IN THE MATTER OF an Inquiry
pursuant to the ***Public Inquiries Act 2006***, SNL 2006, c. P-38.1

- And -

Pursuant to the
Rules of Practice and Procedure of the
Commission of Inquiry on Hormone
Receptor Testing

Submission of Her Majesty in Right of Newfoundland and Labrador

01 December 2008

Jacqueline Brazil Q.C., Rolf Pritchard
Co-counsel to Her Majesty in Right
Of Newfoundland and Labrador
Office of the Secretary to Cabinet
For the Management of Health Issues
West Block, Confederation Building
P.O. Box 8700
St. John's, NL., A1B 4J6

Sandra Chaytor Q.C.
Bernard Coffey Q.C.
Co-counsel to the Commission of
Inquiry on Hormone Receptor
Testing
Commission Offices
50 Tiffany Lane
St. John's, NL., A1A 4H7

Table of Contents

Part I - Introduction 3

Part II - Statement of Facts/Evidence

Pre-July 2005 5
- The Hay Report
- Amalgamations in the Health Care System
- The 2003 Testing Suspension

July-October 2005 10
- 18 July 2005
- 19 July 2005
- 21 July 2005
- 05-08 August 2005
- 15 August 2005
- 30 September 2005
- 02 October 2005
- 03 October 2005

August 2006 23

November-December 2006 26
- 23 November 2006
- 29 November 2006
- 07 December 2006
- 09 December 2006
- 11 December 2006
- 12 December 2006

May 2007 35

Post May 2007 41

Part III - Issues 48

Part IV - Submissions

a) How are the actions of the Province applicable to the Terms of Reference? 50

b) Did the Province have any involvement with or knowledge of the ER/PR Issue prior to July 2005? Did it contribute to the ER/PR Issue during this time period? 53
- The Hay Report
- Amalgamations in the Health Care System

c) How does the Province interact with the Regional Health Authorities? 55

d) Did the Province carry out its roles and responsibilities in a timely manner in regard to the response to, and communication with, the men and women who needed retests and who were being tested for the first time between July 2005 and May 2007? 65

e) Did the Province carry out its roles and responsibilities in a timely and appropriate manner in regard to communication with the public and with those within the health care system respecting the ER/PR issue between July 2005 and May 2007? 65

The 2003 Testing Suspension
Amalgamation
18 July – 03 October 2005
Herceptin Therapy
August 2006
23 November – 12 December 2006
May 2007
ATIPPA
External Consultants' Reports

f) Subsequent to the Inquiry being called, did the Province communicate in a timely and appropriate manner with the public about the ER/PR Issue as new information became known? Did it take appropriate steps to hold the health authorities accountable with respect to this new information? 101

g) What lessons has the Province learned from the ER/PR Issue and from the Commission of Inquiry process? 104

Briefing Notes
Email Archiving
Database Management in RHAs
Coordination in RHAs when Managing Adverse Events
Access to Information
Interaction of the Minister with Regional Health Authorities
Quality Assurance and Accreditation in Laboratories
Pathologists/Oncologists Compensation
Task Force on Adverse Health Events

Part I

INTRODUCTION

1. The Province called the Commission of Inquiry because it had grave concerns about how the Estrogen Receptor/Progesterone Receptor (ER/PR) Issue had been disclosed to the public. Public confidence, and by extension patient confidence, in the health care system had been eroded. However, the women and men who were most gravely affected by the testing problems were the patients. It is the Province's hope that both the patients, their families and loved ones as well as the public will have confidence restored in the system as a result of the scrutiny and accountability achieved through the Inquiry process.

2. In these submissions, the Province wishes to reiterate its apology to patients and their loved ones, as provided by Premier Williams in his testimony on October 28, 2008.[1]

3. The Province hopes that these submissions sets out its involvement in the ER/PR testing process, explains its role where possible and accepts responsibility when it believes it should have responded differently.

4. Out of tragedy often flows true learning that can improve the circumstances of people in the future. The Province will absorb these lessons and use them in

[1] Evidence of Premier Williams, 28/10/2008, p. 284, line 8

implementing public policy. It looks forward to receiving the findings and recommendations of the Commission of Inquiry.

PART II

STATEMENT OF FACTS/EVIDENCE

5. This brief does not recite all facts relevant to the Estrogen Receptor/ Progesterone Receptor Issue ("the ER/PR Issue" or "the Issue"). Rather, Her Majesty in Right of Newfoundland and Labrador ("the Province") will outline facts and address only those issues relevant to the Province's role as set out in Newfoundland and Labrador Regulation 72/07 ("the Terms of Reference").

6. The Statement of Facts/Evidence has been divided into 6 time periods that are relevant to the Province's involvement in the ER/PR Issue. The time periods are: (1) The mid to late 1990's and up to 2005; (2) July-October 2005; (3) August 2006; (4) November-December 2006; (5) May 2007; (6) Post May 2007.

Pre-July 2005

7. Three pre-July 2005 issues that involve the Province were raised in evidence, particularly (1) the Hay Report, (2) Amalgamations in the Health Care System and (3) the 2003 Suspension of Testing.

The Hay Report

8. The Hay Report was prepared by healthcare management consultants commissioned in November 2001 by the Minister of Health and Community Services ("the Minister") to examine Eastern Health's predecessor organization, the Health Care Corporation of St. John's (HCCSJ).

9. The purpose of the consultant's engagement was to conduct an operational review to identify efficiencies and operational improvements that may offer the potential for reduction of operating costs.

10. On May 31, 2002, George Tilley, former CEO of HCCSJ and Eastern Health, responded to the recommendations of the report by way of letter to the Minister of Health and Community Services ("the Minister").[2] Tilley attached a report to the letter which provided an assessment of each recommendation ("Tilley's Report").

11. Tilley's Report quoted HCCSJ Chair, John Abbott regarding the approach that HCCSJ would take in the assessment of the recommendations: "We will thoroughly evaluate all of the recommendations of the report before proceeding with any changes. **At all times, our emphasis will be on maintaining or**

[2] Exhibit P-0041.

improving the quality of care we provide to our patients." (emphasis added)[3]

12. The Tilley Report summarized the HCCSJ assessment as follows: 24 recommendations were completed, 17 were still undergoing assessment, 63 were currently being implemented, 14 were not accepted, and 1 already existed prior to the review.[4]

13. Of the 14 that were not accepted, one dealt with a laboratory issue. This recommendation was for the substitution of three full time equivalent positions for three new pathology assistants. The recommendation was rejected by a the HCCSJ because pathology assistants were not readily available in the province and there were no local training programs.[5]

14. The draft "Technical Brief on Statistical Tables from the Estrogen Receptor/ Progesterone Receptor (ER/PR) Database", dated March 11, 2008[6] includes data on ER/PR test conversions by year between 1997 and 2005. The report acknowledges that different definitions can be used to define conversions from negative to positive. Using one specific definition in Appendix A, Section 4, the total number of conversions from negative to positive is 252 from 1997 to 2005, of which 186 patients were originally tested between 1997 and 2001, and 66

[3] Exhibit P-0041
[4] Ibid., p. 20
[5] Ibid., p.42
[6] Exhibit P-3565

patients were originally tested between 2002 and 2005. Utilization of other definitions of conversion yields similar proportionate results.

Amalgamations in the Health Care System

15. In 2005, the Province reorganized the institutional structure of the health and community services system by reducing the number of regional health authorities from 13 to 4 as has occurred across the country.

16. There was also a desire to provide patient care and services in a seamless fashion.

17. The decision to amalgamate was announced on September 10, 2004, and became effective on April 1, 2005, [7] which was subsequent to a significant majority of the errors.

18. Eastern Health was created from a merger of 7 pre-existing organizations.

19. Clinical consolidation was not part of the amalgamation process. In particular, laboratories were not consolidated.

[7] Evidence of Joan Dawe, 26/03/2008, p. 145, line 14

The 2003 Testing Suspension

20. On April 4, 2003, Dr. Gershon Ejeckam raised concerns about the quality of immunohistochemical testing in the laboratory at the Health Science Centre and stopped laboratory testing for a group of tests until problems with reliability, sensitivity and specificity could be solved.[8]

21. Testing was reinstated on or about May 2, 2003.[9]

22. Dr. Ejeckam's concerns are documented in three memos.[10]

23. The 2003 testing suspension was discussed during briefings between the Department and Eastern Health in July – August 2005.[11]

24. Dr. Ejeckam's memos were not shared with the Province until May of 2007 when the Premier immediately tabled it in the House of Assembly.

---

[8] Exhibit P-0113, p. 1
[9] Ibid., p.2
[10] Ibid.,
[11] P-0159, P-0075, Evidence of Chaplin 05/06/2008, p. 304; Evidence of Abbott 01/05/2008, p. 294-296; Evidence of Minister Ottenheimer 31/03/2008, pp. 135-137

July - October 2005

18 July 2005

25. Susan Bonnell, Eastern Health's former Director of Communications testified that by 15 July 2005 it appeared that a media briefing would likely occur the following week on the developing ER/PR Issue. Accordingly, on 18 July 2005 she directed Deborah Thomas-Pennell, a former Communications Specialist for Eastern Health to contact Carolyn Chaplin,[12] the then director of Communications for the Department and advised that an Eastern Health press release was imminent.[13]

26. Chaplin stated that Bonnell called her on the afternoon of 18 July 2005 to pick her brain on a laboratory issue involving 1200 to 1500 clients. Chaplin asked Bonnell if she was familiar with the Labrador–Grenfell situation and recommended that registered letters might be an appropriate method to contact the affected patients. Bonnell asked Chaplin not to tell the Minister but Chaplin said that it was her responsibility to do so.[14]

27. Paralleling Bonnell's call to Chaplin, Chaplin placed a call to Tilley, then CEO of Eastern Health, and Abbott, then Deputy Minister[15]. Abbott testified that he

---

[12] Chaplin was the Department Director of Communications from December 2003 to August 2005 when she moved to Executive Council as senior communications director. She left Government in August 2006
[13] Exhibit P-0300; Evidence of Bonnell 29/05/2008, pp. 138-140
[14] Chaplin 05/06/2008, p. 152, lines 14-18, pp. 154-164, p167
[15] Abbott was Deputy Minister from 06 December 2004 to 30 May 2007

received a telephone call from Tilley[16], on 18 July 2005 and was informed that there was an issue with breast cancer testing. Abbott then spoke with then Minister John Ottenheimer's[17] secretary to arrange for Eastern Health to brief the Minister. Abbott did not inform Cabinet Secretariat or the Premier's Office as he felt the parameters of the issue were unclear.[18]

28. It was Chaplin's evidence that after speaking with Bonnell she tried to contact Abbott, Minister Ottenheimer and Darrell Hynes,[19] (Minister Ottenheimer's Executive Assistant). Abbott returned her call and advised that he had received a call from Tilley. When she finally spoke to Minister Ottenheimer he asked for a briefing as soon as possible and told her to notify the Premier's Office.[20]

29. Hynes recalled that he was first made aware of the ER/PR Issue by Chaplin on 18 July 2005 who advised that she had just been contacted by Bonnell. He did not speak with Minister Ottenheimer until early on 19 July 2005. He felt the Premier's Office should be made aware of the issue so he discussed this with Chaplin who he understood contacted Elizabeth Matthews, Communications Director for the Premier's Office.[21]

---

[16] Tilley was the first CEO of Eastern Health. He left during the Summer of 2007

[17] Ottenheimer was Minister of Health and Community Services from 01 March 2004 to 14 March 2006. He was on leave for health reasons from 30 March 2005 to 30 May 2005. (Transcript, 31 March 2008, pp 10-11

[18] Evidence of Abbott, 01/05/2008, p. 182, lines 15-25; p. 183, p. 262

[19] Hynes left the Department when Minister Ottenheimer changed portfolios in March 2006 but returned to serve as Minister Osborne's Policy Analyst

[20] Evidence of Chaplin, 05/06/2008, pp. 169-172, pp. 175-177

[21] Evidence of Hynes, 18/06/2008, pp. 174-175, p. 177, lines 1-9

30. Chaplin testified that she reached Matthews by telephone and told her of the issue. Brian Crawley, the Premier's Chief of Staff, was in on the call.[22]

19 July 2005

31. Tilley testified that he had a conversation with Minister Ottenheimer on 19 July 2005 about the ER/PR Issue. Minister Ottenheimer had asked him if Eastern Health needed more resources. He replied that Eastern Health had sufficient resources. If the need for additional resources arose they would be available internally.[23]

32. Minister Ottenheimer testified that he first became aware of the ER/PR issue on 19 July 2005 in a meeting, or phone conversation, with Tilley. He understood that it was an issue of significant public concern and believed it was important that the public know as soon as possible.[24] He did not call the Premier or Premier's Office personally at that time or any time thereafter on this issue during his tenure as Minister.

---

[22] Evidence of Chaplin, 05/06/2008, p. 213
[23] Evidence of Tilley, 17/04/2008, pp. 32-33
[24] Evidence of Ottenheimer, 31/03/2008, p. 60, lines 11-24, p. 65, lines 6-18, p. 66, lines 3-17, p. 72, lines 20-24

33. Chaplin told the Inquiry that on 19 July 2005, she contacted Cabinet Secretariat and spoke to Gary Cake, Assistant Secretary to Cabinet for Economic policy, and advised him of what she had learned respecting ER/PR.[25]

34. Cake advised that on 19 July, 2005, he was covering for Sheree MacDonald, Assistant Secretary to Cabinet for Social Policy, who was on annual leave.[26] He spoke with Chaplin concerning the ER/PR matter and then at 10:32am e-mailed the Clerk of the Executive Council, Robert Thompson,[27] regarding his conversation with Chaplin and also advised that Chaplin had already contacted Matthews.[28] Thompson, in turn, notified Crawley by email at 10:49am.[29]

35. Matthews testified that she first heard about the ER/PR issue on 19 July 2005. She recalls Chaplin's call but not any specifics. She believes she would have had to be satisfied that patients were looked after or she would have pursued the matter. She felt it was the type of issue she would have alerted the Premier about if he was available.[30]

36. The only appointment on the Premier's agenda on July 19 2005 was a swearing-in ceremony at Government House that commenced at 11:00am.[31] Given that it

---

[25] P-0312, p. 1
[26] Evidence of Cake, 13/06/2008, pp. 117-118
[27] Thompson became Clerk in 2003 and Secretary to Cabinet for Management of Health Issues in May 2007. He was Acting DM of HCS from May to November 2007
[28] P-0312, page 1
[29] Exhibit P-0312, pp. 2-3
[30] Evidence of Matthews, 10/06/2008, pp. 75-76; p. 86, lines 8-12; p. 91, lines 17-22; p. 92, lines 16-24; pp. 95-96
[31] Exhibit P-3578

was mid-summer, the Premier believes he was not in the office the rest of the day, but was available by phone if the office needed to contact him.[32]

37. Bonnell recalls telling Chaplin by phone on 19 July 2005 that it was starting to appear that the results were better than originally thought and the issue might not be so serious.[33]

38. According to Chaplin, a few hours after speaking with Cake she became aware that Eastern Health advised that the issue might not be so serious. A short time later Abbott told her that Cake had phoned asking if any follow up was necessary. Abbott was off to a meeting and asked Chaplin to respond. She contacted Cake by email at 2:37pm and advised that follow up was unnecessary as the severity of the issue might be less than originally reported, and the Department would be briefed later in the week.[34]

39. Cake advised that later on 19 July 2005, Chaplin e-mailed him to advise that no action was required and that a briefing would be held for the Department later that week. He expected the Department to decide whether a briefing note was necessary and alert Cabinet Secretariat as required.[35]

---

[32] Evidence of Premier, 28/10/2008, p. 46
[33] Evidence of Bonnell, 29/05/2008, pp. 186-188; pp. 193-194
[34] Exhibit P-0312, p. 5; Evidence of Chaplin, 05/06/2008, pp. 255-256
[35] Exhibit P-0312, p. 5

40. Matthews stated that if she had not already advised the Premier she likely would not have done so upon being advised that action was no longer required.[36] Crawley and Matthews testified that if they had advised the Premier, they would have readvised him about the diminished consequences of the stand-down email.

