm said to me, it has got many slides back which showed the limitations of screening. That is fine. It gave the people in question closure. Actually, they were very happy there was no foul play in their medical care. They are able to move on from that because they have got the truth.

**Deputy Louise O'Reilly:** It is just the truth.

**Ms Lorraine Walsh:** I know of one woman who found her case showed the limitations of screening. She was quite happy to say that she could then park the issue and that what occurred could not have been prevented. She said she could move on with her life.

**Deputy Louise O'Reilly:** It is just the simple quest for the truth.

**Ms Lorraine Walsh:** That is all.

**Mr. Stephen Teap:** It is a very simple thing to set up. The structure is already in place with the HSE and the liaison officers. It is just a case of returning a receipt. It is not rocket science. It also gives people who want to get the truth that bit of comfort that they are supported in doing so. Right now, they are not. Even the stepping stones and how one goes about it are not clear. That is why one is forced down this road. There is no other avenue for us. This is the only one.

**Deputy Louise O'Reilly:** The only door open is the legal one. I can understand that people just want an answer. They are not necessarily looking for an issue. They are just looking for the truth and the small amount of closure that might bring.

**Mr. Stephen Teap:** Exactly.

**Deputy Alan Kelly:** I welcome Ms Lorraine Walsh and Mr. Stephen Teap. I know them quite well at this stage. I compliment them both on the work they have done and continue to do. The journey they have come on and the way they have put themselves forward are simply incredible. I admire them both greatly. This is along with a certain woman who is now watching us on her phone at Dublin Airport on her way to New Zealand, Vicky Phelan. We can all give her a wave. Hello Vicky, who is watching in. She will probably give out to me for saying this.

Today, we have gone through much detail. I know Stephen Teap has been in front of the committee before. This is Lorraine Walsh's first time. She was brave putting forward her points and telling her story. The level of detail she gave of her personal story is unprecedented. I note the solidarity the two witnesses have shown for one another. Many people think that there is a big team involved but it is just the two witnesses and Vicky Phelan. They have gone into an extraordinary level of detail and educated themselves. This learning process across a whole range of issues has been seismic.

I asked for the witnesses to be invited before the committee as part of this process. The most important point is that they get to say what they want to say. I am conscious that much of the

information is important before we meet the Royal College of Obstetricians and Gynaecologists, RCOG, tomorrow morning. Is it fair to say that the witnesses do not have faith in RCOG?

**Ms Lorraine Walsh:** Yes.

**Deputy Alan Kelly:** Ms Walsh could not be more absolute about that.

Do the witnesses believe that all the women affected should be offered an independent review as outlined? That has not been confirmed yet by the Government. We know the issues about the supports and the one outstanding issue, namely, the €2,000 award. That still has to be confirmed but will be, hopefully, in the coming days by the Minister for Health, Deputy Harris, who must sign an order. That is where we are now.

Lorraine Walsh went into the RCOG process, the criteria and the slides. There is quite a level detail on the process around the slide availability and who was part and should be part of that process. Then there was the detail about the letters sent out about being concordant, discordant and the fact that there was not a third category which is basically unknown. Will the witnesses outline the criteria where the RCOG process from the beginning did not work? How did that then manifest itself through slides missing, as well as discordant versus concurrent and the fact that there was not a third category. That is a critical issue. How can there not be a third category? How can there not be a category where slides are missing?

**Ms Lorraine Walsh:** I can give an example about one woman who contacted me. When she got her review back, it had only reviewed the slide that she was actually diagnosed from. It said that the other slide was unavailable. By virtue of this, they had found that she could not have been diagnosed at an earlier stage and there was no missed opportunity. That would have classified her as concordant. The actual opening paragraph in the letter stated that the process of RCOG was to look back at cytology prior to diagnosis. In my opinion, that should have eliminated her from it if the slide prior to diagnosis was unavailable. It does not take a rocket scientist to know that the slide she was diagnosed from was read correctly because obviously she was diagnosed.

When we look at the 70:30 rates, we are told the screening programme is working within the norms that are expected of a 30% rate of discordance. Clearly, we cannot work off those figures. One has to look at the fact that just over half the women involved in this actually consented to the process. One is only looking at half of those screened in the system, basically half of the overall picture.

**Deputy Alan Kelly:** The whole issue concerning the manner in which the criteria were set down and not followed is essentially part of the problem. One cannot have faith in the results generated from them, not just from individual examples but from the manner in which criteria were not executed in the way it was claimed they would.

