COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

June 19, 2008

Appearances:

Bernard Coffey, Q.C. .... Commission Co-counsel
Sandra Chaytor, Q.C. .... Commission Co-counsel

Rolf Pritchard/Stephen Mills .... Her Majesty in Right of NL

Peter Browne/
Jane Hennebury .... Doctors Kara Laing et al
Daniel Simmons .... Eastern Regional Integrated
.... Health Authority
Chesley Crosbie, Q.C./
Pamela Taylor .... Members of the Breast Cancer
.... Testing Class Action
Mark Pike .... NL Medical Association
Jennifer Newbury ..... Canadian Cancer Society (NL Division)
Stacey O'Dea/
Blair Pritchett. .... Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

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MR. RICK SINGLETON - SWORN

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1 COMMISSIONER:
2 Q. Please be seated. Ms. Chaytor.
3 MR. DARRELL HYNES, EXAMINATION BY SANDRA CHAYTOR, Q.C.
4 (CONTINUED)
5 CHAYTOR, Q.C.:
6 Q. Good morning, Commissioner. Good morning, Mr.
7 Hynes.
8 MR. HYNES:
9 A. Good morning.
10 CHAYTOR, Q.C.:
11 Q. If we could have, please, P-1626? Mr. Hynes,
12 this is the next document we have in the
13 chronology in which your name appears, and
14 it's March 3rd, 2006. And it's an e-mail from
15 an Erica Warren on that date. And first of
16 all, perhaps you could tell us, who is Erica
17 Warren?
18 MR. HYNES:
19 A. Ms. Erica Warren was the constituency
20 assistant to Jim Hodder, who at that time was
21 the MHA for Port au Port.
22 CHAYTOR, Q.C.:
23 Q. And do you recall this exchange, what was this
24 about?
25 MR. HYNES:

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1 A. Yes, I remember Erica had called me around
2 that time and we had some phone exchanges and
3 she followed up with this e-mail, which wasn't
4 uncommon for me to get in my role, to get
5 inquiry from an MHA or a minister's office
6 asking for some more information. And she had
7 sent me this information on behalf of a
8 constituent whose name, of course, is blocked
9 out, but just to see what I understood about
10 the issue, I guess, and to provide her with
11 some information that she could go back with.
12 CHAYTOR, Q.C.:
13 Q. Okay. So this was an inquiry from a patient?
14 MR. HYNES:
15 A. Yeah.
16 CHAYTOR, Q.C.:
17 Q. And why would Ms. Warren contact you about
18 this?
19 MR. HYNES:
20 A. Well, I guess the patient had gotten a letter,
21 by the read at the bottom of the e-mail, and I
22 guess had contacted her local MHA just looking
23 for information or assistance about what it
24 all meant. And that's not uncommon,
25 especially in rural Newfoundland that

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1 frequently people go to their MHA as a
2 resource or for front-line information when
3 they, you know, need help or assistance with
4 government. And then Erica subsequently
5 followed up with this e-mail to me, I guess,
6 just to see what I may have known about it.
7 CHAYTOR, Q.C.:
8 Q. Okay. And it says in your reply to Erica,
9 "Hi, Erica. There is a history on this one.
10 Unfortunately, the mistakes that occurred with
11 ER/PR testing has identified some people who
12 may have received inappropriate treatment.
13 This was only detected recently." What did
14 you mean by that, that this is now March of
15 2006, what was only detected recently?
16 MR. HYNES:
17 A. That, I guess, that's probably a poor choice
18 of words there. I mean, obviously if you go
19 back over a period of time, this was first
20 detected approximately a year ago or nine
21 months ago, but I guess it was more that this
22 lady, I believe her situation when she called
23 might have been sometime ago, like, probably
24 five years ago or more and this information, I
25 guess, only recently came to light. So that's

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1 perhaps what I meant there, it was within the
2 past year.
3 CHAYTOR, Q.C.:
4 Q. Okay. And you go on in the second paragraph
5 to state, "We are currently retesting hundreds
6 of samples going back six years. Some change,
7 most do not. All individuals have been
8 contacted, etcetera." So "We are currently
9 retesting hundreds of samples going back six
10 years." This is March, 2006. Did you
11 understand--what did you understand was the
12 stage of the retesting at this point in time?
13 MR. HYNES:
14 A. That would have been my very general
15 recollection at that time. Obviously, you
16 know, it was probably long than six years,
17 probably six and a half to seven, but that
18 would have been my loose understanding based
19 on briefing notes and other information I had.
20 Again, I mean, this type of e-mail I would
21 have gotten fairly frequently and I would not
22 go back with significant detailed briefing
23 notes because, you know, we don't release that
24 information to MHAs or other offices. I would
25 have been trying to give, I guess, Erica a

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1 thumbnail sketch and some idea of what had
2 happened as best I could of what the situation
3 was.
4 CHAYTOR, Q.C.:
5 Q. And in using the term "We are currently
6 retesting." using the word "we" were you
7 differentiating between the department and
8 Eastern Health?
9 MR. HYNES:
10 A. You know, obviously I meant Eastern Health
11 were engaged in that process but, you know,
12 sometimes, unfortunately, you use that
13 interchangeably when you're busy that, you
14 know, I guess it's still government and the
15 Department of Health. But, I mean, obviously
16 Eastern Health were the ones going through the
17 process.
18 CHAYTOR, Q.C.:
19 Q. And you indicate that "All individuals have
20 been contacted." What was your source of
21 knowledge at this point, March of 2006, that
22 all individuals have been contacted?
23 MR. HYNES:
24 A. I certainly would have gleaned that from
25 information through briefing notes and

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1 information in the department. I mean, I
2 think at that point, you know, we were at
3 least told it was widely understood that
4 everyone had been contacted.
5 CHAYTOR, Q.C.:
6 Q. And contacted with what, were they contacted
7 to be told they would be retested or they had
8 been contacted with their results?
9 MR. HYNES:
10 A. You know, I don't know if I had a clear
11 understanding at that time about what exactly-
12 -I mean, all I remember knowing was everyone
13 had been contacted, and whether that was to
14 give the initial or tell them that, you know,
15 all their results were back and, you know,
16 there had been a change or not a change.
17 CHAYTOR, Q.C.:
18 Q. Okay. And you go on and suggest, of course,
19 that "Her diagnosis and treatment should be
20 discussed with her oncologist." You end by
21 saying, "Let me know if you need more." Was
22 there any further contact from Ms. Warren on
23 this issue?
24 MR. HYNES:
25 A. No. Again, when I checked my phone logs, we