41. It was Hynes' recollection that following Chaplin's afternoon contact with Bonnell, he understood that the number of patients affected had been reduced significantly and the issue might not be so serious.[37]

42. Cake forwarded Chaplin's second email to Thompson at 2:51pm.[38]

43. Thompson stated when he became aware of Chaplin's subsequent communication he would have advised Crawley of the change. Since no documentation exists dated July 2005 with the exception of the 19 July 2005 e-mails and since no one in Cabinet Secretariat can recall what happened in the next several days, he is left with the impression that the ER/PR Issue was quickly regarded by Executive Council staff as being well-managed by the Department.[39]

---

[36] Evidence of Matthews, 10/06/2008, p. 91, lines 17-22, p. 92, lines 16-24, pp. 95-96; Crawley, 11/06/2008, p. 88
[37] Evidence of Hynes, 18/06/2008, pp. 218-219
[38] P-0312, pp. 4-5
[39] Evidence of Thompson, 07/05/2008, pp. 321 - 322

44. Cake noted that when MacDonald returned from vacation and was briefed on issues that had arisen in her absence, the ER/PR Issue was not one of the issues raised.[40]

21 July 2005

45. Minister Ottenheimer testified that he was briefed on the matter on 21July 2005 in a meeting involving senior personnel from Eastern Health. He got the impression that Eastern Health was not aware of the extent of the problem.[41] He specifically asked Tilley if this was a resource issue and if the Department could offer any assistance and was told that it was not a funding issue, it was a laboratory / technical issue.[42]

46. Dr. Williams, Eastern Health's former Vice President for Medical and Diagnostic Services[43] testified that the Minister wanted patients contacted via letter.[44]

47. Bonnell testified that the purpose of the 21 July 2005 meeting was to give background to the Minister. She knew that the Minister wanted letters sent to patients and he stated at the start of the meeting his desire for a public press

---

[40] Evidence of Cake, 13/06/2008, p. 56
[41] Evidence of Ottenheimer, 31/03/2008, p. 174, lines 1-14; Evidence of Chaplin, 05/06/2008, p. 346, lines 11-25
[42] Evidence of Ottenheimer, 31/03/2008, p. 219, lines 6-18
[43] Dr. Williams held this position from May 2005 to August 2006 when he returned. He was replaced by Dr. Oscar Howell
[44] Evidence of Dr. Williams, 16/05/2008, p. 165, lines 15-25, p. 166, lines 5-8

release.[45] Eastern Health representatives conveyed to the Minister that this was not the time to notify the public and advised that Eastern Health was going to wait. The Minister acceded to waiting but wanted to be kept advised.[46]

48. Chaplin recalled there were two groups at the 21 July 2005 meeting. Those, including the Minister, who wished to disclose promptly and those who felt disclosure should be delayed until more was known.[47] The comment in Chaplin's notes regarding "positioning" reflects Eastern Health's suggestion that this matter could perhaps be characterized as a technical issue resulting from new more sensitive equipment.[48] Chaplin recalls that she raised concerns about the media becoming informed. She recalls that Minister Ottenheimer asked if Eastern Health had sufficient resources.[49]

49. Minister Ottenheimer stated that he did not discuss the ER/PR issue with the Premier's office as he always regarded the matter as an operational issue for Eastern Health.[50] He understood that Chaplin had contacted the Premier's Office.[51] The matter was not raised with the Premier, the Premier's Office or Cabinet by Minister Ottenheimer.

---

[45] Evidence of Bonnell, 30/05/2008, p. 22, lines 10-18
[46] Ibid., p. 24, lines 18-23
[47] Evidence of Chaplin, 05/06/2008, pp. 272-273
[48] Ibid., 05/06/2008, pp. 312-313
[49] Ibid., 05/06/2008, p. 321, lines 1-11
[50] Evidence of Ottenheimer, 07/04/2008, pp. 77-79
[51] Ibid., 31/03/2008, p. 75, lines 1-8

50. Matthews testified that she never saw Eastern Health's 20 July 2005 briefing note[52] and she does not recall Chaplin discussing the 21 July 2005 briefing with her.

51. The Premier testified to his disappointment that Minister Ottenheimer did not personally advise him of the ER/PR Issue.[53]

05-08 August 2005

52. A follow-up meeting to the 21 July 2005 briefing took place 05 August 2005 in the Executive Boardroom at the Department.

53. Moira Hennessey, Assistant Deputy Minister for Board Services for the Department attended this meeting and recalled being advised that Eastern Health was no longer doing new ER/PR testing although the Ventana machine had been checked out and was fine. Mt. Sinai's retesting of samples was expected to take 3-4 weeks. Eastern Health believed patients should only be contacted if their retest results changed.[54]

---

[52] P-0075, Evidence of Matthews, 10/06/2008, p. 128, lines 13-22
[53] Evidence of Premier, 28/10/2008, pp. 144-145
[54] Evidence of Hennessey, 26/05/2008, p. 256

15 August 2005

54. Tilley's evidence was that he favoured a news release and that the Department favoured letters to patients. When he spoke to the oncologists they favoured individual contact when the results were available. The oncologists spoke forcefully as primary care givers.[55]

55. Chaplin's recollection of the 15 August 2005 meeting was that the patient notification issue was discussed. The Minister always favoured disclosure and was becoming concerned about the mounting delays. Eastern Health officials still recommended waiting on notifying patients and the Minister accepted their advice.[56]

56. Dr. Williams testified that at the meeting on 15 August 2005, Dr. Laing informed the Minister that the problem may not be as bad as originally believed and now was not the time for a letter. The Minister stated that if patients were informed they would have a choice as to how to deal with the issue. However, he accepted Dr. Laing's advice.[57]

---

[55] Evidence of Tilley, 17/04/2008, p. 103, lines 10-21
[56] Evidence of Chaplin, 05/06/2008, pp. 369-371
[57] Evidence of Dr. Williams, 16/05/2008, pp. 193-195

57. Hennessey attended the 15 August 2005 meeting and recollected that the oncologists wanted to wait until the results came back, in 6 to 8 weeks, before notifying patients. Minister Ottenheimer accepted the oncologist's position.[58]

58. It was Hynes' evidence that at the 15 August 2005 meeting the Minister was pushing for patient notification but the oncologists felt it was better to wait on notifying patients until more information was known. Eastern Health preferred to notify patients individually instead of through a public notice.[59]

59. Dr. Cook[60] testified that he attended a meeting at the Department on 15 August 2005 to provide an update to the Minister. The Minister was pushing for public disclosure[61] but Dr. Laing strongly opposed public disclosure until the patients affected were advised of their retest results. She feared that public disclosure at this time would cause unnecessary fear and anxiety.[62] The Minister agreed to Dr. Laing's approach but had reservations.[63]

60. Dr. Laing recalled that she met with Minister Ottenheimer, Dr. Blair Fleming,[64] Hennessey, Tilley, Dr. Cook, and Dr. Williams on 15 August 2005. She gave an overview of ER/PR testing and reiterated her view that disclosure should wait

---

[58] Evidence of Hennessey, 26/05/2008, p. 272, lines 7-12, p. 273, lines 14-24
[59] Evidence of Hynes, 18/06/2008, p. 281, pp. 14-25
[60] Clinical Chief from October 2002 to March 2006
[61] Evidence of Cook, 04/07/2008, p. 165, lines 21-23
[62] Ibid., 04/07/2008, p. 166, lines 2-7
[63] Ibid., 04/07/2008, p. 169, lines 6-12
[64] Department of Health and Community Services

until results were back in 6 to 8 weeks. She also advised that the problem may not be as bad as first thought. Public disclosure was not discussed at this time.[65]

61. Minister Ottenheimer testified that he preferred immediate public disclosure but he acceded to the physicians' recommendation to contact patients individually as their results were received. He was satisfied that the progression of events, including the fact that testing in the St. John's lab had been suspended and samples were being sent to Mount Sinai, and external consultants were reviewing the IHC lab were evidence of the fact that patient safety issues were being addressed.[66]

30 September 2005

62. Tansy Mundon then Communications Director for the Department testified that on 30 September 2005 Bonnell phoned her to report that the ER/PR story was about to break in the ***Independent.*** This was her first dealings with the ER/PR Issue. Before speaking to Mundon, Bonnell had already spoken to Chaplin who was now Director of Communications in Cabinet Secretariat.[67]

63. Matthews' recalls being notified about the impending ***Independent*** article on 30 September 2005.

---

[65] Evidence of Laing, 10/09/2008, pp. 289-296
[66] Evidence of Ottenheimer, 31/03/2008, p. 157, lines 11-21
[67] Evidence of Mundon, 16/06/2008, pp. 27-28

02 October 2005

64. Premier Williams recalls the ***Independent*** Article. He took comfort that Dr. Laing commented that numbers were relatively small and that patients were being contacted.[68]

65. Matthews testified that after the 02 October 2005 ***Independent*** story broke, she presumed the situation was under control and she took comfort from the fact that the information was in the public domain. The article stated that the numbers of patients were relatively small, laboratory issues were being addressed, and patients were being contacted. She saw no need to involve the Premier's Office.[69] Matthews also took comfort in the following days and weeks from the media engagement that was undertaken by officials of Eastern Health, as well as the advertising purchased by Eastern Health.

03 October 2005

66. Abbott testified that the Department prepared a briefing note on 03 October 2005[70] in response to an 02 October 2005 article in the ***Independent.*** It was now obvious that the time span for re-testing had increased from the six-week estimate provided in August 2005. Cabinet Secretariat's 05 October 2005

[68] Evidence of Premier, 28/10/2008, pp 90-92
[69] Evidence of Matthews, 10/06/2008, pp. 146-147
[70] Exhibit P-125, p. 4

briefing note is virtually the same.[71] Both briefing notes provided information and did not seek direction from Cabinet Secretariat or the Premier's Office.

67. Peter Dawe, Executive Director of the Newfoundland and Labrador Branch of the Canadian Cancer Society, testified that in the fall of 2005 he did not see this as a Department issue but as an Eastern Health issue, thus his meetings with Abbott on 03/04 October 2005 did not relate to the ER/PR Issue.[72]

August 2006

68. On 30 July 2006, a story was reported in the ***Independent*** newspaper relevant to the ER/PR Issue.[73]

69. Normally, any issue pertaining to the Department would be the responsibility of Sheree MacDonald who was Assistant Secretary for Social Policy.[74] However, Ms. MacDonald was on vacation and Gary Cake was covering for her.[75]

70. Cake requested a briefing note from the Department on the ER/PR Issue.[76]

---

[71] Exhibit P-124, p. 6
[72] Evidence of Dawe, 03/09/2008, p. 149, lines 21-25
[73] Evidence of Cake, 13/06/2008, p. 213
[74] Ibid., p. 93, line 14
[75] Ibid., p. 117, line 8
[76] Exhibit P-0811

71. On 31 July 2006, Mundon emailed a briefing note to Cake that had been prepared by Heather Predham, Risk Manager Eastern Health.[77] Cake wanted more information and forwarded the email to Marilyn McCormack. The Cabinet Officer responsible for the Department was on vacation so Cake asked McCormack, another Cabinet Officer, to follow up on the briefing note with Department.[78]

72. McCormack worked with Hennessey at the Department to format and expand on the Eastern Health briefing note.[79]

73. It took over two weeks for McCormack and Hennessey to finalize the briefing note and there was considerable communication between them, both verbally and electronically.[80] Predham was also consulted by both Hennessey and McCormack when the note was being revised.[81]

74. McCormack forwarded a final version of the briefing note to Hennessey for her approval on 17 August 2006.[82] The summary section stated that "Eastern Health advises that 22 women were greatly impacted by the change in status of the ER/PR receptor tests."[83]

---

[77] Exhibit P-0815
[78] Exhibit P-1635, Evidence of Marilyn McCormack, 12/06/2008, pp. 215-216, line 18
[79] Exhibit P-0817, Exhibit P-0820
[80] Exhibit P-0192
[81] Evidence of Predham, 21/10/2008, pp. 20-45
[82] P-0172
[83] Ibid., p. 5

75. The briefing note also stated that the reviews by external consultants were still ongoing.[84] This contradicts an 05 October 2005 note which states that the external peer reviews were expected to be completed within weeks.[85] Neither Cake or McCormack noticed this contradiction.[86]

76. Hennessey testified that she recalls bringing the inaccuracy respecting the external reviews to McCormack's attention on 18 August 2006.[87]

77. The note was finalized on 18 August 2006. In the final version, the word "greatly" was removed from the sentence referenced above in paragraph 74.[88] The note concluded by stating that it was provided for information purposes only and that it had been prepared by Predham and Hennessey and reviewed by McCormack and Cake.

78. The inaccuracy respecting the external reviews remained in the final version.

79. The briefing note was circulated to Brian Taylor, Jeff Paddock, Ross Reid, William Parrott, Josephine Cheeseman, Sandra Barnes, the Premier, Crawley, Cake, Matthews, and Thompson.

---

[84] P-0172
[85] Exhibit P-0124
[86] Evidence of McCormack, 13/06/2008, pp. 41-42, line 22; Evidence of Cake, 13/06/2008, p. 270, line 1
[87] Evidence of Hennessey, 27/05/2008, p. 250, line 5
[88] Exhibit P-0125

80. This briefing note was not provided to Minister Osborne and he remained unaware of it until May 2007.[89] He was aware of the statistical information contained therein by virtue of a briefing on November 23, 2006. John Abbott confirmed to the Premier that Osborne did not receive this note.[90]

November - December 2006

81. Tom Osborne who became Minister in March of 2006[91] testified that he viewed the regional health authorities as arm's length organizations and the ER/PR issue as an operational issue for Eastern Health.[92] Throughout his time as Minister his main concern was that primary needs of patients were being met and that any patient who needed a change in treatment was receiving it. In spring 2006, he understood that all patients were being contacted.[93] Minister Osborne went to the House of Assembly in November 2006 understanding that the public would be notified as soon as all individuals were contacted and that a review by Eastern Health was underway to ensure that all patient contact was complete.[94]

82. Dawe explained that he never raised the ER/PR Issue with Minister Osborne as this was an Eastern Health issue and not a Department issue.[95]

---

[89] Evidence of Osborne, 08/04/2008, p. 286, line 8
[90] Evidence of Abbott, 06/05/2008, pp. 96-97, line 16
[91] Osborne was Minister of Health and Community Services from March 2006 to January 2007
[92] Evidence of Osborne, 08/04/2008, p. 98, lines 12-22, pp. 108-109
[93] Evidence of Osborne, 08/04/2008, p. 137, lines 8-17
[94] Evidence of Osborne, 09/04/2008, p. 23, lines 15-19
[95] Ibid., 03/09/2008, p. 148, lines 1-6

23 November 2006

83. Minister Osborne testified that during the 23 November 2006 briefing by Eastern Health the focus was on the number of patients whose results and treatment had changed, (104 + 13).[96] The meeting got heated when the discussion turned to the deceased patients. He was informed that not all deceased patients would be retested because time and resources were better spent dealing with living patients. He felt that it was important to determine the number of the deceased patients whose results converted. Eastern Health advised that it could not complete testing on the deceased without delaying its media briefing.[97] His handwritten notes on a copy of the 23 November 2006 briefing note[98] state "3-4% rate of error" probably evidenced discussion by Eastern Health of a margin of error calculation derived from dividing the 104 patients whose treatment changed into the approximately 2760 tests conducted between 1997 and 2004.[99]