Three women's slides were mislabelled, those of Lorraine Walsh and Vicky Phelan and one other woman. Lorraine Walsh is the patient advocate who is participating in the programme. We have the details of the two reports. Of the 1,038 women, Ms Walsh is one of three whose slides were mislabelled. As she outlined in detail, there are two reports, one of which came 24 hours after the other. Both stated the complete opposite, based on the fact that they could not find the slide that they did not know existed.

**Ms Lorraine Walsh:** They had been mislabelled.

**Deputy Alan Kelly:** They had been mislabelled. Statistically, the chances of that happening mean one would probably win the EuroMillions quicker. It is incredible. Three people having their slides mislabelled and then ending up in this scenario with two reports is incredible.

I want to ask about the sensitive topic of the Department of Health which was raised earlier by Lorraine Walsh. How would Ms Walsh describe the *modus operandi* of the Department of Health regarding her treatment as part of the CervicalCheck steering committee?

**Ms Lorraine Walsh:** Horrendous is probably the one way I would describe it.

**Deputy Alan Kelly:** Throughout her submission, she complimented a whole range of different people in the HSE and across the board, as well as clinicians. The one missing is the Department of Health.

**Ms Lorraine Walsh:** As I said in my statement, one does not forget the way one is treated, dismissed, ignored, made to feel stupid and irrelevant, bullied, threatened and told that if one kept on making accusations or comments, there would be serious consequences. As an individual, I have to be careful in what I say. The Minister for Health appointed me as a patient representative to question this situation and what happened and to try to work with the people trying to put it right. Then, when one looks at and questions that, one can be reprimanded for it, so I must be very careful. Sometimes that puts me into a position of silence because I cannot take that chance.

**Deputy Alan Kelly:** That is horrendous.

**Ms Lorraine Walsh:** It is the truth.

**Deputy Alan Kelly:** We hear an awful lot of commentary on the future. Mr. Teap has spoken very publicly about being a patient advocate and the many different costs of that. When Ms Walsh talked about feeling threatened and fearing consequences, she really meant it.

**Ms Lorraine Walsh:** Yes. As I said, I must be very careful in what I say. I do not want to be sued - not that I have a lot, but I do not want to lose what I have. I did not come into this to point fingers at anybody. I am trying to get the truth, trying to be honest and trying to understand what happened for all of us. As I said, it has been a difficult time and sometimes a patient advocate must ask tough questions. I do not know what else to say. I am afraid to say anything else.

**Deputy Alan Kelly:** Ms Walsh has been very clear. This is not my committee, but she does not have to be afraid in here, as the Chairman said when he read out the note on privilege at the beginning of the meeting.

A lot of questions I was going to put forward have been dealt with so I will drift into a little more detail. I have two questions for Mr. Teap. First, we know of the story of Bernadette Kiely, and I say her name purely because it has been spoken publicly in the Dáil. Ms Walsh might wish to come in on this. Does that case raise additional concerns and issues for the witnesses?

Second, in any of the witnesses' analysis have they looked at comparative, cross-jurisdiction changes as a result of screening and, for instance, mortality rates? Are there any lessons to be learned in this regard or anything that would not necessarily jump out to the committee or the public but that we should be aware of?

**Mr. Stephen Teap:** One of the questions that came out of the case of the person the Deputy mentions was the discovery of audit results in files. We cannot go into detail on an individual.

**Deputy Alan Kelly:** I am talking about the case as a topic as well as the individual.

**Mr. Stephen Teap:** We just need clarity from the HSE that all audit results have been disclosed, that all the people who had discordance on the audit have had disclosure.

**Deputy Alan Kelly:** There is now a fear that there are additional non-disclosures, effectively.

**Mr. Stephen Teap:** This is it. The 221 came on the back of an audit. Discordance was discovered on that audit and that is where Ms Walsh, my wife Irene and all the other women's names came from. Obviously, there were other audit results that did not show discordance that are on women's files today. The HSE just needs to give the clarity that everybody who had discordance in that audit has had disclosure. That is probably the biggest thing that came out of that audit.

**Ms Lorraine Walsh:** I know the woman in question, Bernadette Kiely. I met her with the RCOG review panel back in May. She was one of the patient representatives who came to meet RCOG. What happened, I believe, is that she had an issue with her colposcopy management and the RCOG found discordance in her case, but when she received her file, which she had requested, there was a partial audit report on it but there was a page missing from it. She now wonders, now that the RCOG has found discordance in her case, whether there was discordance when it audited her file previously and, if so, why she was not told about it. The woman deserves to know and to get that second page of her report. She is traumatised-----

**Deputy Alan Kelly:** Absolutely.

**Ms Lorraine Walsh:** -----wondering about it. Obviously, it takes time to put files together and so on, but this is one page that would make a huge difference to her. I think it would have a huge impact on her if she got that page as soon as possible, just to know the truth. It is back again to the truth, every time.