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1 chatted about it once or twice, but I think it
2 was just Erica perhaps called, you know, for
3 more information about medical transportation,
4 what may or may not have been available under
5 that program.
6 CHAYTOR, Q.C.:
7 Q. And what was that issue about, the medical
8 transportation for her?
9 MR. HYNES:
10 A. Government offers a medical transportation
11 assistance plan to assist people who have to
12 travel distances to access medical treatments
13 that are not available in their local
14 community. And where this lady, presumably
15 when it was in Mr. Hodder's district, which is
16 Port au Port out on, you know, the southwest
17 coast, I guess, that, you know, she may have
18 been--if she had to come to St. John's for
19 additional treatment and follow up that there
20 may be some assistance available to her. And
21 I suggested she follow up with the lady named
22 there, who is the manager of the program, for
23 more information to see if she was eligible.
24 CHAYTOR, Q.C.:
25 Q. And do you know whether or not that happened,

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1 not necessarily with respect to this person,
2 but was there any provision made for the
3 patients who had to travel back into St.
4 John's for any additional treatment or
5 consultations?
6 MR. HYNES:
7 A. I'm not--I don't know if Eastern Health may
8 have offered some special offset program for
9 these people specifically impacted. Otherwise
10 they would just be eligible for whatever Pan-
11 Provincial programs there would be available,
12 whether through human resources, labour and
13 employment or the Medical Transportation
14 Assistance Program offered by the Department
15 of Health.
16 CHAYTOR, Q.C.:
17 Q. Did you receive any similar contacts or
18 inquiries from anybody else?
19 MR. HYNES:
20 A. Not that I recall.
21 CHAYTOR, Q.C.:
22 Q. And no contacts directly from patients?
23 MR. HYNES:
24 A. No. I vaguely remember me and Minister
25 Osborne discussing a call he had gotten and I,

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1 looking back now, Ms. Chaytor, I believe
2 that's what lead to our discussion in August
3 of '06, that the minister had gotten one or
4 more calls from constituents in his district
5 that were impacted, I guess, by this process
6 and were asking the minister, you know, what
7 had happened, we can't seem to get answers,
8 etcetera, and that's what lead the minister to
9 ask me to arrange a briefing on the whole root
10 cause issue in August of '06.
11 CHAYTOR, Q.C.:
12 Q. Okay.
13 MR. HYNES:
14 A. That's the only other clear recollection I
15 have about individual patient contacts.
16 CHAYTOR, Q.C.:
17 Q. Okay. And perhaps then we could look at that
18 at P-0169, I believe it is. And this is your
19 handwritten note, which has been transcribed,
20 of August 2nd, 2006 "Meeting with Honourable
21 Tom Osborne." And one of your notes says
22 "ER/PR briefing for minister. What was root
23 cause?" So, Mr. Hynes, your recollection is
24 that the minister received a couple of
25 inquiries from his constituents wondering this

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1 very issue, what happened, what caused the
2 problem. And so at this point in time you
3 started to try and arrange to have a briefing
4 for the minister?
5 MR. HYNES:
6 A. Yes. I mean, I certainly remember during that
7 spring and early summer it was raised a couple
8 of times. I believe I mentioned yesterday the
9 minister raised with Deputy Minister Abbott at
10 the time to have something set up. But I was
11 leaving, starting annual leave this day and I
12 ran through a number of things, the rest of
13 them, of course, are blocked out there because
14 they're not relevant, but I ran through a
15 number of things with the minister and that
16 was a direction, I mean, because he at this
17 point still didn't have a clear understanding
18 himself, and I, before I left, asked Mr.
19 Abbott to set up something.
20 CHAYTOR, Q.C.:
21 Q. Okay. And in the inquiries that were made,
22 you approached Mr. Abbott. Did you also speak
23 with Ms. Hennessey?
24 MR. HYNES:
25 A. No. I recall leaving the minister's office

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1 and John, Mr. Abbott happened to be in his
2 office and going right into his office and
3 chatting about a couple of things he needed to
4 follow up on and that was one of them.
5 CHAYTOR, Q.C.:
6 Q. And do you know whether the minister was ever
7 told that Ms. Hennessey had looked for the
8 findings from the external review reports, the
9 report I showed you yesterday from Dr.
10 Banerjee as well as Ms. Wegrynowski's report,
11 do you know whether or not the minister was
12 ever told that Ms. Hennessey had looked for
13 that information back in November of 2005?
14 MR. HYNES:
15 A. Not that it was shared with me, no.
16 CHAYTOR, Q.C.:
17 Q. And do you think if the minister were aware of
18 that, you'd be aware of it?
19 MR. HYNES:
20 A. I would think so, yes.
21 CHAYTOR, Q.C.:
22 Q. And in relation to this time period, when the
23 minister is posing this question, "What was
24 the root cause" did anyone suggest that
25 perhaps we should ask what happened with the

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1 external reviews?
2 MR. HYNES:
3 A. I don't remember making the link or Mr. Abbott
4 suggesting to me or even me suggesting to Mr.
5 Abbott that, you know, that could form a basis
6 of the briefing, so I don't know if we knew at
7 the time perhaps that the reviews were in and
8 done.
9 CHAYTOR, Q.C.:
10 Q. And in asking what was root cause, what do you
11 understand the minister to be asking, what
12 does root cause mean?
13 MR. HYNES:
14 A. You know, essentially what this was all about,
15 what exactly had happened.
16 CHAYTOR, Q.C.:
17 Q. So what had happened to cause the change in
18 results?
19 MR. HYNES:
20 A. Yes. Whether that was technology or a system
21 error or human error or a systemic problem in
22 the lab, whatever that would mean.
23 CHAYTOR, Q.C.:
24 Q. So I take it the minister at this point in
25 time was realizing that information wasn't

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1 forthcoming or he didn't have that information
2 and he's looking to have this question
3 answered?
4 MR. HYNES:
5 A. Again, you know, he certainly had no comfort
6 level whatsoever. And I remember, you know,
7 he asked me and, I mean, I was supposed to be
8 a senior advisor and I had no answer to give
9 him, which was troubling for me.
10 CHAYTOR, Q.C.:
11 Q. Mr. Hynes, were you involved, during your time
12 with the department, in any of the
13 negotiations with the NLMA for salary
14 increases for the pathologists?
15 MR. HYNES:
16 A. Yes, I remember attending--now, it's, I'll
17 back up a bit, I guess. I mean, obviously
18 negotiations would be through Treasury Board,
19 that's the, you know, the employer of
20 government and that would actually be hands
21 on. But I remember in the '06 there as a fair
22 amount of discussion at the executive meetings
23 of proposals that were going forward to
24 Treasury Board looking for additional salary
25 for oncologists and pathologists, actually.