84. Tilley recalled that representatives of Eastern Health met with Minister Osborne on 23 November 2006. The only numbers he recalled discussing concerned the deceased. He did not recall advising the Minister that certain numbers would not be discussed at the upcoming media briefing. He did not recall the Minister giving any direction regarding public disclosure.[100]

---

[96] Ibid., 09/04/2008, pp. 43-51
[97] Ibid., pp. 50-56
[98] Exhibit P-0134, p. 10
[99] Evidence of Osborne, 09/04/2008, pp. 59-60, 10/04/08, pp. 18-20
[100] Evidence of Tilley, 24/04/2008, p. 107-108, p. 111, lines 19-24, pp. 112-113

85. Dr. Oscar Howell's[101] evidence was that he attended the 23 November 2006 meeting. He recalls a summary of the external reviews and a *strident* discussion between Hynes and Dr. Laing regarding the deceased. He did not recall the Minister providing any direction. He did not recall discussing that certain numbers were not to be released at the upcoming technical briefing.[102]

86. Mundon testified that the meeting on 23 November 2006 involved Eastern Health officials, Bonnell, Tilley, Drs. Howell, Laing and Nash Denic.[103] Mundon, Abbott, Hynes and Minister Osborne attended from the Department.[104] The 3% margin of error, (104/2760) for patients requiring treatment change was put forth by Eastern Health.[105] She recalls Hynes and Dr. Laing arguing about the deceased with Dr. Laing saying she was more concerned about the living and not the dead.[106] Mundon left the meeting understanding that all the numbers in the briefing note would be disclosed at the media briefing.[107] Minister Osborne subsequently discussed with her his expectation that Eastern Health would disclose all the numbers from the 23 November 2006 briefing at the upcoming media briefing but did not follow up that same had occurred.[108]

---

[101] Dr. Howell replaced Dr. Williams as VP Medical and Diagnostic Services for Eastern Health in August 2006
[102] Evidence of Howell, 23/05/2008, pp. 81-87
[103] Dr. Denic became Clinical Chief of Laboratory Services March 2006
[104] Evidence of Mundon, 16/06/2008, pp. 323-324
[105] Ibid., p. 327, lines -28
[106] Evidence of Mundon, 16/06/2008, p. 328, lines 12-25
[107] Ibid.,16/06/2008, p. 361
[108] Ibid., pp. 151-152

87. Hynes' recollection was that at the 23 November 2006 meeting between Minister Osborne, Hynes, Abbott, Mundon, Tilley, Dr. Howell, Bonnell and Dr. Laing, Eastern Health advised that the results from the 101 of the 176 deceased tests would only be released if their families asked and the remaining samples would only be retested if families requested. He did not agree with Eastern Health's decision and said that if he was asking such questions, he was sure the media and families of the deceased would ask the same. Eastern Health advised that this could not be resolved in time for an upcoming media briefing.[109] Bonnell said that the 104/2760 changes in the retest results was within the accepted 3% margin of error.[110] The 104 patients who had a change in treatment was paramount in his mind. He believed that all the numbers discussed at the 23 November 2006 briefing would be presented in the upcoming media technical briefing.[111] Eastern Health advised that causation issues would not be discussed at the upcoming media briefing.[112]

88. Dr. Laing recalled that Minister Osborne was briefed on 23 November 2006.[113] There was a lot of discussion regarding the error rate. Officials from the Province seemed interested in this issue. Discussion highlighted that error was difficult to calculate and that it was better to focus on patients whose treatment had changed. There was discussion around the deceased. She does not recall any heated words on any issue and specifically does not recall Hynes being

[109] Evidence of Hynes, 19/06/2008, pp. 43-49
[110] Ibid., p. 57, lines 5-10
[111] Ibid., pp. 49-50
[112] Ibid., p. 30, lines 20-25, pp. 147-148
[113] Evidence of Laing, 18/09/2008, p. 53

dissatisfied with any of her responses regarding the deceased.[114] She does not recall the Minister being told that certain numbers would or would not be given out in fact she has no recollection of a conversation of that type being had with anyone at any time.[115]

89. Neither Cabinet Secretariat or the Premier's office was advised about the 23 November meeting.

29 November 2006

90. Dr. Howell recalled that there was an internal meeting at Eastern Health on 29 November 2006 to prepare for the media technical briefing. He was not confident with the numbers and their meaning. They were unsure of the error rate and how to calculate it. They could not decide on an appropriate scientific basis to determine which numbers were relevant, they did not know how to factor in the normal false negative rate, and they were concerned about the class-action suit. The decision not to disclose all the numbers was not, however, made at the 29 November 2006 meeting nor was it made at the 06 December 2006 Executive Management meeting.[116]

07 December 2006

[114] Ibid., 18/09/2008, pp. 65-67
[115] Ibid., 18/09/2008, p. 69
[116] Evidence of Dr. Howell, 23/05/2008, pp. 91-99, p. 116-119, Exhibit P-0184

91. Predham's evidence was that on or about 07 December 2006 in response to Bonnell's request she performed some error rate calculations but subsequently expressed her reservations about the calculations.[117] Dr. Howell's response was to say that they would focus on the 117 patients whose treatment had changed.[118]

92. Dr. Denic testified that in preparing for the media briefing in December 2006, there was discussion about whether or not rate of error should be addressed. His concern was around how to define the error rate.[119] Was it based on the number of changes? How did the change in cut-off points affect the number? Would it only refer to patients who required treatment changes? What was the proper denominator? He agreed that rate of error should not be addressed at the briefing.[120] It was decided by Eastern Health not to provide the media with the numbers that had previously been given to the Minister. Only the number of patients requiring treatment change would be provided.[121]

09 December 2006

93. Bonnell testified that the team at Eastern Health could not decide on how to calculate a rate of error. In the end they settled on how many patients required a

[117] Evidence of Predham, 22/10/2008, pp. 137-144
[118] Ibid., 22/10/2008, p. 159, lines 1-6
[119] Evidence of Dr. Denic, 12/09/2008, pp. 213-214
[120] Ibid., 12/09/2008, p. 213-215
[121] Evidence of Dr. Denic, 12/09/2008, pp. 218-219

treatment change. It was also determined that causative factors would not be dealt with as this would be dealt with by the class action.[122]

94. Bonnell's 09 December 2006 internal email informs that the reference to an error rate has been removed from the media materials.[123]

11 December 2006

95. Tilley testified that in hindsight he wished he had disclosed the error rate on 11 December 2005, as it would have saved a lot of trouble.[124] He was unaware whose decision it was to withhold the error rate. A copy of the briefing materials was provided to the Department on the morning of the briefing. Tilley testified that if the Deputy Minister had a problem with what was in the materials provided he would have expected the Deputy Minister to raise the issue.[125]

96. Bonnell stated that on the morning of 11 December 2006 the material to be released to the media was sent to Mundon for the first time.[126] The Department did not have input into the media briefing material; this was Eastern Health's

[122] Evidence of Bonnell, 02/06/2008, p. 18-20
[123] Exhibit P-0184
[124] Evidence of Tilley, 24/04/2008, p. 216, lines 1-12
[125] Evidence of Tilley, 24/04/2008, p. 244
[126] Exhibit P-0104

issue and not the Department's. Eastern Health was not prepared to discuss the questions of what caused the errors and the conversion rates in the tests.[127]

97. Abbot's evidence was that he was unaware that Eastern Health had not disclosed the error rate on 11 December 2006 until May 2007. He believed that all information included in the 23 November 2006 briefing note was to be disclosed.[128]

98. Mundon told the Inquiry that on the morning of 11 December 2006 Bonnell sent her the documents for Eastern Health's technical briefing scheduled for later the same morning. She likely scanned the news release and the key messages and assumed the balance of the numbers were in the associated material. She forwarded the e-mail to Abbott and Hennessey and gave a hard copy to the Minister. She anticipated the briefing on 11 December 2006 to parallel the briefing on 23 November 2006. Mundon testified that she should have detected the disclosure gap in the 11 December 2006 materials but did not.[129]

99. Predham testified that she was present at the briefings on 11 December 2006. She is aware that the number 117 was used. She received a copy of the documentation just before the briefing. She recalls the media asking repeatedly how many results had changed. At the CBC briefing she introduced herself and said that due to the court action Eastern Health could not divulge all details.

[127] Evidence of Bonnell, 02/06/2008, p. 60, lines 1-6
[128] Evidence of Abbott, 08/05/2008, pp. 291-292
[129] Evidence of Mundon, 17/06/2008, p. 11, lines 12-24, p. 24, lines 1-5

Eastern Health was candid that it could not and would not disclose all the numbers so it surprised her that the media was so critical in May 2007.

100. Dr. Howell told the inquiry that in retrospect, Eastern Health should have disclosed the 23 November 2006 briefing note prepared for the Minister on 11 December 2006.[130]

101. The media were very much aware of Eastern Health's lack of disclosure on 11 December 2006. The Department was not diligent. They were briefed on 23 November 2006, but sent no one to the Eastern Health briefing on 11 December 2006, and did not detect the disclosure discrepancy.[131]

12 December 2006

102. Mundon stated that because of the press conference the day before she took it upon herself to forward the 12 December 2006 briefing note to the Premier's Office.[132]

103. Matthews testified that she did not give a copy of the 12 December 2006 briefing note to the Premier.[133]

---

[130] Evidence of Dr. Howell, 23/05/2008, pp. 132-133
[131] Evidence of Premier, 28/10/2008, pp. 204-205
[132] Exhibit P-0197
[133] Evidence of Matthews, 10/06/2008, p. 234

104. Minister Osborne, Abbott and Mundon testified that they were unaware of any concerns about the media coverage that resulted from the medical/technical briefing.[134]

105. In response to the class action law suit, Eastern Health filed an affidavit from Predham dated February 9, 2007.[135] The affidavit disclosed the data that had been sought by the media after the December 2006 briefing with respect to the number of tests that converted and the number of deceased patients.

106. CBC was subsequently advised about the affidavit by Eastern Health in March 2006.

107. During this entire period, Osborne did not discuss the ER/PR Issue with the Premier, the Premier's Office or Cabinet.

May 2007

108. Ross Wiseman became Minister in January 2007.[136] Prior to that he had been Parliamentary Secretary to the Department since October 2003.[137]

---

[134] Evidence of Osborne, 09/04/2008, p. 151; Evidence of Mundon, 17/06/2008, pp. 47-50
[135] P-2543
[136] Evidence of Minister Wiseman 10/04/2008, p. 70, line 11
[137] Ibid.,

109. He was not briefed on the ER/PR Issue during his tenure as Parliamentary Secretary.[138]

110. When he became Minister, he was not specifically briefed about the ER/PR Issue by Departmental officials.[139]

111. At no point between July 2005 and May 2007 did the Department, when called on to provide the Premier's Office with its "top 5" briefing notes for the House of Assembly, include ER/PR in this set of notes.[140]

112. On 15 May 2007, media coverage reported that Eastern Health had refused to discuss the number of patients with changed ER/PR test results in December 2006. The number was now available in court documents, specifically a 9 February 2007 affidavit of Heather Predham filed by Eastern Health in response to the class action law suit.[141] The coverage reported that the data released in the affidavit revealed a 42% error rate.[142]

113. The Minister asked Abbott, Hennessey and Mundon to brief him on the Issue. He also consulted Tilley.[143]

---

[138] Ibid., p. 70, line 5
[139] Ibid., p. 136, line 11
[140] Evidence of Matthews, 10/06/2008, p. 176
[141] Exhibit P-0011
[142] Evidence of Abbott, 06/05/2008, p. 52, lines 1-9; P-0011
[143] Evidence of Minister Wiseman, 10/04/2008, p. 149

114. The Minister was concerned that full public disclosure had not been made at the December 2006 technical briefing and yet Eastern Health had disclosed the information in the class action court documents some two months later.[144]

115. The Minister was provided with a 19 April 2007 briefing note that had been drafted by Beverley Griffiths, a Regional Consultant with the Department, and approved by Hennessey.[145]

116. During his briefing, the Minister was disconcerted when no one could tell him what had caused the problems.[146]

117. The Minister addressed the ER/PR Issue in the House of Assembly throughout the remainder of May 2007.

118. The Minister continued to ask questions of and to be briefed by Department officials during the week of 15 May 2007. He was unable to determine what had caused the ER/PR Issue.[147] It was suggested to him that a change in technology may have caused the problem.[148] He was concerned about how, if and when patients had been notified.[149] He was concerned that samples from deceased

---

[144] Ibid., pp. 161-163, line 22
[145] P-0126; Evidence of Minister Wiseman, 10/04/2008, pp. 157-158, line 21
[146] Evidence of Minister Wiseman, 10/04/2008, p. 181, line 11
[147] Ibid., p. 324
[148] Ibid., p. 183, line 6
[149] Ibid., p. 350

patients were not being retested[150] and about the lack of public disclosure provided by Eastern Health.[151]

119. Some time between the 15th and 19th, Departmental officials advised Eastern Health that the Minister wanted the deceased patients retested.[152]

120. Tilley agreed to provide a copy of the external reviews to Abbott.[153]

121. The Minister advised the Premier and Brian Crawley of the problem on 16 May 2007.[154] This was the first contact to the Premier and Premier's Office by a Minister since this issue commenced in July 2005.

122. At the request of the Premier's Office, Abbott briefed Cabinet on the ER/PR Issue on 17 May 2007.[155] Cabinet requested that options be developed by officials regarding the nature of a public review of the ER/PR Issue.[156]

123. Subsequent to the Cabinet briefing, Minister Osborne advised that he had not seen the 18 August 2006 briefing note.[157]

---

[150] Ibid., p. 247-251
[151] Ibid., p. 354-355
[152] Ibid., 10/04/2008, pp. 251-53
[153] Evidence of Abbott, 06/05/2008, p. 57, lines 13-19
[154] Ibid., p. 345, line 11; Evidence of Minister Wiseman, 10/04/2008, pp. 345-347, p. 353
[155] Evidence of Abbott, 11/04/2008, p. 60, line 22
[156] Evidence of Minister Wiseman, 11/04/2008, pp. 99-100, line 11
[157] Evidence of Minister Wiseman, 11/04/2008 p. 79

124. Later in the day on May 17, the Premier met with Abbott and Hennessey to discuss why the August 18, 2006 briefing note had not been provided to Minister Osborne.[158] At this meeting Abbott and Hennessey acknowledged that the Note had not been given to Osborne.

125. A Cabinet Directive was issued subsequent to the briefing directing "Eastern Health to provide a technical briefing to media and other interested parties."[159]

126. Based on a 2006 proposal by the Department[160], the Province announced on May 18, 2008 that salaried pathologists' compensation would be increased by providing them with the oncology stipend.[161]

127. The Eastern Health media briefing occurred on 18 May 2007.[162]

128. On 22 May 2007, the Members of the House of Assembly were briefed by Eastern Health on the ER/PR Issue.[163]

129. Following a May 21, 2007 decision of Cabinet, the intention of the Province to call a Commission of Inquiry was announced on 22 May 2007.[164]

---

[158] Evidence of Abbott, 06/05/2008, p. 96-97, line 16; Evidence of Hennessey, 27/05/2008, pp. 322-324, line 23; Evidence of Premier, 28/10/2008, pp. 230-232, line 4
[159] P-0241; Evidence of Abbott, 06/05/2008, pp. 114-115
[160] Exhibit P-0199
[161] Exhibit P-0199; Exhibit P-0205; Evidence of Minister Wiseman, 11/04/2008, p. 216, line 15 and p. 335, line 17
[162] Evidence of Minister Wiseman, 11/04/2008, p. 126; Evidence of Abbott, 06/05/2008, pp. 138-139; Exhibit P-0827
[163] Evidence of Minister Wiseman, 11/04/2008, p. 144; Evidence of Abbott, 06/05/2008, p. 145

130. On 25 May 2007, Dr. Howell provided a copy of the 19 June 2003 Ejeckam memo to Abbott. Abbott provided the document to Minister Wiseman who in turn provided it to the Premier.[165] Recognizing the significance of the document, the Premier immediately tabled it in the House of Assembly.