**Deputy Alan Kelly:** The truth is everything. I ask Mr. Teap to respond to my other question.

**Mr. Stephen Teap:** That question probably comes from something I said previously about all these reviews that are ongoing. They seem to focus on just the slides but not the programme as a whole. After I lost my wife, many of the people who have lost people in this made contact with me. This is obviously a burning question for me.

People - researchers and so on - say to me the real measure of whether a screening programme is working is that we should see a downward trend in mortality. From what I have been given and what I have here, which I could share with the committee, I think the statistics show that out of the UK, France, Finland, the Nordic region and Ireland, Ireland is the only country that does not show a downward trend in mortality. If our screening programme is successful, why has our mortality rate stayed static over recent years? We hear about instances at early stages being picked up, but people are still dying seemingly at the same rate as they were years ago. That question needs to be looked at and it has not been to date. All the statistics from the current mortality incidence data seem to stop in 2013, and RCOG's reporting of it stops at 2015. It is 2019. Why are we not up to date with the statistics, given the nature of and the ongoing concerns with the screening programme?

**Deputy Alan Kelly:** That is very interesting information that needs further analysis be-

cause it would cause deep concern. Mr. Teap might share that information with us and we will then perhaps process that through the right channels.

I have two last questions. Both witnesses can give them quick-fire answers. First, we talk about the limitations of screening. I am very much taken by the way in which both witnesses have said everyone needs to come together now. At the end of Ms Walsh's submission she said, "We must heal any divisions and emerge united and strong." I know she means that passionately and believes we should work collectively for everyone. In fairness, let us not forget about all the good stuff happening such as the HPV vaccine, screening, the legacy of Laura Brennan, the implementation of the Scally report and so on. However, there has been some conflict in recent times, with clinicians talking about the limitations of screening, and we know of all the other issues that have arisen. Those of us who are into detail know that certain things are outside the limitations of screening. However, the fact that we do not have a definition in any way of the limitations of screening, as currently constituted or whatever, is a real issue. The witnesses' comments on what I have just said would be helpful.

Second, based on what Mr. Teap said earlier, do the witnesses believe that the new audit process which must be brought in, and which is under something of a review at present, should commence the day after the old one finishes?

**Mr. Stephen Teap:** Yes, definitely. The audit process must commence from then because the information there is obviously vital, but also, given the ongoing situation of those of us who have been impacted by this audit, something must be put in place. I believe it was originally reported that this audit review would be announced in quarter 4 of this year. I have not seen anything yet.

**Deputy Alan Kelly:** Nor have I.

**Mr. Stephen Teap:** I suppose there is a week and a half left to present it, but that is where we are.

As I said in my opening statement, the term "limitations of screening" does not have an explanation to support it. Page 42 of the RCOG review makes it clear that "Screening failures do have serious consequences for affected women". It continues:

These are unfortunately inevitable given the limitations of cytology-based cervical screening. This however should not be taken to suggest that the programme overall is not working.

This is an interesting conclusion, given that the report does not even provide an explanation of the limitations being referred to.

**Deputy Alan Kelly:** Yes.

**Mr. Stephen Teap:** Many of those who have been observing and commenting on the whole CervicalCheck debacle consider the use of the term "limitations of screening" in the manner I have described to be unfortunate, particularly when things such as human error are considered to be one of the limitations in question. I suggest that human error is one of the limitations of being a human. It should not fall into the screening process.

**Deputy Alan Kelly:** That is a very good point.

**Mr. Stephen Teap:** The failures that have been a feature of this debacle seem to be included among these “limitations”. We need to have proper detail and transparency. We need to break it out.