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1 So around the whole period of May, as early as
2 May, right up until August there was certainly
3 frequent discussions around the executive
4 table and the department about the issue. And
5 I remember attending a meeting with Minister
6 Osborne on this issue with a number of
7 oncologists on May 1st, 2006.
8 CHAYTOR, Q.C.:
9 Q. Okay. And, I'm sorry, this was around May?
10 MR. HYNES:
11 A. This was May 1st, 2006, yes.
12 CHAYTOR, Q.C.:
13 Q. And what do you recall about that?
14 MR. HYNES:
15 A. I remember it was, the minister was there and
16 myself, Mr. Rob Ritter, Mr. John Abbott, the
17 Deputy Minister, Dr. Laing was there, Dr.
18 Ganguly, and I believe one or more doctors,
19 and I apologize, I can't recall their names. I
20 don't have my notes here from the meeting in
21 front of me.
22 CHAYTOR, Q.C.:
23 Q. Okay. And what was the purpose of the
24 meeting?
25 MR. HYNES:

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1 A. There was a great amount of frustration around
2 the table that I guess there was ongoing
3 salary issues, which I came to understand had
4 been ongoing with the department for some time
5 were not being addressed. And there was three
6 or four key things that they wanted to get the
7 minister's ear on to try to see if we could
8 get some resolution because in their view the
9 discussions with the department had reached an
10 impasse and were not getting anywhere.
11 CHAYTOR, Q.C.:
12 Q. Okay. And, I'm sorry, the physicians in
13 attendance were Dr. Laing?
14 MR. HYNES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. And who else?
18 MR. HYNES:
19 A. Dr. Ganguly.
20 CHAYTOR, Q.C.:
21 Q. Dr. Ganguly.
22 MR. HYNES:
23 A. Yeah.
24 CHAYTOR, Q.C.:
25 Q. Okay. So was -

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1 MR. HYNES:
2 A. And at least one or two more and I--maybe Dr.
3 Siddiqui sounds familiar but I can't, you
4 know, because I don't have my notes in front
5 of me.
6 CHAYTOR, Q.C.:
7 Q. So these were oncologists?
8 MR. HYNES:
9 A. Yeah.
10 CHAYTOR, Q.C.:
11 Q. Yes, okay. If we could look at, please, P-
12 1652. And, Mr. Hynes, what was the outcome of
13 that meeting with the oncologists?
14 MR. HYNES:
15 A. They raised a number of issues involving
16 salary. Dr. Laing's clinical definition of
17 her administrative duties, that became a
18 fairly significant focal point to the meeting.
19 CHAYTOR, Q.C.:
20 Q. Yes.
21 MR. HYNES:
22 A. Case loads, I'd call it for lack of a better
23 word, what was an appropriate number of
24 patients for an oncologist to see versus the

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1 amount they were paid. And I remember there
2 was also a fore-point about how exactly their
3 payments were administered, whether it was
4 lump sum versus annually or semi-annually,
5 whatever, I remember that was an issue, how
6 exactly the money was transferred, so.
7 CHAYTOR, Q.C.:
8 Q. Okay.
9 MR. HYNES:
10 A. Oh, sorry, the outcome was at the end of it
11 Dr. Ganguly did most of the talking and I
12 remember a couple of times he seemed very
13 frustrated and upset, but at the end of it the
14 minister agreed to review some issues and some
15 information they had and Dr.--or, sorry, Mr.
16 Ritter was to follow up with a letter to the
17 minister very shortly after. And that letter
18 subsequently came in.
19 CHAYTOR, Q.C.:
20 Q. And were the oncologists concerns then
21 addressed at that point in time?
22 MR. HYNES:
23 A. I think partially, but I still--you know,
24 especially some of the information about what
25 would be an appropriate number of patients,

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1 because part of the discussion became, and
2 I'll just go from memory, that a patient in
3 Newfoundland, once you're seen by an
4 oncologist once, you're on that--you're that
5 doctor's patient for life, so to speak,
6 whereas in other jurisdictions once you leave,
7 if you're referred again, it would be an
8 additional billing because you'd be considered
9 a new patient, some of the nuances about how
10 things work. So the minister agreed to review
11 the national literature and the national
12 standards for what would be an appropriate
13 number. Because I believe what the department
14 was proposing was approximately 186 and--or
15 sorry, what they wanted was approximately 186
16 as a standard and I think the department was
17 up around 211, 213 and they viewed that as an
18 unmanageable, too high an amount.
19 CHAYTOR, Q.C.:
20 Q. And so was it lowered after that?
21 MR. HYNES:
22 A. I can't be definitive on what--I know there
23 was a letter wrote to the minister, very
24 detailed, lengthy letter, and I remember the
25 minister, I remember the minister sending a

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1 letter back and I remember we discussed it at
2 an executive meeting and I remember Mr. Abbott
3 saying that they're going to be happy on some
4 things and no happy on others.
5 CHAYTOR, Q.C.:
6 Q. And was there any change to whether or not a
7 patient would be considered a patient for life
8 or if that patient gets seen by another
9 oncologist, was that change made?
10 MR. HYNES:
11 A. You know, that was one of the things that
12 factored into this how the numbers were
13 computed. I don't know if that particular one
14 was changed or not, because again, I don't
15 have--the correspondence was fairly lengthy
16 and detailed.
17 CHAYTOR, Q.C.:
18 Q. Okay. But basically the complaint of the
19 oncologists was workload?
20 MR. HYNES:
21 A. Yeah, to a large degree, yes.
22 CHAYTOR, Q.C.:
23 Q. And what about any meetings or attendance at
24 meetings or taking part in any discussions
25 regarding pathologists' workload and/or