131. On 30 May 2007, the Province announced the appointment of Thompson as Secretary to Cabinet (Health Issues) and Chair of a Task Force on Adverse Health Events. He was also charged with overseeing the Province's participation at the Commission of Inquiry.[166]

132. Despite the fact that patients were stating publicly that they had not been contacted, Eastern Health continued to assure the Minister that all patients had been contacted.[167] The Minister repeated this assurance to the media and in the House of Assembly.

133. The Province continued to release patient numbers to the public based on information provided by Eastern Health.[168]

---

[164] Evidence of Thompson, 08/05/2008, p. 296, line 22
[165] Evidence of Abbott, 06/05/2008, pp. 173-175; P-0111; Evidence of Minister Wiseman, 11/04/2008, pp. 257-267, line 6
[166] Evidence of Robert Thompson, 09/05/2008, p. 5, line 15
[167] Evidence of Minister Wiseman, 10/04/ 2008, p. 303
[168] Ibid., 11/04/2008, p. 185

134. In late May/early June, the Province became concerned that all patients may not have been retested and/or contacted by Eastern Health.[169] The narrative detailing these concerns is set out in the next section.

Post May 2007

135. In early June, the Province had some concerns as to whether all patients who had tested negative between 1997 and 2005 had been retested and/or contacted about the retesting.[170] As was previously emphasized by Elizabeth Matthews, the Province was concerned that communication with the public be accurate.[171]

136. Specifically, the concerns manifested on 07 June 2007 in a telephone conversation and exchange of emails between Thompson, Tilley and Predham. This was the first time that Eastern Health had moved away from its assurance that all patients had been contacted about their retests, and admitted that some patients may not have been contacted.[172]

137. Later in June 2007, with the cooperation of Eastern Health, the Department engaged the Newfoundland and Labrador Centre for Health Information (NLCHI)

---

[169] Ibid., 10/04/2008, p. 260; Evidence of Thompson, 09/05/2008, pp. 48-58; Exhibit P-0471; Exhibit P-0960
[170] Evidence of Thompson, 09/05/2008, pp. 48-58; Exhibit P-0471; Exhibit P-0960
[171] Exhibit P-0212, p. 1.
[172] Exhibit P-0013; Exhibit P-0471; Exhibit P-0960

to construct a database of all communication and retesting activity of the ER/PR patients that had been retested.[173]

138. It was originally believed the database would be prepared in 4-6 weeks, but the project took many months longer due to the variety of sources that needed to be included and the complex approach taken to ensure that high quality data was obtained.[174]

139. In July 2007, Eastern Health (Louise Jones, Acting CEO and Wayne Miller) asked the Department (Thompson) to consider diverting NLCHI's work onto a broader search for all ER/PR patients using an alternative methodology.[175]

140. The Department was open to the idea of Eastern Health conducting its own database project, but did not want NLCHI resources diverted.[176]

141. During the late summer and early fall of 2007, new searches for patients were conducted in all regional health authorities resulting in the identification of additional deceased and living patients that met the criteria for retesting but had not been retested. Additionally, the reconciliation of various sources of information from Eastern Health and Mount Sinai showed that a larger number of patients than previously reported had been retested.

---

[173] Evidence of Thompson, 09/05/2008, pp. 99-109
[174] Exhibit P-3563; Evidence of Dr. Donald MacDonald and Dr. Reza, 23/10/2008, p. 44-45
[175] Evidence of Thompson, 09/05/2008, pp. 215-218; Exhibit P-0997
[176] Ibid., p. 217-218, line 25

142. By October 2007, the Department had received enough information from NLCHI to confidently state that the number of retested patients was around 1000, not 939 as had been reported by Eastern Health in December 2006.[177]

143. On 02 November 2007, a press release was issued by the Minister conveying this information to the public and also identifying that 15 people who should have been retested in 2005-06 had been identified in the previous three months.[178]

144. By 22 February 2008, the database project was substantially complete and allowed the Minister to publicly advise on the total number of retested patients (1013), and the number of patients who had never been contacted or had never had contact confirmed. (49)[179]

145. In this press release, government also explained decisions it had made about new funding to regional health authorities for better data management, information systems, and a policy on coordination of multi-patient adverse events.[180]

146. The media sought additional data comparing the deceased and living in terms of the proportion that had changed test results. As this calculation had not been

[177] Ibid., p. 252, line 17
[178] Exhibit P-0128
[179] Exhibit P-1050, p.2; Exhibit P-0128, Evidence of Thompson, 09/05/2008, p. 310, line 9
[180] Exhibit P-1050, p. 2-4

performed at that time, this data was subsequently requested by Thompson from NLCHI, resulting in a press release on 18 March 2008. This release stated that of the 322 deceased patients, 108 had changed results, and of the 691 living patients, 275 had changed results.[181]

147. On 14 March 2008, the Office of the Secretary to Cabinet (Health Issues) submitted a draft statistical report on the ER/PR database to the Commission of Inquiry, not including data on communications issues.[182] This report provided breakdowns of original and retest statistics by year, region and several other variables.

148. On 14 April 2008, the office of the Secretary to Cabinet (Health Issues) provided a note to the media and the Commission of Inquiry summarizing the database results on communications. The note stated:

> The database identified 35 people who may never have been contacted with any information as of February 21, 2008, and 15 people who were informed that they were being retested but may not have been informed about their test results as of March 13, 2008. Since those dates all contacts except one have been made. The database also identifies 4 patients whose retest results were "no tumour" but insufficient information exists to determine if they have been contacted, and 19 living patients who were unable to be contacted after numerous attempts. Remaining contacts will be completed in the week of April 14, 2008.

149. Thompson also testified about the new information. He stated:

> 18 MR. THOMPSON :
> 19 A. Well , now that - - on April the - - in April , we concluded essentially all the reporting that we planned to do on it with the final communications tables, so really it concluded in April.
>
> 24 COFFEY , Q.C. :

[181] Exhibit P-0274
[182] Exhibit P-3565

> Q. And it was then , I take it , wherever else you sent it, it was delivered to the Commission at that time?[183]

150. Additionally, concerns had developed over whether all patients whose results had been sent to their physicians had been contacted by their physicians. On this point, Eastern Health had launched a verification process to reduce this uncertainty.[184] Eastern Health was also giving consideration to the idea of an alternative search process to address concerns that the original search process for patients, using the Meditech system, may not have captured all patients.[185]

151. In March 2008, a newly self-identified patient came forward. She should have been retested but had been missed.[186]

152. Because of the newly self-identified patient, NLCHI and Eastern Health examined the feasibility of alternative search strategies using the Meditech system. The results of this feasibility assessment were provided to Thompson as well as to Eastern Health officials. Thompson wrote Jones an email on 13 April 2008 and advised that "we hold the strong view that alternate search strategies must be completed by Eastern Health".[187]

---

[183] Evidence of Thompson, 09/05/2008, p. 321, line 18
[184] Ibid., 24/10/2008, p. 223, line 10
[185] Evidence of Thompson, 24/10/2008, p. 219, line 6
[186] Ibid., p.132, lines 1-10
[187] Ibid., p.132, lines 9-13; Exhibit P-3347

153. In the Spring of 2008, Eastern Health decided not to implement an alternative search process because it was unlikely that additional patients would be found and the cost to complete the search would be high.[188]

154. During the spring and early summer of 2008, new cases that had never been retested, though should have been retested, started to emerge.[189] NLCHI continued its work with Eastern Health to gather data on these cases so that a clear understanding of them could be obtained.

155. By the end of July, this process had not been completed and the Province intervened to accelerate the data collection.[190]

156. By mid-August, 2008, it was evident that 10 newly identified patients existed.[191] This finding caused the Office of the Secretary to Cabinet (Health Issues) to re-launch a dialogue with the CEOs of the regional health authorities regarding the quality of the original search processes and the possibility of conducting an alternative search process.[192] An evaluation of the original search strategies was carried out by NLCHI, resulting in a recommendation for a comprehensive search process in Eastern Health, and a reconciliation of searches in other health

[188] Ibid., p.132, lines 17-22; Exhibit P-3648; Evidence of Patricia Pilgrim, 02/10/2008, pp.160-162
[189] Ibid., pp. 224-227, line 4
[190] Evidence of Thompson, 24/10/2008, pp. 226-227, line 24
[191] Exhibit P-3648, p. 3
[192] Evidence of Dr. Reza/D. McDonald, 22/10/2008, p. 255, line 11

authorities against a Meditech list from Eastern Health.[193] This process is still ongoing as of December 1, 2008.

157. Between October 17 and October 21, 2008, Thompson wrote the CEOs of the regional health authorities on behalf of the Minister advising them to conduct search activity in an effort to ensure that all patients that required retesting had been found.[194]

[193] Ibid., pp. 252-255
[194] Exhibit P-3553; P-3556; P-3560; P-3562

Part III

ISSUES

A. How are the actions of the Province applicable to the Terms of Reference?

B. Did the Province have any involvement with or knowledge of the ER/PR Issue prior to July 2005? Did it contribute to the ER/PR Issue during this time period?

C. How does the Province interact with the Regional Health Authorities?

D. Did the Province carry out its roles and responsibilities in a timely manner in regard to the response to, and communication with, the men and women who needed retests and who were being tested for the first time between July 2005 and May 2007?

E. Did the Province carry out its roles and responsibilities in a timely and appropriate manner in regard to communication with the public and with those within the health care system respecting the ER/PR issue between July 2005 and May 2007?

F. Subsequent to the Inquiry being called, did the Province communicate in a timely and appropriate manner with the public about the ER/PR Issue as new

information became known? Did it take appropriate steps to hold the health authorities accountable with respect to this new information?

G. What lessons has the Province learned from the ER/PR Issue and from the Commission of Inquiry process?

Part IV

SUBMISSIONS

A. How are the actions of the Province applicable to the Terms of Reference?

158. Section 3 of Newfoundland and Labrador Regulation 72/02 sets out the Terms of Reference for this Inquiry. The Commission of Inquiry shall

> a) inquire into why the estrogen and progesterone hormone receptor tests done between 1997 and 2005 in the Newfoundland and Labrador health system resulted in a high rate of conversions when re-tested;
> b) inquire into why the problem with the estrogen and progesterone hormone receptor tests was not detected until 2005, whether it could have been detected at an earlier date, and whether testing protocols during that period between 1997 and 2005 were reasonable and appropriate;
> c) inquire into whether, once detected, the responsible authorities responded and communicated in a timely manner to those women and men who needed re-tests and those who were being tested for the first time;
> d) inquire into whether, once detected, the responsible authorities communicated in an appropriate and timely manner with the general public and internally within the health system about the issues and circumstances surrounding the change in test results and the new testing procedures;
> e) advise whether the estrogen and progesterone hormone receptor testing systems and processes and quality assurance systems currently in place are reflective of "best practices"; and
> f) make the recommendations that the commission of inquiry considers necessary and advisable relating directly to the matters of public concern referred to in paragraphs (a) to (e).

159. Given that health services such as the operation of laboratories, and patient testing and treatment, are the responsibility of the regional health authorities, all the terms of reference fall in the domain of Eastern Health and other health authorities, with the Province having an indirect involvement in 3(c) and 3(d) given its role of holding subordinate agencies accountable for their mandates and

budgets. In other words, the Province's role is engaged in the third and fourth terms because regional health authorities are accountable to the Province, and the Province must be diligent in the kind of oversight it provides.

160. With respect to 3(d), the Province is also directly accountable for how it communicated with public about the ER/PR Issue.

161. The Province submits that the key features of 3(c), as it applies to the Province are:

> "responsible authorities" include all government officials (public servants, political staff, Ministers and the Premier) to the extent that they were involved directly or indirectly;
>
> "responded and communicated" refers to operational activities involving patients that are not the direct responsibility of government, but would be the subject matter of accountability discussions between government and Eastern Health; and
>
> "a timely manner" is not defined in policy or law, so the Province submits that it should be judged in the context of reasonableness.

162. The Province submits that the key features of 3(d), as it applies to the Province, are:

> "responsible authorities" include all government officials (public servants, political staff, Ministers and the Premier) to the extent that they were involved directly or indirectly;
>
> the activity under scrutiny is communication with the "general public" which includes the manner in which government exercised appropriate oversight regarding Eastern Health's communication with the general public, but also includes direct communication by government with the general public;
>
> the content of communication under scrutiny includes "circumstances surrounding the change in test results and the new testing procedures", which can be interpreted as meaning facts and explanations about the testing problem and how it has been fixed; and
>
> "appropriate and timely manner" can be judged against the requirements of policy or law, if such requirements exist, or against the standard of a reasonable person in a similar position of responsibility with a similar amount of information.

163. The reference to internal communications within the health system in 3(d) of the Terms of Reference is regarded by the Province as the responsibility of the regional health authorities.

164. Along with exploring how the Province may have been involved in the ER/PR Issue under paragraph 3(c) and 3(d) of the Terms of Reference, the Commission, appropriately, has explored under 3(a) and 3(b) of the Terms of Reference whether government officials may have known about the testing problems prior to 2005 or made systemic decisions regarding the health system that may have contributed to poor test results. In this Brief, the Province will submit that it played no role in the ER/PR Issue until July 2005.

B. Did the Province have any involvement with or knowledge of the ER/PR Issue prior to July 2005? Did it contribute to the ER/PR Issue during this time period?

The Hay Report

165. Because of its implementation date, the Hay Report could not have contributed to the ER/PR Issue until 2002. Therefore, the focus of the question must be narrowed to whether the Hay Report recommendations were a contributing factor to the continuance of testing problems from 2002 forward.

166. The draft Technical Brief on the ER/PR database illustrates that the number of test conversions that occurred prior to 2002 was proportionately greater than from 2002 onward.[195]

167. The assessment process for the Hay Report recommendations was undertaken by HCCSJ with an emphasis on maintaining and improving quality. Only 14 recommendations were rejected and only one of those pertained to the laboratory, addressing the substitution of personnel. The rationale for rejecting this recommendation was not based on quality or safety, but rather on the availability of trained personnel.[196]

---

[195] Exhibit P-3565
[196] Exhibit, P-0042, p. 42

168. Based on the foregoing, there is no evidence that the Hay Report recommendations, to the extent they were implemented after HCCSJ's assessment, were a contributing factor to ER/PR testing problems after 2002.

169. Nothing in the Hay Report or in other evidence provided to the Inquiry suggests that the Hay Group was mandated to look at ER/PR testing issues or found any ER/PR testing irregularities in its general examination of laboratory operations.

170. The Province would never expect or condone the implementation of the Hay Report at the cost of patient safety.

Amalgamations in the Health Care System

171. Amalgamation had been under consideration by the Province in 2004 and 2005.

172. The Province's intention in pursuing the merger was to create more cost-effective organizations by consolidating administrative structures and overhead costs.

173. Amalgamation and the creation of the four regional health authorities did not occur until 2005. Problems associated with the ER/PR Issue pre-dated amalgamation.

C. How does the Province interact with the Regional Health Authorities?

174. An analysis of the response of the Premier's office, Cabinet Secretariat and the Department and its Minister to the ER/PR Issue should be grounded in an overview of the relevant legislation and the conventions surrounding the principle of Ministerial Responsibility.

175. The legislation in force through out the ER/PR matter was the ***Hospitals Act*** RSNL 1990, c. H-9. which lays out the relationship between the Minister, the Department and the Regional Health Authorities. This ***Act*** was repealed on 01 April 2008 and replaced with the ***Regional Health Authorities Act*** SNL 2006 c. R-71.[197]

176. To the extent that the relationship between the Minister, the Department and the Health Authorities was defined during the relevant times it was defined through this ***Act.*** As with similar legislation the ***Hospitals Act*** is a mechanism through which the House of Assembly confers the authority to perform certain functions to a corporation or corporations. The ***Act*** creates a series of corporations and Boards to manage the corporations.