**Deputy Alan Kelly:** Yes.

**Mr. Stephen Teap:** I know Ms Walsh is dying to jump in. When I talk about these matters, I try to base my explanations on fact. When Irene was diagnosed with cervical cancer in September 2015, she had already participated in CervicalCheck on invitation on two occasions. She knew exactly what cervical screening was about. She knew what going for a smear test meant. She understood the information that would be gathered. The day she was told she had cervical cancer, she immediately asked how it was not picked up by her smear test. That was the first question she asked. I did not have a clue what she was talking about, but she knew. I now know what she meant. The explanation that was given by her consultant at the time was that screening has limitations because it does not pick up everything. It was suggested to us that when Irene went for her smear, it might have been taken next to the tumour rather than on the tumour, or that the number of cells on the slide might not have been adequate to determine the reading. That was the explanation we were given, essentially. I know for a fact from the independent review of Irene’s slide which was carried out that the opposite actually happened. The suggestion that was made to us was not reflective of what was actually the case. I know that Irene’s case does not fall within the limitations of screening - it falls outside those limitations. People need to understand this can happen. We must remember that six or seven people have gone through the High Court to prove their own independent reviews. The laboratories have admitted liability. Human error is a factor. Error is a factor in the breach of duty of care to women with regard to screening.

**Deputy Alan Kelly:** That has been very well explained.

**Ms Lorraine Walsh:** I would like to come back to the doctors and where we have all been at over the past year and a half. This debacle has pushed us all into a position of defence. When one is pushed into a position of defence, one will come out fighting. That is what happens. I realise that the patients and the clinicians all want the same thing. As a woman who has survived cervical cancer, I am left with the scars and the life-changing conditions. The same thing applies to every other woman in this country who has had cervical cancer, regardless of whether she is in the 221+ group or whether she has been part of the RCOG review. They are all suffering in some way and they have all been left with scars. The clinicians here do not have adequate support to support these women in living with the after-effects of cervical cancer. We spoke earlier about the supports that are in place for the 221+ group. I accept that some supports are in place. More importantly, the system must support these women. Earlier, I provided a list of ways in which these women can have a better quality of life. That goes across the board. We need to focus on that. That is why I want to stop looking backwards. We have got all the answers we are going to get here.

The RCOG review was not ideal, as I have said, but we have got many answers from Dr. Scally’s work, the implementation of which is really important. All of that involves looking back, but we need to start looking forward now. This is the time to start working together to ensure the clinicians can give support to these women when they come in. If a woman complains of a swelling in her foot, her clinician should be able to refer her to somewhere appropriate where she can get early intervention. Similarly, a woman like me might come in at 34 years of age to say that she really wants to have a family and to ask if there is any way this can be done. Maybe I could have had my eggs frozen. I believe the Government is currently provid-

ing €300,000 towards oncofertility to a private clinic. It used to be a public clinic, but it is now a private clinic. That money should not be going to a private clinic. It should be in the public system so that a person who is in the public system can be referred directly into it. Some provision should be made for the future fertility of a man or a woman who is about to go through treatment, for example by preserving his sperm or her eggs. No direct path exists in this regard at the moment. That needs to be re-examined. It is about supporting these women so that they have a better quality of life. That is what the doctors want. As survivors, that is what we want too. That is what we have to achieve.

**Chairman:** I thank Ms Walsh and Deputy Kelly. I call Deputy O’Connell.

**Deputy Kate O’Connell:** I thank the witnesses for coming in. It is nice to see Mr. Teap again. Ms Walsh is very welcome. I will pick up where she left off when she spoke about wanting “to stop looking backwards” and needing “to start looking forward now”. It is probable that nothing more important has been said here today. We need to work together. This has been going on for a long time. There is a lot of hurt. There is a lack of trust. Many of us in this committee have uncovered things. At the time, we were made to feel stupid as well. Everything came out in the wash in the end.

Deputy O’Reilly spoke about the 10% limitation rate, or whatever arbitrary rate it was, that we were quoted here at an early stage. The lack of knowledge about the limitations of screening caused a lot of trouble from the start for the witnesses and for those of us who were trying to get to the bottom of things. At the end of the day, we are all trying to improve people’s lives and improve survival rates.

I would like to examine some of the witnesses’ proposals. Before the regime started, we had the highest rate in Europe of people dying of cervical cancer. I take it from what the witnesses have said that one of the negative aspects of advances in healthcare is that it is not good enough for those who have survived life-limiting conditions to be able to say that they have lived if they cannot live the best lives they possibly can after their aggressive, invasive and personal treatment has come to an end. I fully support Ms Walsh’s call for supports for oncofertility treatment. It is tragic for a woman to have to shelve her dreams of having children at an early age because of a lack of direction or support at a moment when she could have done with such assistance. I would be very supportive of that.

