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REPORT OF THE JOINT SERVICE INVESTIGATION INTO THE COLONOSCOPY SERVICE AT SHEPTON MALLET NHS TREATMENT CENTRE – 4th OCTOBER 2005 to 31st March 2008

Bonallack and Bishop welcome the thorough investigation which has been carried out into the standard of care given to colonoscopy patients at the Shepton Mallet NHS Treatment Centre.

Dr Mak performed 5009 colonoscopies at the Centre and 1828 results were reviewed as part of the review procedure. 489 patients were advised to have continuing surveillance for existing conditions and 97 had further fast-track examinations. Of the 97 patients fast-tracked 6 have been found to have bowel cancer and three have, to date, died.

The shortcomings in the procedures at the Treatment Centre can be summarised as follows:

- ★ insufficient vetting of Dr Mac's abilities during the recruitment process
- ★ lack of clinical review of his competence whilst working at the Centre
- ★ the fact that Dr Mak did not obtain a clear view of the whole of the colon in some patients
- ★ a higher than average number of complaints against Dr Mak
- ★ the fact that some patients could have undergone a less invasive procedure to diagnose their problem
- ★ lack of medical leadership for the endoscopy team

As a result of the allegations against him, Dr Mak was suspended from practice in April 2008 and resigned from his position in May 2008. The case has been referred to the GMC who have not taken

any further action, we presume because Dr Mak has now returned to his home country of Holland to practice.

Denise Broomfield, Head of Clinical Negligence at Salisbury and Andover-based firm Bonallack & Bishop Solicitors, is advising two of the families who have suffered the death of a family relative from cancer as a result in the Centre's failure to diagnose, as well as representing other patients of the Centre. She says:

“It is reassuring to see that the Centre has taken the conduct of Dr Mak and the tragic results that his substandard care has caused seriously and has introduced new procedures to deal the shortfalls. However, the shortcomings which have been identified in the report are all matters that are standard within the medical profession and I can see no reason why they could not have been in action before the Centre opened its doors to treat patients. People have died as a result of this failure and any investigation, no matter how thorough, can ever bring them back. Hopefully, with the new safeguards which have been introduced, it will not happen again.”

If you would like any advice regarding your or a family member's treatment at the Shepton Mallet NHS Treatment Centre please contact Denise Broomfield or Lin Revell on 01722 422300 or e-mail denise.broomfield@bishopsllaw.com.

Useful web links

- ★ [Our full commentary on the report](#)
- ★ [A copy of the full report](#)
- ★ [Our clinical negligence advice](#)
- ★ [Our initial response to the misdiagnoses](#)

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