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1 remuneration, did you take part in any of that
2 discussion?
3 MR. HYNES:
4 A. No, I don't remember. I remember certainly at
5 one point, I believe, one of the ministers met
6 with the group, because, again, there was a
7 significant amount of frustration. I was not
8 a party to that meeting, but I do remember,
9 again, during the whole period of, you know,
10 the whole period of May to June, July, August,
11 '06 in the executive meeting it was discussed
12 a number of times because the pathologists, I
13 believe they were getting very low on numbers,
14 which meant, you know, there was a fair number
15 of vacancies and their ability to attract and
16 retain people they viewed was significantly
17 impacted by their salary.
18 CHAYTOR, Q.C.:
19 Q. And the exhibit I've brought up here, Mr.
20 Hynes, 1652, this is a PowerPoint presentation
21 Mr. Ritter gave regarding a presentation on
22 pathologists' remuneration. And I just take
23 you quickly through this. Does this look
24 familiar, were you in attendance for this
25 PowerPoint presentation? I believe it may

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1 have taken place around sometime in July of
2 2006?
3 MR. HYNES:
4 A. No, I don't remember seeing this.
5 CHAYTOR, Q.C.:
6 Q. Okay. And if we could look, please, at P-
7 0173? This is an e-mail from Ms. Mundon to
8 yourself, amongst others in the department,
9 including the minister. And the subject is
10 "41 Join Class Action Bid on Faulty Breast
11 Cancer Test." And it's a copy of the CBC News
12 story of the same date, October 19th. Was
13 this issue, the class action, the subject of
14 discussion in the department around this time?
15 MR. HYNES:
16 A. I'm sure it would have been discussed. I
17 can't be definitive about an individual
18 conversation, but I'm sure we would have been
19 aware of it.
20 CHAYTOR, Q.C.:
21 Q. Okay. And -
22 MR. HYNES:
23 A. Because, I mean, once legal action has
24 commenced, there's a different mind set about
25 what you can say and do in government.

1 CHAYTOR, Q.C.:
2 Q. Okay. Well, tell the Commissioner, please,
3 about that?
4 MR. HYNES:
5 A. You know, from my view, I guess, government,
6 Madam Commissioner, is very cautious once
7 we're served with any legal papers that, I
8 mean, what you can say and do publicly is very
9 restricted, and that would always be the
10 advice I was given in my various positions.
11 CHAYTOR, Q.C.:
12 Q. Okay. And why would that be, why would you be
13 restricted in what you can say?
14 MR. HYNES:
15 A. I can only give a personal example. I
16 remember when I was in the Department of
17 Education with Minister Ottenheimer, we chose
18 to meet with an individual who was suing the
19 government and the minister chose to meet with
20 him and he asked me to sit in on the meeting.
21 We met with the individual, and after the fact
22 I was taken to task by the deputy or assistant
23 deputy minister at the time asking me what I
24 thought I was doing. And when I inquired, he
25 said, b'y, he said, you know, this gentleman

1 got an action against government. He said,
2 you can't be jeopardizing our case and you
3 know, jeopardizing the Department of Justice's
4 case because you're going to be called as
5 witness and compromise evidence. I didn't
6 understand some of the stuff he was telling
7 me, but I just thought it was a bit--you know,
8 in my view the minister could meet with
9 whoever he wanted if it was an education
10 issue.
11 CHAYTOR, Q.C.:
12 Q. Okay. And of course, in this case the
13 government wasn't directly sued, the
14 government is not a defendant to the class
15 action. Does that make any difference in the
16 government's ability to be able to speak on
17 the issue?
18 MR. HYNES:
19 A. No, but I guess if, I guess, you know, you
20 could say there would always be the--always be
21 the--that you could be brought into it after
22 the fact as a named defendant, I guess. So
23 again, I mean, once legal papers were served,
24 I mean, I remember always being told, I mean,
25 you know, you got to try to step back and not

1 get involved and not say anything.
2 CHAYTOR, Q.C.:
3 Q. So Mr. Hynes, from this point forward then,
4 once the action was served, did that influence
5 Government's speaking on the ER/PR issue?
6 MR. HYNES:
7 A. Well, I mean, this was still very much
8 Eastern--it was up to Eastern Health to
9 communicate what the results were and as
10 tissue samples come back. I mean, I don't
11 remember any--I don't believe there was ever
12 any media inquiries or ever any information
13 that we didn't respond to, and I mean, you
14 know, I guess you'd have to check with the
15 communications people on that. So I mean,
16 Government would never deliberately not
17 respond to an issue, but I mean, this was
18 still very much Eastern Health's issue to
19 manage and respond to and answer, you know,
20 answer inquiries about how many patients have
21 been sent away, what's the--you know, what's
22 the rate of error or what's the rate of how
23 many are back, how many are sent away still
24 and that kind of thing.
25 CHAYTOR, Q.C.:

1 Q. So we seen in some of the briefing notes that
2 there is reference to now that the legal
3 action has commenced, then we'll have to let
4 the Courts determine or for that to take its
5 course in terms of particularly what may have
6 went wrong or whether or not error--there was
7 an error in this case. Do you remember that
8 being discussed in the Department at the time,
9 that you would be somehow limited or
10 restricted in addressing issues such as what
11 went wrong and whether or not there was error?
12 MR. HYNES:
13 A. Not me myself, because I still don't remember
14 having a clear understanding of what went
15 wrong, but I guess, the Minister, the advice
16 to the Minister certainly would have been to
17 be cautious because what you could say could
18 jeopardize Eastern Health's authority or
19 future claims against Government, and again,
20 there was, you know, a fairly widely
21 understood premise, in my view, that once a
22 government agency, and Eastern Health
23 indirectly, I mean, ultimately reported to
24 Government, that you'd have to be very
25 cautious about what you were saying and doing

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1 in public.
2 CHAYTOR, Q.C.:
3 Q. So Eastern Health's decision in December 2006,
4 if their decision was based on legal advice,
5 to be careful what they said about the cause
6 of the problem or the extent of the problem,
7 how many people had been impacted because that
8 might jeopardize the defence, that would have
9 been understood by Government and acknowledged
10 by Government as being something that you have
11 to be careful and cautious on speaking to, if
12 it's going to jeopardize the defence?
13 MR. HYNES:
14 A. No, I don't remember specifically being told
15 by Eastern Health that that's what they were
16 going to do and why.
17 CHAYTOR, Q.C.:
18 Q. But if that is what they decided to do for
19 those reasons, that would not be questioned by
20 Government?
21 MR. HYNES:
22 A. I'm not sure I'm following your question.
23 CHAYTOR, Q.C.:
24 Q. If there's an understanding that once an
25 action is started that you have to be cautious