I would like to look back at this from the start, insofar as that is possible. The witnesses have tried to find the truth and to restore trust in a system in which many of us had lost faith. Although many of us had faith in Dr. Scally’s recommendations, I understand Mr. Teap’s point that it is not good enough just to tick boxes. We need to track these recommendations and make sure they do what they set out to achieve. From day one, there was a huge lack of governance in the HSE with regard to the handling of the cervical cancer issue. As Dr. Scally said, the system was “doomed to fail at some point”. One of the greatest failings of this whole debacle relates to the impact of having an audit without considering that there were real people at the end of it who had lost their lives. It showed a complete disregard for Mr. Teap’s late wife, for his children and for our lives as people. Not much consideration was given to the significant investment in this area, the whole point of which was to prevent the things that happened to Mr. Teap from happening.

I understand that all of this is very hard because I have had difficulties with it. Members of the committee met representatives of RCOG a couple of weeks ago. We will see them again in the morning. There are many questions we have to ask. I do not want to misquote Ms Walsh,

but I do understand that everything falls within the limitations of screening. As a logical human being, it is very hard to swallow when we see that despite the best efforts, somehow some people's lives appear to have been saved. There was the outsourcing of the service abroad, which many people had an issue with at the time. There was the lack of concordance with the standards on the contracts with regard to the American College of Pathologists versus other standards. There was the explicit statement in the contract that there was to be no outsourcing to other laboratories, yet this happened. There was the issue of people going on quality assurance visits and not noticing pretty much anything that was going on. Then we had the guy in Salford just to finish it off. Does Deputy Kelly remember this individual who was on his own?

**Deputy Alan Kelly:** I do.

**Deputy Kate O'Connell:** Given all of these things, it is only logical for me and Ms Walsh to ask how it could fall within the limitations of screening. We have listened to the witnesses today and we will interrogate more witnesses tomorrow hopefully. I stated last week at a meeting of the committee that I have faith in the Royal College of Obstetricians and Gynaecologists with respect to its professional capacity and whose side it is on. In terms of somebody having a smear looked at - not the one on which the diagnosis was made but the one previous to that - I have a major concern that the default position was that it was concordant. I hope I am not misinterpreting what Ms Walsh said in that regard earlier. That is a serious flaw in the review and I hope to interrogate it more at tomorrow's meeting.

I do not want to trivialise the administration issues - for want of a better term - but the witnesses spoke of getting a smear result that was over-labelled or re-labelled. The whole point of the RCOG review was to instil confidence in a system we had lost confidence in. I can only imagine what it must have been like to receive a call to say that a slide was missing and then that it was concordant and then that somebody else's label was on it. That all feeds into the view that this was sloppy work that has had a real impact on people's lives - the witnesses' lives in this case.

**Chairman:** I am sorry to interrupt Deputy O'Connell but it has just come to my attention that Ms Walsh needs to leave at 7 p.m. to catch a train.

**Deputy Kate O'Connell:** In terms of what Ms Walsh, Mr. Teap and the wider group have done, I am very sorry that they have given so much of themselves and that people ignored them, treated them like they were stupid, isolated them or did not value their input. Their input to this committee has been extremely valuable in uncovering and guiding us in trying to do work on their behalf. A huge learning arising from the lack of governance in this case can be applied in future in the HSE. Many of us were very shocked at the mess of the governance structure. Mr. Teap made a very important point that the patient representative groups should not be from a particular age group just because people are available, and that provision is made for it to be truly representative.

I am concerned by Mr. Teap's comments on the rates of cervical cancer. Cervical cancer rates in Ireland were rising higher than anywhere else before cervical cancer screening was introduced. When RCOG was before us for a private meeting - we will speak to its representatives tomorrow - I asked what the outcome would have been if we had not bothered screening or if we had taken smears and not read them. The gist of the response, which we will check publicly at tomorrow's meeting, was that Ireland had a 4% year-on-year increase in mortality and now we have 7% year-on-year decrease. I am not sure where RCOG is getting those figures from but I hope, on the witnesses' behalf, to interrogate them tomorrow. It is very important

that screening is having a material impact and is not just an inconvenience.

I hope we will get the witnesses' questions answered tomorrow insofar as possible. Despite the difficulties, I encourage them to stay as part of this process. We need Mr. Teap and Ms Walsh to help us to do our job. We have not been where they are and I hope I never will be. To improve things for the future, we need the witnesses to stay involved, if possible. I know that will be very difficult but-----

**Ms Lorraine Walsh:** To be honest, the difference is that it is the Deputy's job. It is not my job. We have taken 18 months out of our lives to do this. We cannot sustain that. It has been two days per week and we just cannot sustain it.