[197] Although some Eastern Health witnesses suggested that they always conducted themselves as though the ***Regional Health Authorities Act*** was in force it was not in force until 01 April 2008. Since the amalgamations creating the four regional Health Authorities references in the ***Hospitals Act*** have been read as references to the ***Regional Health Authorities***.

177. Regional health authorities had and have responsibility for the operation and delivery of health and community services. While the Minster is provided with certain roles such as the appointment of boards and approving budgets, the legislation clearly holds hospital boards responsible for operations. The powers and duties of a Hospital/Regional Health Authority is defined in s. 17 of the ***Act***:

(1) The powers and duties of a hospital board are

(a) to maintain, manage and operate the hospitals under its jurisdiction and to provide in them accommodation for the treatment and care of all patients, whether suffering from disease or accident, and, subject to the regulations, to fix fees and arrange terms for services rendered to patients and to enter into contracts for the admission and care of those patients;

(b) to provide facilities for proper medical and surgical attendance, nursing, food and medicine, and all things and appliances of a medical, surgical, dietetic and sanitary character that may be required for the treatment of patients;

(c) subject to the approval of the minister, to add to or extend the hospital or its facilities and to build or provide additional buildings for the purposes of the hospital, including nurses' home or staff quarters that it may consider expedient;

(d) subject to the approval of the minister, to educate and train nurses and other hospital personnel;

(e) to accept subscriptions and donations, whether lands, buildings, money or other property and devises and bequests, for 1 or more of the purposes referred to in paragraphs (a) to (d) and, subject to the approval of the minister, to sell and dispose of or to lease and accept surrenders of leases of and manage all land, buildings and other real property, except real property referred to in paragraph (g), so received and not required to be or capable of being occupied or used for the purposes of the hospital;

(f) to take steps by personal or written appeals, public meetings or otherwise that it may consider appropriate for the purpose of obtaining contributions, in the form of donations or annual subscriptions or otherwise, to the funds of the hospital or the hospital board;

(g) to administer, in furtherance of the objects of the hospital board, all funds which it may receive and to sell and dispose of or to lease and accept surrenders of leases of and manage all real property donated or devised to the hospital board; and

(h) generally to do all those things that it considers appropriate for the purpose of the attainment of the above objects.

(2) The powers and duties conferred on a hospital board by subsection (1) are subject to those qualifications, modifications, limitations and restrictions that may be imposed by this Act and the regulations.

(3) Nothing in this Act prevents a hospital board from inviting a member of the medical staff or the administrator of a hospital operated by it, an employee of the board or other person to attend a meeting of the board.

178. The authority conferred upon the Province by statute provides that the Lieutenant Governor in Council, creates the Hospital Boards, (s. 4), the Minister appoints the Board members, (s. 8) and approves the hospital/regional health authorities' budgets. (28).

179. Commission Co-counsel inquired about the Minister's ability to exert authority over a regional health authority. The statute gives the Minister authority to exert influence through the budget process, capital budgeting, appointment of board members and the approval of new services. Ministerial intervention in the provision of specific services is not contemplated by the ***Act***. Nonetheless, health authorities generally recognize the influence of the Minister's Office and may, though not always, accommodate a Minister's request on matters not specified in the ***Act***. Typically, the Minister restricts his or her activity to areas within the ambit of the ***Act***. The Minister who wishes to direct a particular course of action on a matter within the responsibility of the Authority, for example responding to an adverse event, must rely on the influence of his/her office, the threat of removing board members, and replacing them, or the approval/ disapproval of budget items.

180. Responding to adverse events, from small single-patient events to large multi-patient events, like ER/PR testing, are, nonetheless, generally operational matters pertaining to services provided by RHAs to their patients, residents and clients. Thus, a number of the Province's witnesses including Thompson, Abbott,

and Ministers Ottenheimer and Osborne remarked that they viewed the ER/PR Issue as an operational issue for Eastern Health and their approach to the ER/PR Issue reflects this and is consistent with the aforementioned principle that the ER/PR Issue was one that fell within the purview of the authority delegated to Eastern Health. This view is shared by both Tilley and Dawe.

181. Beyond the specific statutory provisions, there are, however, important responsibilities of the Minister and the Department to hold RHAs to account for the provision of health and community services in their regions, including the quality of care and the patient safety record. This broad accountability function typically occurs on an annual basis through performance reports provided to the Minister. Specific adverse events do not fall neatly within the broad accountability processes.

182. The ***Act*** does not create statutory obligations on the Minister or Department, or any other element of the Government, to be involved with an adverse event that happens in a RHA. Therefore, informing the Minister or Department about an event is not a required activity under the law.

183. The principle of Ministerial Responsibility is that the Minister is accountable to the legislature for all the statutes, organizations and resources assigned to the Minister by the legislature. Nonetheless, RHAs are subordinate agencies created by the ***Act*** within the responsibility set of the Minister. The Minister is

answerable to the House of Assembly for all matters that occur within RHAs and needs to be informed at all times to discharge this responsibility. A similar function arises answering questions in the media.

184. The legislature does not expect the Minister to be the chief executive of RHAs even though it can expect the Minister to be answerable for the activities of RHAs. The imperative is to be well informed and to report to the legislature. This duty must be performed recognizing that the legislature also created the RHAs as self-governing entities, with Boards of Directors, CEOs and the resources and legal mandate to carry out their functions.

185. Consistent with this approach, Tilley testified that when briefing the Minister in July-August 2005 he was not seeking direction from the Minister, but rather informing the Minister so that the Minister could respond if questioned in the House of Assembly about the ER/PR Issue.[198]

186. Even though these relationships are not always precise, the RHAs must supply sufficient information to the Minister to ensure that the Minister can hold the RHA accountable for its management of RHA affairs, including adverse events. Two questions arise. How serious should the event be to trigger informing the Minister and the Department, and what does the Minister/Department do with the information?

[198] Evidence of Tilley, 17/04/2008, pp. 74-75

187. Firstly, the Task Force on Adverse Events will provide recommendations on how occurrences should be reported and how a serious occurrence or adverse event should warrant a separate briefing note to the Minister. There is no doubt however, that the ER/PR Issue warranted early and comprehensive briefings to the Minister.

188. Secondly, in possession of adverse event information, the Minister should exercise due diligence in evaluating this information and to be confident in the actions of the RHA.

189. Although Ministers and Departmental officials recognize that subordinate agencies are accountable to the legislature through the Minister, there are no written procedures or expectations on how to fulfill this accountability during a serious adverse event. Thus, throughout the ER/PR Issue, formal guidance for Ministers on this type of issue did not exist. In consequence, the following expectations are advanced. Due diligence by the Minister and Departmental officials requires the collection and examination of information. The regional health authorities briefing for the Minister on a serious occurrence or adverse event should address the following points (in one or more briefings as the information becomes available):

1) Action being taken to avoid further potential harm to patients;

2) Action being taken to provide diagnosis and treatment for patients who may have been harmed;

3) Action being taken to determine the causes of the problem;

4) Explanation of the causes of the problem to the Department;

5) Explanation of how the problem is being fixed based on the identified causes; and

6) Action being taken to disclose the problem to patients and, if necessary, inform the public.

190. If the information provided by the regional health authorities satisfactorily addresses these points, the Minister has discharged the accountability function. If the answers are not satisfactory, the Minister can ask for additional explanations, ask for alternative courses of action to be considered, or issue a directive for different action under the authority of the ***Regional Health Authorities Act.*** The directive power under the ***Act***[199] was not created with this type of use in mind; nonetheless it does exist if necessary. If ever used in this context, of course, it would be a serious expression of lack of confidence, and thus a sign of a deeper problem.

191. Prior to the passage of the current ***Act***, if the Minister was dissatisfied with the course of action being pursued by a regional health authority, the legal authority did not exist to issue a directive and the Minister was restricted to using the

[199] s5 - (1) The minister may give directions to an authority including directions for the purpose of ...
(2) An authority to which the minister gives directions under subsection (1) shall comply with the directions.

general influence of the Ministerial office to accomplish these ends. This general influence could be very effective if the will or requirement existed to utilize it. However it would be a rare circumstance where the Minister had lost confidence in the regional health authority's actions to the extent that such influence would need to be used.

192. This framework provides a lens to analyse the actions of the Department and the Minister as the ER/PR Issue developed.

193. It is also necessary, in the same context, to provide a framework for assessing the role of Cabinet Secretariat and the Premier's Office. These agencies, including the Premier, play leadership and coordinating roles for government. Formally, leadership and coordination occurs through the Cabinet process, where collective decisions are made by Cabinet on the policy direction of the government.

194. Leadership and coordination also occurs through communication between officials, such as through briefing notes and meetings. Emails and telephone conversations are also channels of leadership and coordination, though less formal. Issues that are being addressed within a department are not normally brought forward to Cabinet Secretariat unless they are priorities of the government or require a Cabinet decision. When direction or decision is

required, the briefing notes or Cabinet Submissions prepared by departments are explicit in the kind of direction or decision that is being sought.

195. Sometimes, issues within a department are raised with Cabinet Secretariat for information purposes because of their intrinsic significance, even though direction or decision is not required. When information on such issues is sent to Cabinet Secretariat, officials will ensure it is circulated to senior officials and the Premier. It is possible that such information may result in questions or direction back to line departments, but such feedback would not be the norm. Similarly, it is possible that Cabinet Secretariat may request information on a topic that has not been initiated by the line Department, but this is not the norm.

196. To tie this discussion back to the relationship between Ministers and subordinate agencies, like regional health authorities, it is reasonable to expect that departmental officials would inform Cabinet Secretariat about an issue of intrinsic significance that is happening in a subordinate agency, but not request or expect direction or a decision on the issue. It is also reasonable to expect that Cabinet Secretariat would rely upon departmental officials to generate follow-up notes or submissions to Cabinet Secretariat based on how the issue was unfolding. Sometimes, Cabinet Secretariat may track an issue closely, including the request of information or provision of direction, but such action would not be the norm.

197. The coordination of public communication is overseen by the Communications and Consultations Branch of Executive Council. Formal requests for approval of communications plans or press releases will normally be made by line departments to the Communications and Consultations Branch. Information about issues of intrinsic significance and/or issues that generate significant public interest or concern are usually initiated by departments. Periodically, questions or direction may be initiated from the Communications and Consultations Branch.

D. Did the Province carry out its roles and responsibilities in a timely manner in regard to the response to, and communication with, the men and women who needed retests and who were being tested for the first time between July 2005 and May 2007?

E. Did the Province carry out its roles and responsibilities in a timely and appropriate manner in regard to communication with the public and with those within the health care system respecting the ER/PR issue between July 2005 and May 2007? [200]

The 2003 Testing Suspension

198. The relevance of the testing suspension as it pertains to the Province relates to whether the officials of the Province acted in an appropriate and timely manner once the Province became aware of the suspension in July 2005.

199. As the Province had no knowledge about the testing suspension until July 20, 2005, scrutiny of its response does not begin until this time.

200. The 20 July 2005 briefing note of Eastern Health[201] provided to Minister Ottenheimer on 21 July 2005 stated that, "Eastern Health Vice President of Quality, Diagnostic and Medical Services Dr. Williams has also asked that an investigation be conducted into the five-week stoppage of immunoperoxidase

[200] Issues (iv) and (v) are analyzed jointly in the context of the various time frames that the Province was engaged in the ER/PR Issue
[201] P-0075

staining for ER/PR receptors in 2003 by Dr. Ejeckam." The government officials who attended this meeting have testified that they cannot recall the 2003 testing suspension as an item of particular significance or discussion.

201. Dr. Williams testified while there was some discussions with Dr. Ejeckam in 2005 emphasis was not placed on it by Eastern Health. He testified that "(b)y that time we had already made the decision to retest and it would be hard, I don't know of anything that Dr. Ejeckam could have said that would have changed our mind based upon the information I had at the time."[202] The testing suspension was clearly not his focus.

202. Notes of the 21 July 2005 briefing meeting for Minister Ottenheimer by officials of Eastern Health, written by Chaplin, indicate that reference was made to the 2003 testing suspension during the meeting.[203] However, the information contained in the 20 July 2005 briefing note and discussed the next day was not a primary focus of the discussion. Other issues such as patient notification, testing suspension, numbers of patients affected, the retesting process, the causes of the problem and the review to be conducted by external consultants were the main issues discussed.

203. Eastern Health was not focused on the 2003 testing suspension in July 2005 and accordingly it did not focus the Province on this issue.

---

[202] Evidence of Dr. Williams, 15/05/2008, p. 42

[203] P-0159; Evidence of Chaplin, 05/06/2008, p. 304, p. 332; Evidence of Abbott, 01/05/2008, p. 296-298; Evidence of Ottenheimer, 31/04/2008, p. 136

204. Beyond the 21 July 2005 meeting, no other references were made to the 2003 testing suspension until the Ejeckam memo was received by the Province in May of 2007. When the Province received the source documents, the Premier immediately tabled the memo in the House of Assembly.[204]

205. Therefore, the Province submits that it acted in a timely and appropriate manner when it was informed about the 2003 Ejeckam testing suspension. Eastern Health did not focus the Department on the significance of the suspension. Its significance was not apparent to the Province until Dr. Howell forwarded one of the Ejeckam memos to Abbott in May of 2007.[205]

Amalgamation

206. Eastern Health medical and laboratory officials were able to identify, evaluate and launch a retesting initiative during 2005. Its senior management and communications officials allocated considerable time to being briefed, reviewing the issues and making decisions.

207. If Eastern Health believed in the summer of 2005 that it did not have adequate resources to carry out the response to the ER/PR issue, it could have accepted the Minister's offer for additional resources. In the absence of doing so,

[204] Evidence of Minister Wiseman, 11/04/2008, p. 261, line 5
[205] Evidence of Abbott, 06/05/2008, pp. 173-175

amalgamation or lack of resources cannot be regarded as an impediment to responding in an appropriate and timely manner to patients or the public.

208. The testimony of Minister Ottenheimer and Tilley informs this submission.

209. In the 21 July 2005 briefing by Eastern Health for Minister Ottenheimer, the Minister asked Tilley if he required extra resources to handle the activities associated with the ER/PR issue.

210. Minister Ottenheimer's testimony on this point was as follows:

> "I remember, as I mentioned earlier, specifically saying to Mr. Tilley "is this" - -or asking, "is this a resource issue , and can we be of some assistance?" and he again indicated that it was not a money issue that would rectify some of the problems that had been identified. I feel that Eastern Health were fully aware that if further assistance, whether that being the case of personnel or resources, financial resources, if they were required, my sense is that Eastern Health realized that that would have been made available in view of the offer that was made by me personally, as Minister, on the very first day that this was raised with me."[206]

211. Tilley confirmed that Ottenheimer had made such an offer, that it was declined and that Eastern Health had the option of reallocating funds internally if necessary:

> MR. TILLEY:
> A. Well, very clear in the game resources were aligned within the organization to help us move forward within the lab. I think that's represented in one of the statements that we've already looked at. Secondly, if we needed additional resources to help us move that, we weren't going to wait to knock on the Department of Health's door. We were a billion dollar organization, we managed our resources efficiently, but this was a very important issue and if we needed more resources, we would simply have dedicated them to it.
>
> COFFEY, Q.C.:
> Q. Internally?
>
> MR. TILLEY:

[206] Evidence of John Ottenheimer, 31/03/2008, p. 219

A. Internally.

COFFEY, Q.C.:
Q. So it didn't cross your mind, I take it , to go to the Department and ask for more personnel or whatever sort might be necessary - -

MR. TILLEY:
A. I didn't see that as an issue, no.