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1 in what you say because it may jeopardize the
2 defence, if Eastern Health made a decision to
3 limit certain information in December 2006
4 based on legal advice, then that would be
5 accepted by Government?
6 MR. HYNES:
7 A. No, I wouldn't use the word "accepted" because
8 in December, I don't--we never knew. I don't
9 believe anyone--I know personally, I never
10 picked up on the fact that what we were told
11 in November was not released in December.
12 CHAYTOR, Q.C.:
13 Q. And if, though if the Government were to have
14 been told out front, "this is what we're going
15 to do. Here's what we're going to do. It's
16 based on legal advice. We can't jeopardize
17 the defence," would Government have taken any
18 issue with that?
19 MR. HYNES:
20 A. Well, I mean, I can only speak to my
21 understanding, Ms. Chaytor. My understanding
22 was, from November to December, they weren't
23 going to talk about issues of causation, but
24 the numbers and everything else that we were
25 shown in November would be released as it was.

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1 It was only the issue of causation, and my
2 notes bear that out, was going to be, you
3 know, probabilities for the Courts to clarify.
4 CHAYTOR, Q.C.:
5 Q. So you understood that they wouldn't be
6 speaking on the issue of causation and that
7 was related to the ongoing litigation?
8 MR. HYNES:
9 A. That's my understanding from November 23rd,
10 2006, yes.
11 CHAYTOR, Q.C.:
12 Q. If we could look, please, at P-1477? And it's
13 page four of this document, Mr. Hynes. By the
14 way, is your mouse working today?
15 MR. HYNES:
16 A. I think so.
17 CHAYTOR, Q.C.:
18 Q. Is it? Okay. It's working for you?
19 MR. HYNES:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. No, it's not.
23 MR. HYNES:
24 A. Oh, maybe.
25 CHAYTOR, Q.C.:

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1 Q. Is it? Okay, you're good. This is your notes
2 from an executive meeting of October 20th,
3 2006, and I believe all we have actually are
4 your notes, so thank you for that. We don't
5 have the minutes. And you make a note "ER/PR,
6 after year all patients still not notified."
7 So Mr. Hynes, as of October 20th, 2006, so a
8 year and some months after the Government is
9 first notified of this issue, I take it it was
10 known within the Department that there were
11 still patients not notified of either the
12 issue or of their results?
13 MR. HYNES:
14 A. Well, I mean, that's a reflection of
15 discussion at the executive table, and I seem
16 to recall there was a certain sense of
17 frustration with it as well.
18 CHAYTOR, Q.C.:
19 Q. And what do you recall about that?
20 MR. HYNES:
21 A. I just remember a discussion among the
22 executive people there, and I don't have the
23 list, because I mean, there was formal minutes
24 kept, so I didn't record who happened to be in
25 attendance, but just that despite everything

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1 we had been told, here we were a year later
2 and all people were still not notified and
3 there was certainly a sense of frustration
4 among the Department officials that, you know,
5 we were at this point.
6 CHAYTOR, Q.C.:
7 Q. How did the Department know that all the
8 patients were still not notified?
9 MR. HYNES:
10 A. I don't know, Ms. Chaytor, if this was raised
11 by a certain individual based on new
12 information or if this could have been a media
13 report that day that someone reflected on and
14 that generated the discussion. I mean, I'm
15 not sure what originated the discussion, but I
16 certainly remember from the note, that was the
17 sense around the table.
18 CHAYTOR, Q.C.:
19 Q. And did you understand that it meant not
20 notified at all about the issue or had not
21 been notified of the results?
22 MR. HYNES:
23 A. I think there was--my sense of it anyway was
24 there was still people out there who hadn't
25 been contacted at all.

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1 CHAYTOR, Q.C.:
2 Q. At all, okay, and what was done about that?
3 MR. HYNES:
4 A. I believe at the meeting for October 20th, I'm
5 not sure if we would have been meeting with--
6 if we would have known the meeting subsequent
7 next month with Eastern Health officials to,
8 you know, flush out the issues. So we may
9 have--you know, we may have deferred to the
10 meeting that we knew was coming on November
11 23rd of 2006.
12 CHAYTOR, Q.C.:
13 Q. So a month later?
14 MR. HYNES:
15 A. Month later, or you know, I vaguely remember
16 Mr. Abbott making some comments, but I'm not
17 sure if he said he was going to follow up or
18 it was just he just reflected on it, you know,
19 this is -
20 CHAYTOR, Q.C.:
21 Q. I take it this was of concern within the
22 Department?
23 MR. HYNES:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. And was the Minister advised of this?
2 MR. HYNES:
3 A. I don't know. I'm unaware if I specifically
4 would have told him. I mean, sometimes after
5 these executive meetings, I would give him a
6 briefing, if I thought there was something
7 important. I mean, this may have been fairly
8 widely known, that he may have known and I may
9 have not felt that necessary.
10 CHAYTOR, Q.C.:
11 Q. So I take it if it wasn't fairly widely known,
12 you would have brought this to his attention?
13 MR. HYNES:
14 A. Yeah, if I thought this was a new startling
15 revelation that I would have--I certainly
16 would have made sure he was aware.
17 CHAYTOR, Q.C.:
18 Q. Okay.
19 MR. HYNES:
20 A. But again, I'm not sure of the context of who
21 raised this and how it came to the table.
22 CHAYTOR, Q.C.:
23 Q. Okay. Well perhaps we could look at P-0173,
24 please? And this is the news story that I had
25 taken you to about "41 join class action bid,"

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1 October 19th story from CBC, and this refers
2 to Mr. Crosbie and quotes Mr. Crosbie as
3 saying "they haven't been given any
4 information since a year ago about the rate of
5 reversal or error rate, if you want to call it
6 that." And then the patient, Geri Rogers, is
7 saying she "was alarmed to hear of mistakes.
8 They said a year ago it was ten percent, which
9 I'm hearing through the grapevine might be a
10 lot higher than that. If it was any lower,
11 then I suspect they would have told us about
12 that." And she goes on and is quoted to say,
13 "I want to know what went wrong. I want to
14 know whether it was human error or was it the
15 test itself." And at that point, she's not--
16 indicates she's not part of the class action.
17 So this is the news story right before,
18 anyhow, at least one that we're aware of right
19 before your meeting of October 20th. So does
20 that help put it in context as to what may
21 have been discussed?
22 MR. HYNES:
23 A. I'm just trying to see in the story if there's
24 any reference though to a patient who had come
25 forward and said perhaps, you know, they still