**Deputy Kate O'Connell:** I understand. It can only be a massive burden. That Ms Walsh was not respected in doing this must have made it harder. I cannot see how the witnesses have done it. Their input is very valued. While I cannot speak for the whole committee, I value that input. Everything Mr. Teap and Ms Walsh have contributed has helped us in our work. I hope it will continue tomorrow. I thank them for coming in today.

**Chairman:** I thank Deputy O'Connell. Our last two contributors will be Deputies Durkan and Smith.

**Deputy Bernard J. Durkan:** I thank the witnesses for attending and the time they have devoted to this very important subject. I acknowledge the stress they and their families and friends have been put through.

Arising from Deputy Louise O'Reilly's earlier question on whether there was a 10% - or a more vague - conclusion arising from the tests, when was the group told how imprecise the system was? If a system has a 30% variation between one and the other, the people concerned are entitled to be told. They were not told. The ridiculous excuses that were given at the time caused a great trauma and difficulty for the people concerned and their wider circle. As Ms Walsh stated, different action could have been taken if that information had been made available. How did the group react when the question was asked about the accuracy of the test?

**Ms Lorraine Walsh:** Does the Deputy mean from the RCOG review?

**Deputy Bernard J. Durkan:** Yes, from Ms Walsh's experience from the beginning.

**Ms Lorraine Walsh:** When I brought my concerns to the Department of Health, I was told at the time that there were processes in place and the Department would not be asking RCOG about its internal processes, but that the HSE had a process in place that would pick up any inaccuracies that would come through.

**Deputy Bernard J. Durkan:** Did the Department make any attempt to give an honest answer to the question?

**Ms Lorraine Walsh:** On top of that, we wrote to it after that and it wrote back. I have brought a copy of that letter which I will pass on to the committee. It basically gives the same answer that there was a verification process in the HSE. If we take the RCOG report, RCOG had its own verification process in putting the letters together. This was a three-step process that involved checking three databases. If RCOG was checking three databases, how did I get an inaccurate report? In addition, if I did not have as much information as I had, I would not have known to question it and go back. How many women are sitting at home who do not know

to question the result or go back to get the right answer?

On the colposcopy management, I understand that the case files of 106 women were reviewed. This was to do with the length of time between their colposcopy and their diagnoses. RCOG, on page 43 of its report states: “We found evidence that CervicalCheck clinical practice guidelines have not always been adhered to...”. However, it then states: “This is far from concluding that colposcopic practice in the CervicalCheck programme is substandard...”. Correct me if I am wrong, but this means that out of the 3,000 women who were diagnosed with cervical cancer, only 1,038 were part of the RCOG review, and only 106 of those files were actually reviewed in relation to colposcopy management. I am not sure how RCOG can say that despite finding 57 cases of colposcopy management issues, this is “far from concluding that colposcopic practice in the CervicalCheck programme is substandard”. I would love to have clarification on that.

**Deputy Bernard J. Durkan:** Rightly so.

**Mr. Stephen Teap:** The Deputy asked when, since the beginning of this, we got clarification on the 10% limitation of screening. I remember being glued to the proceedings of this committee, the Dáil and the news at the beginning of this when I saw all these figures, the 10%, 15%, 20% and 30%, being thrown around. Nobody had a clue or had been given an explanation at any stage of what the limitations of screening were. They still do not know today. Some clarification is being given in the percentages, but the first time everybody started singing from the same sheet was when Dr. Gabriel Scally released his report in September last year. He said that 15 out of 20 women will be read correctly and in HPV screening 18 out of 20 women will be read correctly. That is the first time we got some form of clarification on the numbers. This is what I mean about having one document we can all refer to but, unfortunately, we still do not have a document that gives an explanation of what somebody means when they speak about the limitation of screening. Every time we hear somebody say the words “limitation of screening” we must ask the person what he or she means by that and listen to what he or she says.

**Deputy Bernard J. Durkan:** The imprecise nature of the conclusions is the important thing. It is obviously better for a patient suffering from a condition or suspected of suffering from a condition if somebody can say that it is absolutely accurate or 50% accurate because the patient knows what to do. The patient can take action, whether that is getting a second opinion or whatever else, if he or she has that crucial information at the start. The sad part of it is that the system has undoubtedly saved many women’s lives, but it was in operation for several years with an imprecise nature and failed to give the information to the women on time so they could decide for themselves what had to be done next, whether to get a second opinion or to go elsewhere.

My next question is on the attitude of the Department of Health. Ms Walsh mentioned that it was impervious to her concerns, to say the least. What type of bullying and threats occurred and at what level did they take place?