COFFEY, Q.C.:
Q. Or more money. Did Mr. Ottenheimer offer or ask if this was a financial matter?

MR. TILLEY:
A. He did.

COFFEY, Q.C.:
Q. And you assured him that it wasn't?

MR. TILLEY:
A. That's what I did indicate, we had the resources lined up internally to do this. [207]

212. In conclusion, the Province would never insist that a health authority implement efficiencies at the expense of patient safety. If patient safety was being jeopardized, it was incumbent on the authority to bring the issue to the attention of the Minister and to seek financial assistance as required. With respect to the ER/PR Issue, assistance was offered by the Minister and rejected by Eastern Health.

18 July – 03 October 2005

213. Whether the Department found out on 18 or 19 July 2005 is not significant. What is significant is that a series of meetings transpired between Eastern Health and the Minister commencing with the briefing of the 21 July 2005 and ending with the 15 August 2005 meeting.

[207] Evidence of Tilley, 17/04/2008, pp. 32-33

214. Most individuals testified that Minister Ottenheimer consistently expressed a preference through out these meetings for immediate disclosure. Eastern Health's position evolved through these meetings.

215. Eastern Health attended the 21 July 2005 briefing of the Minister according to Tilley for the purpose of advising the Minister, not to seek his direction. According to Bonnell Eastern Health attended the briefing already aware of the Minister's preference regarding disclosure. Minister Ottenheimer testified to having the impression that Eastern Health seemed uncertain. At this point Eastern Health had uncertainty regarding the scope and gravity of the ER/PR issue. The briefing was inconclusive but the Minister asked to be kept advised.

216. After advising Eastern health of their position, on or about 10 August 2005, the Oncologists attended the 15 August 2005 briefing of the Minister. Their advice to the Minister as the primary caregivers was to wait to contact patients until the retest results were back in September. This would avoid generating harmful anxiety as patients awaited their results. The Minister was further advised that medical ethics and Eastern Health policy dictated that individuals must be notified before any broader disclosure, thereby excluding any general public disclosure for the time being.

217. The Minister's acceptance of the Oncologist's and Eastern Health's view is consistent with the framework proposed earlier in paragraph 189.

218. First, the Minister satisfied himself that action was being taken by Eastern Health to avoid further harm to the public. He had been briefed that ER/PR testing was no longer being performed in St. John's and was being sent out of province.

219. Second, the Minister was assured that that appropriate diagnosis and treatment of those affected was occurring. Specifically, Eastern Health advised that original ER/PR tests were being retested and that the plan was to contact those whose treatment changed.

220. The Minister was also advised that external consultants were coming to look at the lab; thus he would have been assured that action was being taken to determine causes.

221. While some may criticize the Minister for relying on Eastern Health and the physicians, the Province submits that;

    a. the Oncologist in this situation was a primary care giver and the individual most intimately connected with the patients;

    b. there was a relationship of trust between the Department and Eastern Health; the Minister has no reason to question the

management of this matter by Eastern Health, a matter which Eastern Health had alerted the Department to;

c. thus, there was no reason for the Minister to intervene in an operational matter that appeared to be well managed that was within the jurisdiction of a subordinate agency.

222. Although the regional health authorities fall within the legislative purview of the Department and its Minister an analysis of the matter should consider the role of Cabinet Secretariat and the Premier's Office.

223. Neither Cabinet Secretariat nor the Premier's Office are intended to function as a government within the government, monitoring and reevaluating all the work and decisions done by line departments. Such a concept if it were employed would be unworkable and impractical and defeat the purpose of line departments.

224. Premier Williams, Matthews,[208] and Crawley all testified that the Premier's Office is a busy work environment with a high volume of transactions with at least 125,000 – 150,000 contacts annually.[209] It expects to be advised of significant matters but, as a practical matter, it does not take an active hand unless it is a matter normally within the purview of the Premier's Office (i.e., Lower Churchill negotiations), the Premier's Office is asked to become involved by the line

[208] Evidence of Premier, 28/10/2008, pp. 15-17, line 16; Evidence of Matthews, 10/06/2008, pp. 61-64
[209] Evidence of Crawley, 11/06/2008, p. 9, lines 1-6

department, or the Premier's Office perceives that the Department is not responding adequately.

225. Thus, Eastern Health has direct operational responsibility for matters delegated to it. If the Minister is unhappy with the way Eastern Health handles a matter, he/she will use his/her authority and influence to bring about a different result. The Premier's office is one step removed and unless it detects something extraordinarily off course, it will rely on the Minister's advice and the Minister will take the lead role. In this case the Premier's office, in the absence of some sort of alert or other indication, would have assumed that the matter was being managed in an acceptable manner by the subordinate agency and the line department.

226. The structure of Government is such that Cabinet Secretariat would not normally intervene in the management of a matter particularly if it perceived that it was being managed adequately by the line department and/or the subordinate agency. The 19 July 2005 e-mails around Cabinet Secretariat are evidence of a *ramping up* in response to the perception of a possible crisis followed by a stand-down reduction of alert status in response to Chaplin's subsequent e-mail and, more importantly, notification that the Minister would receive a briefing in a few days.

227. If the Premier had been advised of the "ramping up" email on the morning of July 19, he was also likely advised of Chaplin's "stand-down" email in the afternoon. If he was not briefed about the initial email prior to receipt of the "stand-down" email, his staff would not likely have advised him about the Issue at all or qualified the Issue as not being that serious. The Premier's staff asked if patients were being dealt with appropriately and were problems in the labs being addressed.

228. There is no evidence that an immediate response (i.e., a decision or other intervention), was required by Cabinet Secretariat or the Premier's Office. To the contrary, the email said no action was required. Therefore, the belief in Cabinet Secretariat and the Premier's Office would have been that this was no longer a crisis requiring immediate response and to the extent that it required any monitoring it was a matter for the Department. The matter was within the legislative responsibility of the Department and its Minister.

229. It has been suggested that briefing notes should have been forwarded to Cabinet Secretariat on 20 July 2005 and 15 August 2005. It is unlikely given the way events unfolded in October 2005 that the provision of notes to Cabinet Secretariat at the suggested times would have materially impacted how this matter developed during this period.

230. As the ER/PR Issue unfolded in the Summer and Fall of 2005, the involvement of the Premier, Cabinet Secretariat, the Minister, and the Department was consistent with the belief that this was an operational matter, that was being reported on in the media and appropriately handled by a subordinate agency, which had reported to the Department, alleviating the necessity for further involvement by the Cabinet Secretariat or the Premier's Office.

231. This belief was substantiated by the manner in which events unfolded after the ***Independent*** published its story on ER/PR on 02 October 2005. The information from Eastern Health confirmed that testing and retesting were occurring at Mount Sinai. External reviews had been conducted and Dr. Williams had reported to the media several times in October a plausible explanation for what had occurred.

Herceptin Therapy

232. Abbott testified that Tilley approached him during the late summer/ early fall of 2005 proposing that the Province include funding in the 2006/07 budget for Herceptin therapy, used in treating the early stages of breast cancer. Tilley said this was an urgent request as he was under pressure from the Oncologists who had been at a conference and learned that this therapy was used in other provinces. Their patients were also making inquiries about Herceptin.[210]

[210] Evidence of Abbott, 05/05/2008, pp. 45-52

233. A Cabinet Submission prepared in late October 2005 outlined the various options to be considered.[211] Three options were considered by cabinet; 1) maintain the status quo; 2) approval of new treatments for breast cancer, colorectal cancer and multiple myeloma; or 3) approval for new treatments for breast cancer only. The third option was recommended and approved at that time.

234. The Cabinet Submission contained, *inter alia,* a communications plan which stated, "given recent media reports about ER/PR testing and the public's resulting loss of confidence in the health system, it is important that Government respond to the needs of breast cancer patients".

235. Commission co-counsel questioned witnesses about the implications of this communications plan. Premier Williams responded that his government does not make drug funding decisions based on what will generate good publicity.

236. Although a new drug for breast cancer treatment was the only funding approved in October 2005, ultimately $6.4 million was allocated for new colorectal cancer, multiple myeloma treatments and Herceptin therapy in the 2006-07 budget which was approved in the Spring 2006 session of the House of Assembly.[212]

---

[211] Exhibit P-1533
[212] Exhibit P-0128, pp. 27-28

August 2006

237. The August 2006 Briefing Note which was generated as a result of a 30 July 2006 ***Independent*** story by Stephanie Porter.[213] The article does not raise concerns about retesting, patient contact or public disclosure. It primarily discusses the class action law suit. Bonnell is quoted near the end of the piece as saying, "almost all" individuals impacted have been contacted. "We are getting near the end, but we're still doing data collection.....".[214] While the report does not state that all patients have been contacted, it certainly leaves the impression that all retesting is concluded, almost all those affected have been contacted and that Eastern Health is managing the ER/PR Issue appropriately. While the media report is troubling and graphically portrays the human cost of the testing mistakes, it would not cause the Province to lose faith in how Eastern Health was managing this matter.

238. The Province acknowledges that the Note contained inaccuracies and that it was not provided to the Minister by the Department executive.

239. Briefing note accuracy has always been emphasized by the Province. The inaccuracy contained in this note has caused Cabinet Secretariat to re-emphasize the crucial importance of note accuracy to the public service.[215]

---

[213] Exhibit P-1151
[214] Ibid., p. 3
[215] Exhibit P-0126, p. 38; Evidence of Minister Wiseman, 11/04/2008, p. 225-228, line 21

240. The failure of the Department executive to provide a copy of the note to the Minister has also been addressed government-wide by a new policy which demands that all notes forwarded to the Premier's Office must be signed by ministers before leaving departments.

241. There was also inconsistent evidence lead respecting who was responsible for drafting the note. The Province submits that whether the Note was drafted by Cabinet Secretariat or by the Department is irrelevant. The Province as a party to this Inquiry takes responsibility for the Note.

242. Irrespective of the problems with the Note, the question is whether a more accurate note would have caused the Department, Cabinet Secretariat or the Premier's Office to raise an alarm and question whether all patients who required retesting had been retested and advised of the results. Applying the framework set out in paragraph 189, the Province submits that it would not have had such an impact. Neither would the Note have raised issues or concerns respecting public disclosure.

243. The Note contains assurances from Eastern Health that retesting was proceeding and was practically completed. The Note raises no concern that patients who should have been tested may have been missed or that patients who were retested were not contacted. The risk of such occurrences, it was

believed, was further decreased by extensive media coverage that would have allowed self-identifiers to come forward.

244. Neither does the Note give the impression that information that should have been in the public domain was being withheld. The Note gives the impression that all that should be done is being done and it was provided for "information purposes only."

245. The Province was relying on Eastern Health to keep it updated about the ER/PR Issue and had no reason to question the accuracy of the information. Up to this point, the Province had been given no reason to lose confidence in how the Issue was being managed and this Note does not change that perception.

246. Neither the drafters nor recipients of the note identified the data about test conversions as a troubling issue that should trigger urgent public disclosure. In retrospect, while the data in the note was significant, the significance was not recognized by the authors. If Eastern Health, and to a lesser extent the Department, had appreciated the significance of the numbers, their significance should have been brought to the attention of Cabinet Secretariat and the Premier's Office. However, it is not reasonable to expect that readers of the Note, specifically Cabinet Secretariat and the Premier's Office, would have discerned the importance of the numbers from reading a briefing note that did not stress this issue.

247. Testimony from many Eastern Health witnesses confirms that Eastern Health itself believed that it was managing the ER/PR Issue properly. This belief was evident in the briefings it was providing to the Province and the Province had no reason to doubt this information. Tilley refused financial assistance from Minister Ottenheimer. There was no evidence that Eastern Health ever sought the assistance of the Province with this Issue. To the contrary, the briefings provided to the Province were provided at the request of the Province and left the impression that Eastern Health had the Issue in hand.

248. Until a problem is brought to the attention of the Province by an authority such as Eastern Health, it is unreasonable to expect the Province to assume that an issue is not being properly managed. It is unreasonable to expect the Province to look for a problem in the absence of evidence of a problem. Given the size and number of government departments and agencies, this is an impractical management approach and holds the Province to an unreasonable standard. Unless Eastern Health raised concerns with the Department and then the Department raises these concerns with Cabinet Secretariat and the Premier's Office, no alarm would be raised. The responsibility to bring these concerns forward lies with Eastern Health and it did not do so in the 18 August 2006 Briefing Note.

249. The Province was confident that Eastern Health was managing the ER/PR Issue because retesting was in progress, an external review had been completed, the laboratory was closed pending a resolution to the problem, patients were being notified, Eastern Health was communicating publicly, and the media was reporting on the Issue. Placed against this backdrop, it was reasonable for the Province to assume that the note was routine.

250. It was reasonable for the Province to rely on the clinical and technical expertise within Eastern Health to address the ER/PR Issue. No such expertise existed within the Department, Cabinet Secretariat or the Premier's Office. Today, and largely due to the evidence that was lead at this Inquiry, it is submitted that the drafters and readers of this Note wish they had understood more about the testing problems at the time. However the Note does not raise these concerns. An expectation that the 18 August 2006 note should have caused the Province to lose faith in Eastern Health would demonstrate hindsight bias and the Province should not be held to such a standard. Eastern Health did not seek help from the Province and provided no information to the Province that would cause a loss of faith in its ability to address this significant adverse health event.

23 November – 12 December 2006

251. Minister Osborne and other officials from the Department of Health and Community Services were briefed by representatives of Eastern Health on 23

November 2006 in the Speaker's Boardroom. The Minister was provided with a summary of the retest data.

252. The numbers presented by Eastern Health in the 23 November 2006 briefing note are substantially similar to the numbers integrated into the 18 August 2006 briefing note. These numbers if properly interpreted indicate that the error or conversion rate is 317 out of 939[216]. It is unreasonable and perhaps, hindsight, to expect that the Minister or his staff who attended the 23 November 2006 briefing, some of whom had also read the 18 August 2006 briefing note, would realize this. It is clear that there was discussion, lead by Eastern Health which focused in on 104 (+13) whose results changed and who also had a treatment change. It is evident that there was discussion around an error rate which again focused on the number 104 out of 2760 producing what was referred to at the meeting as the margin of error of 3 or 4%.

253. There is no evidence that specifically what would be disclosed publicly was ever discussed, but Department witnesses contend that they assumed that all the information disclosed in the briefing note would be disclosed. This is a reasonable assumption considering;

[216] Thus number would ultimately prove to be inaccurate and also included deceased for whom no conversion or error rate had been calculated.

a Eastern Health, a subordinate agency was providing a briefing to notify the Department about ER/PR developments in light of an upcoming media technical briefing;

b While the question was not specifically asked by the Department, Eastern Health gave no indication that only a subset of the information would be disclosed at the upcoming briefing;

c At this point the Department had no reason to doubt Eastern Health; thus the impending media briefing would have been viewed as a useful and appropriate opportunity for transparency on the part of Eastern Health. The Minister and the Department regarded the media briefing as the logical next step that met Eastern Health's responsibility to make public disclosure.

254. The assumption by the Department that there will be full disclosure by Eastern Health is even more plausible when one realizes the subsequent discussion which unfolded within Eastern Health, of which the department was unaware.

255. There is evidence of an evolution in Eastern Health's thinking through a series of internal meetings and discussions which culminated in a decision on or about 09 December 2006 that the only number which would be disclosed, other that the total originally tested, (2760), and the total retested, (939) would be the 117 patients requiring treatment change.

256. It is evident from Dr. Howell's testimony that a decision about what to release was made after the briefing on 23 November 2006. According to Dr. Howell's evidence this decision was made after the 06 December 2006 Executive Management Meeting. Dr Nash Denic was not as specific as to the date but testified that the decision was made in December. It is clear from Bonnell's evidence and her correspondence that the decision, however motivated, was made by 09 December 2006. Thus she notes that the draft materials which she has prepared for the 09 December 2006 differ from earlier drafts because there is no longer a reference to the error rate. This was solely a decision of Eastern Health of which the Department was not given advance notice.