1 hadn't heard anything.
2 CHAYTOR, Q.C.:
3 Q. I don't think we see that in this news story.
4 MR. HYNES:
5 A. But it very well, you know, Ms. Chaytor, may
6 have generated discussion, you know, because
7 obviously a lot of times with these
8 transcripts, what you found was the actual
9 verbal story on CBC Radio may have been
10 different from what was on a print wire story,
11 so to speak.
12 CHAYTOR, Q.C.:
13 Q. And if we could look at P-0179, please?
14 Sorry, 0174, and this is the same date as your
15 executive meeting, and it's early in the
16 morning and Minister Osborne has asked for a
17 briefing note on this, and it's indicated here
18 that the Minister, of course, needs a briefing
19 note re: the attached, and I believe that
20 attachment was the news story. So the
21 Minister was certainly looking for an update
22 at this point in time.
23 So Mr. Hynes, from what I understand, you
24 had, back on August 2nd, the beginning of
25 August when the Minister was asking what is

1 the root cause, at that point in time, you
2 approached Mr. Abbott and you were looking to
3 set up a briefing then with Eastern Health?
4 MR. HYNES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. And that actually doesn't get arranged until--
8 or doesn't take place until November 23rd
9 2006?
10 MR. HYNES:
11 A. Yeah.
12 CHAYTOR, Q.C.:
13 Q. And what do you understand to be the reason
14 for the delay in having that briefing take
15 place?
16 MR. HYNES:
17 A. I understand that it was because Eastern
18 Health were getting towards the end of the
19 analysis and data compilation and, you know,
20 basically they were going to meet with us when
21 they were ready to release the numbers and the
22 information and give us a briefing and heads
23 up, I guess, on what they were going to go
24 with publicly, and you know, my recollection
25 and understanding is that information was not

1 available earlier than November when it took
2 place.
3 CHAYTOR, Q.C.:
4 Q. So they were waiting to have completed the
5 process before they did the briefing?
6 MR. HYNES:
7 A. That's correct, absolutely.
8 CHAYTOR, Q.C.:
9 Q. Tell us then about the meeting on November
10 23rd. I take it you attended?
11 MR. HYNES:
12 A. I did.
13 CHAYTOR, Q.C.:
14 Q. And who else was in attendance?
15 MR. HYNES:
16 A. Mr. Tilley was there, George Tilley; Dr.
17 Howell, who by this time has succeeded Bob
18 Williams; Dr. Laing; John Abbott, our deputy
19 minister; Tansy Mundon, director of
20 communications for the Department; and Susan
21 Bonnell from Eastern Health.
22 CHAYTOR, Q.C.:
23 Q. Okay.
24 MR. HYNES:
25 A. And myself, of course.

1 CHAYTOR, Q.C.:
2 Q. And how did the meeting go?
3 MR. HYNES:
4 A. The meeting went good. It was late in the
5 afternoon, as I recall, and it was over
6 outside the House of Assembly because the
7 House was sitting and we were in the Clerk's
8 boardroom, which is a fairly small boardroom
9 for the number of people we had, but the
10 Minister came out of the House and came into
11 the meeting and I think Mr. Tilley basically
12 led off the discussion with--and presented us
13 a document that I had seen for the first time,
14 the document with the numbers in it of what
15 the exact breakdown were with number of
16 patients and the various categories.
17 CHAYTOR, Q.C.:
18 Q. Okay. If we could look at P-0125, please,
19 page 42? Is this the document, Mr. Hynes?
20 MR. HYNES:
21 A. Yes, that's correct.
22 CHAYTOR, Q.C.:
23 Q. Okay, and this is called ER/PR case analysis,
24 and it's a one-page document on Eastern Health
25 letterhead.

1 MR. HYNES:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. And Mr. Tilley led the discussion around this
5 document, I take it?
6 MR. HYNES:
7 A. Yeah.
8 CHAYTOR, Q.C.:
9 Q. And was there anything in particular around
10 the document that stands out, in terms of what
11 was presented?
12 MR. HYNES:
13 A. Well, you know, seeing this for the first
14 time, I'm trying to take it in, I guess, and
15 follow the discussion, but I remember there
16 was discussion certainly around the 104
17 number, which of course was later revised to
18 117, I think, in the final. That there was
19 significant focus on the change in results and
20 for individuals that this impacted their
21 treatment, and then, you know, in my own mind,
22 I harkened back to when Dr. Laing told me that
23 people could have been helped if they had to
24 get the drug in a timely way, that you know,
25 this was 104 perhaps of these people.

1 CHAYTOR, Q.C.:
2 Q. So these were 104 who were still living, these
3 104?
4 MR. HYNES:
5 A. Yes, yeah, that's correct.
6 CHAYTOR, Q.C.:
7 Q. And how did the number, you said changed
8 eventually to 117, what's your recollection as
9 to how that happened?
10 MR. HYNES:
11 A. I believe Minister Osborne raised some issue
12 there with how the numbers were arrived at,
13 but I can't be--I mean, I remember he raised
14 it and it was--you know, I think the final
15 number was 117 when it was corrected.
16 CHAYTOR, Q.C.:
17 Q. And so you remember a focus on the number 104
18 or those who required a change in treatment?
19 MR. HYNES:
20 A. Yeah.
21 CHAYTOR, Q.C.:
22 Q. Is there anything else about the numbers that
23 stood out or you recall being discussed?
24 MR. HYNES:
25 A. No, just that on the bottom there and that's

1 actually my circle around that document, 101
2 retested and results received.
3 CHAYTOR, Q.C.:
4 Q. Yes.
5 MR. HYNES:
6 A. I remember making a note on my copy saying
7 "what were the results?" and I passed that to
8 Minister Osborne, because in my view, that was
9 significant, because if they had--you know,
10 deceased people, if the tests were redone and
11 known, then that would significantly impact
12 the numbers above. I mean, you know, people
13 that had changes, people that were impacted or
14 could have had a change in treatment plan. I
15 mean, even though they were deceased, that
16 information should have been able to be
17 accessed, I guess.
18 CHAYTOR, Q.C.:
19 Q. So you were asking how many of the deceased
20 had changes in their results?
21 MR. HYNES:
22 A. Yeah.
23 CHAYTOR, Q.C.:
24 Q. And what answer was given?
25 MR. HYNES:

1 A. Well, I remember passing the note to the
2 Minister and a discussion began and, you know,
3 because I guess, after waiting a year and a
4 half to see this, my view was, you know, why
5 not release the full numbers. If you're going
6 to release all this, and there was ever
7 indication they were, why not release the full
8 information? And I think it came down to, you
9 know, time. We want to get this out. It'll
10 take additional time if we got to send away
11 these people and wait, and everything else.
12 So they ultimately decided they would only do
13 it if the family asked, and I remember there
14 was discussion and Dr. Laing made a statement
15 that, I mean, she was obviously concerned for
16 the living and not the dead, because those
17 were the ones that she could help at that
18 point, and I remember, and by this point, the
19 meeting had gotten fairly heated, that I said
20 "well, you know, you better have a better
21 answer on December 10th when you go to the
22 media, because the families and the public are
23 going to want a better explanation than what
24 you're giving us." And it was a fairly
25 strident point, but at that point then, Mr.

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1 Tilley interjected to change the tone and the
2 mood of the meeting.
3 CHAYTOR, Q.C.:
4 Q. Okay. So you said the meeting had gotten
5 fairly heated at this point in time?
6 MR. HYNES:
7 A. Yeah.
8 CHAYTOR, Q.C.:
9 Q. So this was a heated exchange, I take it,
10 between yourself and Dr. Laing?
11 MR. HYNES:
12 A. Yeah. I mean, my voice, I was certainly
13 excited and my voice was raised and I remember
14 she had a fair amount of emotion in her face.
15 Her face got quite red because--and I
16 appreciate too, that looking back, I mean, she
17 was probably the one that over the past 15
18 months had been dealing with some of these
19 patients and, you know, it had been an
20 emotional ordeal for her. But in my mind, it
21 was still a fairly paramount point that if you
22 had this information, people are going to want
23 to know, and you know, all they were saying is
24 "well, we're not--we're concerned on a go-
25 forward basis with the living" but that's not-

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1 -if I was asking, I knew the media and the
2 families would be asking, and they didn't have
3 an answer.
4 CHAYTOR, Q.C.:
5 Q. Mr. Hynes, why were you upset about it?
6 MR. HYNES:
7 A. Well, I mean, you know, I mentioned earlier,
8 and perhaps this is the better context, I
9 mean, I still remember back in that meeting of
10 November of '05 when Dr. Laing told myself and
11 Minister Ottenheimer that there was people
12 that no question could have been impacted and
13 deceased, if they had to get this treatment.
14 So here we were, after a year and a half of
15 waiting for this information, the information
16 was not complete and you know, again, in my
17 view, if it was my loved one, my son or
18 daughter, you know, my mother or father, I'd
19 want to know, and again, you know, this would
20 significantly impact the situation and it was
21 unresolved, in my view.
22 CHAYTOR, Q.C.:
23 Q. Was there any other discussion around the
24 deceased patients?
25 MR. HYNES:

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1 A. No, just that I think they said they weren't
2 going to retest them in the interest of time,
3 at that point, or you know, do the analysis on
4 the 101 and they weren't going to, you know,
5 do the other 73 unless they were asked by the
6 families, and in the interest of time, and
7 they were going to move forward with their
8 announcement.
9 CHAYTOR, Q.C.:
10 Q. Okay. So they were going to move forward with
11 the media technical briefing?
12 MR. HYNES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. Did you understand though that the deceased
16 would be retested at some point down the road
17 or not unless the families requested it?
18 MR. HYNES:
19 A. No, not unless the families requested.
20 CHAYTOR, Q.C.:
21 Q. And what was the Minister's position on that?
22 MR. HYNES:
23 A. The Minister, you know, I seem to recall was
24 with me that, I mean, we shared the view that,
25 you know, again, if you're going to do a

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1 complete thorough disclosure, then it should
2 have been everybody, and again, if it was my
3 son or daughter, I mean, I still remember
4 making the point and I didn't mean to be
5 flippant or offensive to the doctor, but I
6 mean, I still--you know, I said "if I'm asking
7 it here now, the media is going to want to
8 know. The public is going to want to know.
9 These families are going to want to know" and
10 Eastern Health didn't have an answer.
11 CHAYTOR, Q.C.:
12 Q. Who did you understand had made the decision
13 not to retest the deceased unless the families
14 requested it? How had that decision come
15 about and who had made the decision?
16 MR. HYNES:
17 A. I can't--I don't know what Eastern Health, you
18 know, their internal process. I know at the
19 meeting, I don't believe Dr. Howell spoke at
20 all. So it's only really Dr. Laing who kind
21 of led the discussion on that particular
22 issue. So I don't know if she was the one
23 that made the decision, but she was certainly
24 the one that defended it.
25 CHAYTOR, Q.C.:

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1 Q. So in terms of Dr. Laing's comment about being
2 concerned with the living as a priority,
3 obviously, if people can be helped, the
4 decision wasn't that "well, we'll do the
5 living first and then we'll retest the
6 deceased"? The decision was "we're not going
7 to retest the deceased unless the families
8 requested"?
9 MR. HYNES:
10 A. That's right.
11 CHAYTOR, Q.C.:
12 Q. Were they going to make an announcement to
13 that effect at the technical briefing, so that
14 families would be aware of that and be able to
15 come forward?
16 MR. HYNES:
17 A. Well, again, my clear memory is that all this
18 information, this page was going to form the
19 basis of the--you know, like this is not a
20 confidential briefing note for the Minister or
21 anything like that. I mean, I don't remember
22 ever being told "Darrell, don't worry about
23 your concerns on the numbers because we're not
24 going to release that to the people" or "we're
25 not going to release that part of it." If it

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1 was such a--if they weren't going to release
2 all of it, then think they--you know, why
3 didn't they speak up? I mean, at least from
4 my perspective, all this information was going
5 to be released.
6 CHAYTOR, Q.C.:
7 Q. Okay. Including how many of the deceased had
8 been retested and that the remainder could be
9 retested upon request?
10 MR. HYNES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. What other concerns did you have regarding the
14 numbers or was it just around the deceased?
15 MR. HYNES:
16 A. You know, that became a fairly focal point to
17 the meeting, but I mean, there was other
18 discussions around rates of error that -
19 CHAYTOR, Q.C.:
20 Q. And what do you recall around that?
21 MR. HYNES:
22 A. Well, I mean, if I--can I go to my notes?
23 CHAYTOR, Q.C.:
24 Q. Absolutely. It's at P-1628, please? And
25 these are your notes from the meeting of