**Ms Lorraine Walsh:** On the last day I was in the Department of Health, I brought up my concerns and I was told that the HSE’s system was going to cover it. I said that women were contacting me at the time and telling me that they were receiving reports that were inaccurate and I asked: “When this goes wrong who will they blame? They will blame the HSE”. In fact, of all people in this situation the HSE has put a huge effort into getting this right. It worked closely with the clinicians to ensure women were treated properly. It listened to us on how women should receive disclosure. Instead of telling them how they would receive the disclo-

sure, it offered them options as to how it would be most appropriate to disclose to them, be that a letter or a meeting. I was told in the Department that they did not like my tone. I was shot down. It was not the first time. We have had tough days in the Department of Health previously. I have been reduced to tears many times in the Department. It was a tough spot. Notwithstanding the fact that it has been an emotional 18 months, it has been life changing for us and that has an impact as well. Funnily enough, the people in the HSE never made me feel like that.

**Deputy Bernard J. Durkan:** I am conscious of the need to conclude shortly. In the meetings in which Ms Walsh was reduced to tears and so forth, was there nobody there who could have said: "We understand your concerns and trauma, for obvious reasons". People could have taken Ms Walsh and people in that situation aside and told them they understood why they were upset and offered to help them. Was there nobody there to say that?

**Ms Lorraine Walsh:** It is controlled by the chair, which is controlled by the people in the Department of Health. If they do not like what is being said around the table, they cut people off, including people in the HSE and us. Who is there to say that?

**Deputy Bernard J. Durkan:** Did the chair influence the meetings you were at to that extent?

**Ms Lorraine Walsh:** Of course. I have had people in the HSE come to me after meetings and say that they felt how badly I was treated in the meeting, they felt the pressure and felt that the way I was treated in meetings was inappropriate.

**Mr. Stephen Teap:** Recall what I said earlier about the patient representative platform and the fact that none exists. This is the protection that must be introduced so patient representatives have a structured platform, which is designed to give respect to everybody throughout and gives some support not only to those like us who come from tragic backgrounds but also to those who are proactively engaging with the system.

**Chairman:** To conclude, I call Deputy Bríd Smith. We are conscious that Ms Walsh must catch a train.

**Deputy Bríd Smith:** Can I ask Ms Walsh a question before she goes?

**Ms Lorraine Walsh:** Of course.

**Deputy Bríd Smith:** It is an honour to meet both witnesses because they are fighting for everybody and particularly for women who are suffering and do not have answers or the truth. When Ms Walsh says we must stop looking back and go forward, I know where that feeling comes from because she is surrounded by reports and analysis and even attempts to hoodwink, obfuscate and hide the truth. On the other hand, and I put this to the Minister and the head of the HSE at the RCOG meeting last week, what has happened with the 221 cases is a little like an aeroplane crashing in Dublin Airport in which a number of people are killed and we respond by saying that this is within the statistical norm so we should move on because there is nothing to see. We would never do that if there were such a tragedy, but with this tragedy I am sick of being mansplained to by being told that I do not understand that this is within the statistical norms and falls within the limitations of screening.

The audit of the 221 has gone under the radar. There was a big palaver when the Scally and RCOG reports were coming out, but the breakdown of the percentage is clear in the 221 audit. I repeatedly asked Mr. Tony O'Brien, the Minister and the Taoiseach the laboratories that the

221 slides came from and never received a reply, but it is buried in that report. The slides from Quest Diagnostics in Illinois were five times higher than those from the Coombe and the slides from Quest Diagnostics in New Jersey were four times higher. Those from CPL in Texas were seven times higher than those from the Coombe and even those from MedLab Pathology based in Dublin, an offshoot of CPL, were twice as high as those from the Coombe. The point I was trying to get at is the one that Ms Walsh made with regard to colposcopy when she said it should not be private, but public.

**Ms Lorraine Walsh:** The oncofertility.

**Deputy Bríd Smith:** Yes. I concur. The roots of this, and this is just as if we were looking at what happened in Dublin Airport when people lost their lives in an accident, is that we gave the screening for women's health to four for-profit laboratories in the US. Many of them were simultaneously conducting clinical tests for the US military, which is a massive industry, and nobody looked at what happened. Dr. Scally looked at how the laboratories are performing now, but did he look at worker X who got Ms Walsh's screen wrong, how many tests he or she did that day and in what length of time, what type of pressure he or she was under, what was his or her qualification and what was his or her rate of pay. None of that was done.