257. The first time that the Department could have detected that all the numbers in the 23 November 2006 briefing note would not be disclosed by Eastern Health was on the morning of 11 December 2006 when an advance copy of the briefing materials was e-mailed to Mundon. This package was received by Mundon and then relayed to others within Government.

258. Witnesses for the Province testified that if they read the materials, they did not notice the missing data. While the error rate is not disclosed in Eastern Health's 11 December 2006 materials this likely would not have stood out in the minds of Department personnel as the 317 figure was never discussed by Eastern Health at the 23 November 2006 meeting. An error rate of 3-4% was discussed. The

figure of 117 patients requiring a treatment change emphasized on 11 December 2006 would have sounded familiar as this was discussed on 23 November 2006.

259. Hennessey, who did not attend the 23 November 2006 briefing but who nonetheless received a copy of the 23 November 2006 briefing note, observed the difference between the briefing note and the materials released on 11 December 2006 by Eastern Health but had no expectations about what would be released and therefore did not detect that there was anything unusual.

260. A number of witnesses testified that journalists attending the briefing on 11 December 2006 inquired about the total number of conversions and Eastern Health apparently made clear that they would not disclose this for a variety of reasons including the pending litigation. Department officials would have been unaware of this discussion between Eastern Health and the media because the Department failed to send a representative to the briefing.

261. While this may be regarded as an oversight by the Department, it should be remembered that the Department had already been briefed and expected that all the numbers divulged at the 23 November 2006 briefing would be disclosed on 11 December 2006. Eastern Health's notice to the contrary was not sent to the Department until the morning of 11 December 2006. Unquestionably, the presence of an observer would have alerted the Department to Eastern Health's refusal to disclose an error rate.

262. In any event, the subsequent reports of the media on the following days provided additional opportunities for the Department to detect this issue. The Province failed to do so. Witnesses for the Province testified that notwithstanding the media commentary they did not appreciate that there was a discrepancy between what was presented to the Department on 23 November 2006 and what Eastern Health presented on 11 December 2006. These witnesses further testified that they did not become aware of this discrepancy until May of 2007.

263. The media story in May 2007 of the error rate, the fact that it had been withheld by Eastern Health, and the absence of a plausible explanation, generated such a loss of public confidence that it resulted in the calling of the Inquiry. This illustrates the Province's expectation that full disclosure should have been made on 11 December 2006, some 18 months after the Issue arose. Dr. Howell and Tilley both recognized this when they acknowledged in their evidence that Eastern Health should have provided complete disclosure on 11 December 2006.

264. Had the Province detected the incomplete disclosure by Eastern Health in December of 2006 it could have intervened and either released the numbers it had in its possession, as it did November 2007, or used its influence and prevailed on Eastern Health to make further disclosure.

265. At this point ER/PR testing had not been reinstated and individuals had been retested and contacted, though we know today that some individuals had been missed. In addition the Department was advised that external consultants had visited Eastern Health and that the consultant's recommendations were being implemented.

266. In May of 2007 when the Province became aware of Eastern Health's incomplete disclosure it acted appropriately in directing the Inquiry, requiring various briefings, and directing certain investigations.

267. The principle of Ministerial accountability for a subordinate agency applied to this situation requires that on becoming aware that Eastern Health had not made full disclosure, the Province intervened to insure that the public was notified. This is precisely what occurred in May 2007. Once aware of Eastern Health's incomplete disclosure the Province acted decisively.

May 2007

268. The Province submits that the Premier, Minister Wiseman and officials within Cabinet Secretariat and the Premier's Office responded appropriately when they learned that Eastern Health had not made full public disclosure during its technical briefing in December 2006. The Province called a public inquiry and thereby ensured full disclosure to the public respecting the ER/PR Issue.

269. When the Inquiry was called, the Province was unaware that some patients who should have been retested had been missed and that other patients who had been retested had not been advised of the results. However, the Inquiry process, and particularly the Province's decision to hire NLCHI to create a foot print of Eastern Health's actions, has lead to the discovery of further patients who were either not tested or were retested but not contacted by Eastern Health.

270. Some concerns were raised regarding how the Province conducted itself respecting the ER/PR Issue in May of 2007.

271. Abbott's and Hennessey's involvement in decisions made during this time period was explored.[217] It was implied that the Province took advice regarding how to proceed from persons who may have been in a conflict of interest.

272. While Hennessey did not support calling a public inquiry, Abbott testified that he had suggested to Minister Wiseman that a public inquiry was the best approach to address the Issue.[218]

273. The Province submits that Abbott and Hennessey were asked for advice on the type of inquiry and the terms of reference of the inquiry because they were the two senior officials of the Department with the most information about the issues.

---

[217] Exhibit P-830; Exhibit P-0822; Exhibit P-833; Evidence of Hennessey, 28/05/2008, pp. 197-199
[218] Evidence of Abbott, 06/05/2008, p. 130, lines 9-22

Furthermore, the direct preparation of the options for consideration by Cabinet did not rest with Abbott and Hennessey. Ultimately, it is clear that whether or not a conflict existed, Cabinet considered several options and took the broadest, most powerful method of addressing the ER/PR Issue through a full public inquiry.

274. The Province was questioned about why no government officials sought copies of the Banerjee and Wegrynowski external reviews (hereinafter referred to as "the External Reviews") in May of 2007. It has been implied that if the Province had seen the External Reviews that this Inquiry may have been unnecessary.[219]

275. Minister Wiseman acknowledged seeing a spreadsheet of recommendations generated for the External Reviews.[220]

276. The Province submits that a review of these documents in May of 2007 would not have addressed the extreme patient and public concerns that had arisen around the ER/PR Issue. Specifically, it would not have addressed the public communication problems that had manifested since May of 2005. Even if the External Reviews precisely explained what had caused the problem, a key motivation for calling a public inquiry was rooted in the loss of confidence in how Eastern Health had managed public disclosure of this Issue.

---

[219] Evidence of Minister Wiseman, 14/04/2008, p. 106
[220] Ibid., p 106; Exhibit P-0050

277. While the Terms of Reference asked the Commissioner to investigate causation, answering that question alone would not have avoided a public inquiry.

278. Minister Wiseman was also questioned about the appropriateness of the press release issued by the Province announcing the Commission of Inquiry.[221] Specifically, Ms. Chaytor questioned the Minister about the appropriateness of the backgrounder portion which "gives a lot of information and cites what are purported to be facts around the very issues that are being asked of the Commissioner to determine."[222]

279. The thrust of Ms. Chaytor's questioning illustrates that many of the purported facts were subsequently found to be inaccurate. Many of these inaccuracies were subsequently repeated in briefing notes and in the House of Assembly around this same time.

280. The Province acknowledges that its confidence in Eastern Health's ability to manage the ER/PR Issue had been shaken at this point. However, the concern was not focused on patient retesting and contact. Rather, the Province's concerns went to Eastern Health's public communication approach, particularly during the 11 December 2006 briefing. While some media reports were stating the opposite, Eastern Health was still assuring the Province that all affected patients had been retested and contacted and the Province accepted this

[221] P-0212
[222] Evidence of Minister Wiseman, 11/04/2008, p. 168

assurance.[223] Matthew's email emphasized that the press release had to be accurate.[224] While it is unacceptable that the some of the information was subsequently determined to be inaccurate, it was reasonable for the Province to expect that Eastern Health would be ultra-cautious about the accuracy of the information that it was providing to the Province and to the public at this time. Accordingly, it was reasonable for the Province to rely on this information.

281. Eastern Health never corrected the public statements made by the Province. In fact, it reinforced the Province's comfort in its early June 2007 advertisement.[225]

282. As soon as the Province became aware that some patients may have been missed in late May/early June, it acted appropriately. It hired NLCHI to create a data base outlining how Eastern Health had managed the ER/PR Issue. The primary purpose of the data base was to ensure that patients had been retested and/or contacted. [226]

283. Commission counsel expressed a further concern with the May 2007 press release.[227] Ms Chaytor questioned the appropriateness of the Minister stating that, "There was full disclosure to patients and their families once test results became available. Unfortunately, test results came back at different times, and there was a delay in the retesting process which lead to some patients feeling

[223] Evidence of Abbott, 06/05/2008, p 181-183; P-0457
[224] P-0212
[225] P-0227; P-0212
[226] Evidence of Thompson, 09/05/2008, pp. 99-109, P-0474
[227] P-0212

they were not informed in a timely fashion. Unfortunately, Eastern Health's primary concern was notifying all affected individuals".[228]

284. The Minister acknowledged that it may have been inappropriate for him to purportedly answer questions that were intended to be addressed by the Commissioner.[229] He further stated that it was not said with intent to undermine the authority of or to influence the Commissioner. Commission counsel accepted this testimony and further stated that she was confident that such statements would not influence the Commissioner.[230]

ATIPPA

285. There were two ATIPPA requests directed at the Province that were of concern to Commission Co-counsel.

286. In February 2006, the Department of Health and Community Services received an ATIPPA request from Mark Quinn at CBC.[231] The request sought memos, briefing notes, and e-mails associated with the ER/PR issue. ATIPPA requests directed to the Department are handled by Reginald Coates.

---

[228] Evidence of Minister Wiseman, 11/04/2008, p174-175
[229] Evidence of Minister Wiseman, 11/04/2008, p 176
[230] Evidence of Minister Wiseman, 11/04/2008, p 178
[231] Exhibit P-1672

287. Coates, Director of Legislative and Regulatory Affairs for the Department testified about Mark Quinn's 03 February 2006 ATIPPA request for information on documents relating to ER/PR. The package of documents considered for release were reviewed by Eastern Health, the Department of Justice and Cabinet Secretariat. As was his habit, Coates also sent third parties impacted by the disclosure a copy to review. As the Department proposed to release Eastern Health briefing notes, Eastern Health was asked for comment. Tilley requested that Coates redact a reference to Dr. Williams' request in a 20 July 2005 Eastern Health briefing note, "for an investigation into Dr. Ejeckam's 5-week stoppage of immunoperoxidase staining for ER/PR receptors in 2003". Tilley explained that this was a Quality assurance measure and should be removed under s. 8.1 of the ***Evidence Act.*** [232]

288. Tilley's evidence corroborated Coates' evidence on this point. It is clear that in redacting this passage Coates was simply taking direction from Tilley.[233]

289. Commission Co-counsel made the observation that the manner of this redaction, a *whiting out* of the passage without notation was misleading because it was not apparent that there had been a redaction. Coates stated that this practice has been amended and all redactions are now evident along with a reference for the statutory rationale.[234]

---

[232] Evidence of Coates, 20/06/2008, pp. 74-75
[233] Evidence of Tilley, 12/05/08, pp. 273-274
[234] Evidence of Coates, 20/06/2008, p. 106, lines 1-11

290. The second ATIPPA request emanated from the ***Telegram's*** Robert Antle in June 2007.[235] Coates testified that this request received more scrutiny from Cabinet Secretariat and the Premier's Office then was his past experience.[236] In light of the events of May 2007 this is hardly surprising, but begs the question whether or not the request was, notwithstanding the alleged additional scrutiny, appropriately handled.

291. Renee Pendergast, the former ATIPP coordinator for Cabinet Secretariat commenced her duties with Cabinet Secretariat in June 2007.[237] She testified that her office becomes involved in other departments' ATIPP requests when s. 18 of the ***Act***, (Cabinet confidence), and s. 20, (advice to Ministers etc.) are engaged.[238] She maintained the removal of third party identifying material was mandatory under s. 30 of the ***Act*** irrespective of whether the information was already in the public domain.[239] Pendergast contradicted Coates' testimony and stated that the involvement of Cabinet Secretariat and the Premier's Office in this ATIPPA request was not "extraordinary".[240]

292. The Province submits that the redacted package provided to Antle was consistent with the requirements of the ***Act***. As a practical matter, it was obvious from the examination of both the redacted and unredacted versions conducted

---

[235] Attachment to Exhibit 1673
[236] Evidence of Coates, 20/06/2008, p. 108, lines 1-4
[237] Evidence of Pendergast, 25/09/2008, p. 158, line 11
[238] Ibid., 25/09/2008, pp. 168-169, p. 175, lines 17-21
[239] Ibid., 25/09/2008, pp. 195-196
[240] Ibid., 25/090/2008, p. 187, lines 2-9, p. 188, lines 1-9

during the hearing that nothing of consequence was removed. On review it was Pendergast's opinion that s. 18 was not involved however s. 20, (advice to government) was. She and Coates disagreed on the applicability of s. 20 however her judgment prevailed and questions for the Minister were, following review, removed. One consequence of Pendergast's review was that material was redacted from the Antle request which had not been redacted from the Quinn request.

External Consultants' Reports

293. The issue of the external consultants' reports is one which does not fit comfortably in any particular spot in the timeline. It was an issue that Commission co-counsel pursued with all three Ministers and various Provincial employees, however the placement of this issue at this point in the brief is arbitrary.

294. Earlier in this brief in paragraph 189 a framework was proposed to assist in evaluating the effectiveness of a minister in discharging his/her accountability function. Part of that function involved understanding what had occurred and being answerable to the House of Assembly. Presumably, an understanding that something has been fixed must flow in part from an understanding of what has gone wrong.

295. When Eastern Health first briefed the Minister about ER/PR on 21 July 2005 it was unclear what had caused the problem. Eastern Health's 20 July 2005 briefing note advised that an external technical consultant from Mt. Sinai had been retained to review the IHC lab.[241]

296. A briefing note prepared by Eastern Health dated 30 September 2005 advised that two reviews had been conducted, one by a technologist and one by a pathologist. Debriefings were held and reports were received in October and November 2005.[242]

297. In the 06 October 2005 ***Globe and Mail*** newspaper, Dr. Williams states, "With 40 steps in the testing procedure, if you have a problem in any particular step, it can affect the results you get. There are checks and balance in there, but in this case, in some of these cases, these things did not appear to work."[243]

298. On 20 October 2005 Dr. Willliams tells CBC, "There's 40 steps in that process, any problem in any one step can cause a problem with the testing results."

299. Dr. Williams tells VOCM on 25 October 2005 that, "We've done a lot of research. This is a very difficult procedure. There's about 40 steps involved from the time the breast tissue in (sic) obtained in the surgical suites to the time it's, a report is generated by the pathologist . . . we've had an outside consultant come, the head

[241] Exhibit P-0075
[242] Exhibit P-0141
[243] Exhibit P-0093

of the cancer pathology section BC Cancer Institute and the chief tech of Mount Sinai visited our labs in September and in the process of doing a quality for us, doing a quality review. And they will be making some recommendations as to how we can improve this testing. But there's 40 different steps in the procedure, I guess we won't know which of these particular steps were involved in each particular case but some steps are very problematic and you know, they can be affected by a number of things, even the humidity of the lab at the time some people can say can affect the out come of some of these tests because they're very, very sensitive."

300. The timing of these statements by Dr. Williams and the knowledge that reviews had been conducted probably gave many individuals the impression that Eastern Health now knew the cause of the problem. Accordingly, the Department's 07 November 2005 briefing note[244] is the first of several to contain a statement along the lines of, "There are a number of steps in the testing process. Any problem in any step can cause a problem with the test result. When the problem is identified, changes in policies and practices may be necessary to minimize a reoccurrence of inconsistent test results."

301. In 2008 following a court application the external reviews were released. They paint a picture different from the impression conveyed by Dr. Williams in October – November 2005.