**Ms Lorraine Walsh:** This is one of the big questions. The slides of both Vicky Phelan and myself were reviewed in CPL in Texas, or that is where they were reported from. In the Quest Diagnostics slides one could see where they had been read and reported. Dr. Scally looked into this because it is something we raised with him after his first report. We wanted to know where our slides went, who read them and where they had been sent to, but he could not find that out through the CPL process. CPL said at the time that it did not have those files, they were not available and that they had been destroyed. There are many questions and, as I said, we got many answers. We still have many questions.

**Deputy Bríd Smith:** Does Ms Walsh mean Dr. Scally could not find it out?

**Ms Lorraine Walsh:** No, he could not.

**Deputy Bríd Smith:** He did not report that he could not find it out. He did not report to us that he was told by Clinical Pathology Laboratories, CPL, that the files were destroyed.

**Ms Lorraine Walsh:** He said that when he asked for them, the laboratory stated the files were not available.

**Deputy Bríd Smith:** I do not know if he should have accepted that. We now have people going to the High Court or the judicial process seeking access to the slides. They may not be able to delve into the matters I mentioned, including conditions and standards, but we know the outsourcing was to substandard laboratories that were not ISO-accredited, with 100 slides done per worker per day as opposed to 60 slides per worker per day done in Irish labs. This is the substandard nature of what has gone on.

I understand the witness saying we should stop looking back in anger and move forward with a proper process but if we do not look back, history will be repeated. Outsourcing to private and for-profit services, whether it is for fertility issues or CervicalCheck, will bring such issues. Fertility treatment probably will not kill a person but not having the correct analysis of a cervical smear test may do so.

What do we say to women who fall outside the audit being closed? Where do they stand in

all this? I have a friend who is terminally ill and she had four clear smear test results in a row, having been tested on an annual basis. All of a sudden she has stage four cancer. She had to go private to get the audit done, and as has been mentioned it cost approximately €4,000 plus solicitor fees. Only yesterday she was informed definitively that there was a serious misreading of her slides, as there were plentiful dodgy cells. It is a clear case of negligence that still must be proved. What do we say to people like her? She is a working class woman whose community had to fundraise in order to get the audit done. Could we not do something while they are still around to show we care and are looking after their interests?

**Chairman:** I thank the Deputy. I do not mean to interrupt but I do not want Ms Walsh to miss her train and it would not be fair to leave Mr. Teap on his own.

**Mr. Stephen Teap:** I can answer the question on my own.

**Ms Lorraine Walsh:** I will be ordering a taxi. We must believe what Dr. Scally has told us and he and his team have done extensive work on this. I specifically asked where my slide went, who read it and what happened to it. He said he tried extensively to get those answers but he could not. We must arrive at a particular stage when the people tasked with getting answers say they cannot get them. I am ready to try to move on with what is left of my life. I am not saying I am happy about what happened, as I am definitely not. We have seen all the reports that have been commissioned and we have their results. We can either accept what we have been told or we can spend the rest of our lives trying to get answers and perhaps still not getting them. I do not want to waste any more of my life. I have already wasted so much of it.

**Deputy Bríd Smith:** Ms Walsh should absolutely not have to do that.

**Ms Lorraine Walsh:** I am not trying to be negative.

**Deputy Bríd Smith:** It should not be down to Ms Walsh.

**Ms Lorraine Walsh:** We must get to a stage where we can try to move on with what is left.

**Mr. Stephen Teap:** I am sorry to hear about Deputy Smith's friend. It is a question we have faced as many people consented to the RCOG review but the Deputy knows the massive delay with that. These people were not part of the original audit either. One gentleman contacted me whose partner passed away and, like the Deputy's friend, a number of smears had reported as negative also. He asked me what to do and I told him there were two options. These were to wait for RCOG to come back or to get an independent review, which would cost money. The Deputy's friend got the independent review. With the people diagnosed with cervical cancer since the audit stopped we have no option but to say they should either wait until the audit re-opens or they can get an independent review. That is all that is available, unfortunately. It is not right.

**Chairman:** On behalf of the committee I thank Ms Walsh and Mr. Teap for coming in. My experience and, I am sure, that of many members of the committee is that patient voices are the most powerful voices coming to give evidence to committees. It is extremely important that we hear patients or their voices because they are so powerful. I thank the witnesses for their clear, calm and detailed evidence given today. They have certainly raised a large number of questions that we will be able to put as a committee to the Department, the HSE and the RCOG reviewers. I thank the witnesses for their time and eloquence.

*The joint committee adjourned at 7.10 p.m. until 10 a.m. on Wednesday, 18 December 2019.*