[244] Exhibit P-0124, pp. 8-9

302. Minister Ottenheimer stated that he never asked for the external consultants' reports because he was of the understanding that the process was incomplete and that following an implementation stage and a review stage a final report would eventually be issued. He expected and anticipated that upon completion he would get the report in its totality. During this period it was also his understanding that patient safety concerns had been addressed as ER/PR testing was no longer being carried out in St. John's, and the original results were being retested.[245]

303. Minister Osborne testified that he did not ask for a copy of the external consultant reports but he did ask what were the root causes, what were the recommendations and what measures had been put in place. He was told that it was believed that the root cause was an error with the DAKO system and not a lab (i.e. human) error. In spring 2006, it was his understanding that a "newer better system picked up the error". It would have been useful to him to know of the conclusions reached in Dr. Banerjee's reports. He was never advised of the conclusions in the reports, he never asked for those reports but in hindsight he should have.[246]

304. Abbott testified that he did not request the external reports until May of 2007. Eastern Health said they were implementing recommendations, making

[245] Evidence of Ottenheimer, 07/04/2008, p. 318, lines 2-12
[246] Evidence of Osborne, 08/04/2008, pp. 273-274

improvements, and had a handle on the situation. The Department's approach was non-interference with an Eastern Health operational matter.[247]

305. Hennessy advised that she did not expect to see the reviews as she assumed they were protected under the ***Evidence Act.***[248]

306. Tilley advised that when Abbott requested the reviews in May of 2007 he agreed to provide them and put them in an envelope which became misplaced. He next found the envelope the day he was clearing his desk in preparation to leave and left it for his successor to deal with.[249] It was Jones' evidence that when she found the envelope left by Tilley, she felt that the reports were privileged and should not be disclosed to the Department.[250]

307. During the public hearings the question was frequently asked of Government witnesses why they had not asked for the external reviews.

308. The Province submits that the explanations given by Dr. Williams as set out above would have seemed a cogent answer to the layperson who had no reason to suspect that Eastern Health was not being entirely candid. For those witnesses who believed, erroneously, that the reports were protected by the ***Evidence Act*** this would have been the end of the matter. For those witnesses

[247] Evidence of Abbott, 05/05/2008, pp. 31-32
[248] Evidence of Hennessey, 27/05/2008, p. 130, lines 8-10
[249] Evidence of Tilley, 17/04/2008, pp. 3-4
[250] Evidence of Jones, 28/04/2008, pp. 349-351

who anticipated that they might eventually see the report it would not have been urgent to do so given the explanation already provided and the expectation that the report would only reaffirm this explanation.

309. Given the Minister's duty to be diligent and accountable, what emerges is the advisability of the Minister being provided with such reports. He or she, can then state that the causes are known and relate to the solution.

F. Subsequent to the Inquiry being called, did the Province communicate in a timely and appropriate manner with the public about the ER/PR Issue as new information became known? Did it take appropriate steps to hold the health authorities accountable with respect to this new information?

310. When the Task Force was established, the necessity for the NLCHI database exercise was not anticipated. However, when doubts emerged about Eastern Health's assertions that all patients had been contacted, an objective database exercise was initiated and NLCHI was engaged.[251]

311. The Province did not agree to Eastern Health's request to broaden the scope of the database project. The methodology was more complex and completion of the database would be delayed by an unknown amount of time. The Province hoped that the data base may prove useful to the Inquiry and was concerned that this delay may cause the database not to be completed by the time the Inquiry was then scheduled to conclude in July of 2008.[252]

312. Reliable revised data that informed the public about the number of people that had been retested emerged in October 2007, and this number was made public on 02 November 2007.[253]

---

[251] Evidence of Thompson, 09/05/2008, pp. 99-109
[252] Ibid., pp. 217-218, line 55
[253] P-0128

313. When the database project was initiated, it was not expected that cases would be found that should have been retested but had been missed. The Province initiated the project due to concerns it had about if, how and when affected patients had been advised of the retesting process and results. However, by November 2, 2007 the Province reported 15 such cases. Some of these patients were living, so the database project served to advance patient care.[254]

314. On successive occasions, when data was available, the Province took steps to release this information to the public in a timely way.[255]

315. When the media wanted additional information on the number of deceased that had changed results, this information was produced and released.[256]

316. At the outset of the database exercise, there was no concern about the quality of the original search strategies. This concern has now emerged and an alternative search strategy has begun.[257]

317. Throughout the database project, the Province stepped beyond its normal role of holding health authorities to account for their mandate and budget. Normally, the government, through the Minister, will receive accountability and performance reports on health services, ask appropriate questions, monitor appropriate

[254] See Facts/Evidence section, paragraphs 141 - 143
[255] See Facts/Evidence section, paragraphs 141 - 148
[256] Exhibit, P-0274
[257] See Facts/Evidence section, paragraphs 150 - 157

measures, and thereby gain assurance that the legislative mandate and the assignment of budgetary resources is being appropriately implemented. From time to time, the Minister may become more involved in an issue if there is a serious public concern, but often such concerns include matters of access to services, capital expenditure or matters that affect budget resources, all areas where the Minister has a recognized role. The database project was different in that the Province, through NLCHI, was directing a specific data gathering exercise, and closely monitoring the communication and disclosure activities of the regional health authorities. This very detailed level of oversight on this issue was necessitated by unusual circumstances where, after a loss of confidence in May 2007, the Province wanted to direct the new data-gathering exercise. In future, the Province regards good database management during adverse events as a regional health authority responsibility.

318. The Province submits that it acted appropriately during the post May 2007 time period. It communicated appropriately with the public, it facilitated better patient care and it provided valuable information to the Commission of Inquiry by initiating and then providing the Inquiry with the data gathered by NLCHI.

G. What lessons has the Province learned from the ER/PR Issue and from the Commission of Inquiry process?

Briefing Notes

319. The Province and particularly the Premier's Office were very concerned about the inaccuracies included in the 18 August 2006 Briefing Note.[258] While the Province has submitted that a more accurate note would not have likely changed how the Province responded to the Issue,[259] changes have been made to ensure that accurate information is circulated within government.

320. The Clerk of the Executive Council has directed all departments that notes prepared for the Premier's Office must be routed through Cabinet Secretariat.[260]

321. Only briefing notes that have been approved by the responsible minister will be forwarded to Cabinet Secretariat.

322. A consultant was hired by Executive Council to make proposals on briefing note commissioning, preparation and dissemination. The report is not yet completed.

---

[258] Evidence of Premier Williams, 28/10/2008, p. 14, line 14
[259] See Paragraph 242 above
[260] Exhibit P-0126

Email Archiving

323. Emails disclosed by Eastern Health from employees for the Province were sometimes not retrievable in the Province's email archives. Similarly, emails between employees for the Province might be available in one person's archive but not in the other. Major gaps in email archives were noticeable as well.

324. An erroneous assumption existed that all government email is kept indefinitely on a back-up device.

325. A revised email policy was approved by Treasury Board in August 2007.

326. On 23 April 2008, the Clerk of the Executive Council sent a directive to Deputy Ministers stating that all emails that qualify as public records must be retained. A public is a record "created by or received by a public body in the conduct of its affairs…." This directive served to remind departments to ensure that emails that constitute public records are properly archived.

Database Management in the Regional Health Authorities

327. The Province recognized that searching for affected patients as the ER/PR Issue unfolded may have been impeded by the lack of quality information management infrastructure and personnel.

328. On 22 February 2008, the Provinces announced a $2.1 million investment for the consolidation of clinical information systems within Eastern Health, a plan for consolidations of similar systems in other regional health authorities, a needs assessment for electronic document tracking systems for each health authority, and funding for five new data management professionals throughout the system.[261]

Coordination with the Regional Health Authorities in the Management of Adverse Health Events

329. Evidence disclosed at the Commission of Inquiry showed that a lack of coordination and communication existed between the four regional health authorities throughout the ER/PR Issue.

330. On 22 February 2008, the Province announced a new policy stating that whenever a multi-patient adverse health event occurs affecting more than one regional health authority, a single official within one of the authorities shall be charged with clear organization-wide authority to direct patient contact and data

[261] Exhibit P-1050, p 2, p 3

management. The responsible person must also have access to an appropriately trained data management professional to provide timely and auditable reports.[262]

Access to Information

331. Section 20 of the ***Access to Information and Protection of Privacy Act***,[263] ("ATTIPA") states that:

> 20(1) The head of a public body may refuse to disclose to a an applicant information that would reveal
>
> (a) advice or recommendations developed by or for a public body or a Minster

332. Evidence was lead during the Inquiry that illustrated confusion about whether the questions included in Question and Answer briefing notes for ministers were advice and therefore automatically exempted under section 20(1)(a).

333. Coates testified that all questions were removed from Questions and Answer briefing notes before the notes were released under ATIPPA requests and that no consideration was given to whether or not the questions constituted advice. As well, no notations were made on the documents to indicate why and where a portion had been redacted.

---

[262] Exhibit P01050, p.4; Evidence of Thompson, 09/05/2008, pp.287-289
[263] RSNL 2002, c. A-1.1

334. ATIPPA coordinators are the persons employed by the Province to interpret and apply ATIPPA and to coordinate ATIPPA responses. They have been instructed to examine the questions included in Question and Answer briefing notes on a case by case basis to determine whether the questions constitute advice. As well, margin notes are now made on documents to highlight a redaction.

Interaction of the Minister with Regional Health Authorities

335. How the Minister interacts with Regional Health Authorities is addressed under Issue C above, beginning at paragraph 174.

336. Due in part to the ER/PR Issue, the Province was motivated to clarify the role of the Minister respecting his/her interaction with the regional health authorities.

Quality Assurance and Accreditation in Laboratories

337. The Province has provided funding for improved quality assurance and accreditation at the Eastern Health laboratories.

338. On 22 February 2008, the Province announced $100,000 for the necessary planning associated with the establishment of a laboratory accreditation system and $175,000 per year for Eastern Health to follow through on education, training and quality assurance activities related to ER/PR testing.

339. In the press release, the Minister stated that, "This funding will allow for pathologists and technologists to participate in relevant raining programs each year, and allow for external reviewers to visit the Eastern Health laboratory to assess current practice against best practices elsewhere."[264]

340. The Department is currently establishing a Quality Network team lead by the Department. The team will assess quality initiatives and other programs with a view to ensuring that laboratory standards exist across the health care system.[265]

341. The Premier raised the issue of pathology laboratory accreditation at the 2008 Council of the Federation meeting.[266] The Council directed Health Ministers to review this topic and pursue appropriate collective action. Since that time, Health Ministers have asked the Province to take the lead role on this issue and to develop proposals for consideration. The Department is drafting letters to all jurisdictions in order to schedule a meeting. At this meeting, the Department hopes to identify issues and challenges and then report back to the Minister.

---

[264] Exhibit P-1050, p. 2
[265] Ibid., p. 3
[266] Evidence of Premier Williams, 28/10/2008, p. 33

Pathologists/Oncologists Compensation

342. The Province recognized the need to stabilize pathologist and oncologist employment.[267] The current environment of public concern, combined with high workloads and shortages, created the possibility that additional oncologists and pathologists would leave the province. Therefore, the Province acted outside the normal bargaining timelines with physicians to provide incremental compensation to oncologists and pathologists.

343. In May 2007, the Province provided the oncology stipend to pathologists.

344. In May of this year, the Province announced a substantially improved salary package for the pathologists. Pathologists working in St. John's would now receive an average total compensation package of $348,000 and those working outside St. John's would receive an annual package of approximately $364,000.[268] The compensation package is on par with that of pathologists practicing in Ontario.[269]

Task Force on Adverse Health Events

345. The Task Force on Adverse Health Events ("the Task Force") was established to research a broad array of events, from single patient to multi-patient to events

[267] Exhibit P-0199
[268] Evidence of Robert Ritter, 11/06/2008, pp. 320, 322, 326
[269] Evidence of Dr. Nebojsa (Nash) Denic, 11/09/2008, pp. 169-173

that involve more than one regional health authority. It has been mandated to determine whether a change in law, policy and practice is required to properly respond to adverse health events.

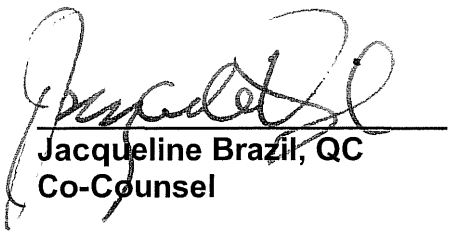
346. Thompson describe the Task Force's mandate as follows:

> "Well, our mandate was to look at the general category of adverse events, all the way from single patient events to multi-patient, multi jurisdiction events and determine whether our health system in this province has the current capacity, the current policies and resources to respond in a timely and effective manner when events occur. So we've completed a review of existing policies and interviews and case studies and so forth, and we're going to look at, in the report, all the stages of adverse event management, from the identification of an occurrence that may be an adverse event, look at how it gets assessed at that stage and how assessment tools are used, if a further investigation is required into serious adverse events. We'll be looking at disclosure processes and disclosure policies. We'll also be looking at the evaluation processes, monitoring of all of those policies and systems, how they work, and so all the steps and stages between identification and the final implementation of recommendations, including, I should add, the whole area of coordination within RHAs when there's a multi patient event, the whole area of leadership and also public communications, because sometimes, of course, public concern may be engaged in regard to an adverse event and an RHA may need to develop a public communications plan. Se we're trying to capture the whole breadth and make recommendations on the whole area.[270]

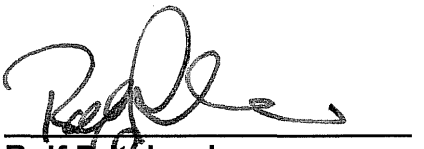
347. The Task Force Report will be released publicly in early December 2008 and will be available for the Commission's use at that time.

[270] Evidence of Thompson, 24/10/2008, pp 129-130, line 11

The foregoing is respectfully submitted on behalf of Her Majesty in Right of Newfoundland and Labrador this first day of December 2008.



Jacqueline Brazil, QC
Co-Counsel



Rolf Pritchard
Co-Counsel

Office of the Secretary to
Cabinet for the Management
Of Health Issues
West Block, Confederation Building
St. John's, NL

Bernard M Coffey, QC / Sandra R Chaytor, QC
Commission of Inquiry on Hormone Receptor Testing
50 Tiffany Lane
St. John's, NL
A1A 4H7

Daniel W Simmons
White, Ottenheimer & Baker
PO Box 5457
6th Floor, Baine Johnston Centre
10 Fort William Place
St. John's, NL
A1C 5W4
Counsel for Eastern Regional Health Authority

Peter N Browne, QC / Jane C Hennebury
Curtis, Dawe
PO Box 337
11th Floor, Fortis Building
139 Water Street
St. John's, NL
A1C 5J9
Counsel for Dr. Kara Laing et al.

J David B Eaton, QC / David B Pritchett
McInnes, Cooper
PO Box 5939
5th Floor, Baine Johnston Centre
10 Fort William Place
St. John's, NL
A1C 5X4
Counsel for Central Regional Integrated Health Authority, Western Regional Integrated Health Authority, and Labrador-Grenfell Regional Integrated Health Authority

Jennifer L Newbury
Martin, Whalen, Hennebury & Stamp
PO Box 5910
15 Church Hill
St. John's, NL
A1C 5X4
Counsel for Canadian Cancer Society, Newfoundland and Labrador Division

Chesley F Crosbie, QC
Ches Crosbie Barristers
169 Water Street
St. John's, NL
A1C 1B1
Counsel for Members of the Breast Cancer Testing Class Action

D. Mark Pike, QC
Benson Myles
PO Box 1538
9th Floor, Atlantic Place
215 Water Street
St. John's, NL
A1C 5N8
Counsel for Newfoundland and Labrador Medical Association

Daniel M Boone
Stewart McKelvey
PO Box 5038
11th Floor, Cabot Place
100 New Gower Street
St. John's, NL
A1C 5V3
Counsel for Healthcare Insurance Reciprocal of Canada