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1 November 23rd, 2006, which have been typed,
2 and it says that the meeting took place 3:40
3 p.m. with the individuals you noted being in
4 attendance. The first note that you have
5 here, Mr. Hynes, is "lawsuit pending,
6 difficult to do media." What was said around
7 that?
8 MR. HYNES:
9 A. Basically that Eastern Health were not going
10 to get into causation or what I understand to
11 be causation at the briefing because that
12 issue was before the Courts, which is
13 reflected further on in the notes.
14 CHAYTOR, Q.C.:
15 Q. Now Mr. Hynes, the article that I took you to,
16 October 19th, the CBC piece that I took to
17 you, what was being discussed was about what
18 had happened. This all originated--trying to
19 get this briefing originated because the
20 Minister, on August 2nd, was asking what is
21 the root cause, and in the meeting then,
22 you're being told that they can't get into
23 causation because of the lawsuit. Did they
24 offer the explanation as to the cause to the
25 Department? Was the Minister told in that

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1 meeting?
2 MR. HYNES:
3 A. No, not that I recall. The only discussion
4 was that they said they were going to stand by
5 the lab and stand by their people.
6 CHAYTOR, Q.C.:
7 Q. And what did you understand that to mean?
8 MR. HYNES:
9 A. That they weren't going to get into internal--
10 at least, you know, in the media they weren't
11 going to get into what internally may have
12 happened.
13 CHAYTOR, Q.C.:
14 Q. And who made that comment, they'll stand by
15 their lab and stand by their people?
16 MR. HYNES:
17 A. I seem to remember it was either Ms. Bonnell
18 or Mr. Tilley.
19 CHAYTOR, Q.C.:
20 Q. Did anybody -
21 MR. HYNES:
22 A. I don't remember Mr. Howell speaking at all
23 during the meeting.
24 CHAYTOR, Q.C.:
25 Q. Did anybody challenge that?

1 MR. HYNES:
2 A. No, well, I mean -
3 CHAYTOR, Q.C.:
4 Q. From a patient's perspective?
5 MR. HYNES:
6 A. Yeah. I mean, again, if--I mean, I guess the
7 rest of us knew if the lawsuit was pending,
8 and later on the meeting they get into their
9 legal defence and all that, so I--you know, I
10 don't know if it even occurred to us to
11 challenge what we understood was going to be
12 something ultimately settled with the Courts,
13 because I mean, you know, they never told us
14 that there was a clear--they never indicated,
15 at least at the meeting, that they clearly
16 understood what the problem was, and it was
17 specific thing. It was more around general
18 issues and probabilities was going to be the
19 legal defence.
20 CHAYTOR, Q.C.:
21 Q. So regardless of what they feel they can go
22 out and tell the broader public, because
23 they're feeling restricted because of the
24 lawsuit, and you're hearing that in the
25 meeting, why aren't they able to tell the

1 Department?
2 MR. HYNES:
3 A. They should have been, and I don't know--I
4 guess, I don't know if we never specifically
5 asked or asked forcefully enough, but you
6 would think they would have been able to
7 provide confidential advice to the Minister to
8 say, you know, here's what really happened.
9 CHAYTOR, Q.C.:
10 Q. And the purpose of the meeting originally was
11 for the Minister's question of what is the
12 root cause to be addressed. That question
13 still doesn't get answered at this meeting?
14 MR. HYNES:
15 A. No, because I think once we were told that the
16 lawsuit was pending, it was going to be
17 difficult to discuss causation, I think we
18 moved off it as a topic at the meeting.
19 CHAYTOR, Q.C.:
20 Q. And the Minister is obviously aware that
21 that's going to be a hot topic in the media as
22 well, because on October 19th, he asked for an
23 update on his briefing note, after receiving
24 the article, CBC news report in which that
25 question is being posed?

1 MR. HYNES:
2 A. Yeah, the class action, yeah.
3 CHAYTOR, Q.C.:
4 Q. And the Department knew that Eastern Health
5 would be moving forward with the media
6 technical briefing in December and not
7 speaking to the issue of what caused the
8 problem?
9 MR. HYNES:
10 A. That was certainly my understanding, yes,
11 ma'am.
12 CHAYTOR, Q.C.:
13 Q. Was there anything else that Eastern Health
14 indicated in that meeting they would be
15 restricted in being able to speak of?
16 MR. HYNES:
17 A. No, it was purely causation that they weren't
18 going to do anything to jeopardize their legal
19 defence or compromise their case, and that was
20 based on their, you know, advice from their
21 insurance company or lawyers.
22 CHAYTOR, Q.C.:
23 Q. You indicated that--or perhaps we'll just
24 continue on then to help you with your
25 recollection here. You have "December 10th

1 for briefing, complex." What was being
2 referred to there?
3 MR. HYNES:
4 A. That was just my note that that was the date
5 they were tentatively looking at for the
6 briefing, and again, it was going to be a
7 complex matter. I believe what they were
8 going to do was have, you know, a team of
9 clinicians, oncologists, have a technical
10 piece to explain the process of ER/PR and how
11 the lab worked and how--you know, explain the
12 very complex medical stuff, and then they were
13 going to have, you know, Mr. Tilley or whoever
14 to answer questions and actually lead the
15 press conference, so just how--you know, how
16 the press conference was going to unfold, I
17 guess.
18 CHAYTOR, Q.C.:
19 Q. And then we have 109 changes and then--and I'm
20 not sure if that was something different from
21 your handwritten note, if the nine was
22 actually a four or not, but "109 changes
23 (recommendations on what to do) three percent,
24 2800 cases, within margin of error." And so
25 this document speaks to the three percent.

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1 These are your handwritten notes from the
2 meeting. What was said around that? What
3 does that mean?
4 MR. HYNES:
5 A. I remember Ms. Bonnell speaking to this point
6 and basically saying that there was only 109
7 significant changes which would mean
8 recommendations on their treatment plan or
9 course of treatment, I guess, and of course,
10 109 of 2800 was approximately three percent.
11 CHAYTOR, Q.C.:
12 Q. And Ms. Bonnell said that?
13 MR. HYNES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. And what was meant by "within margin of
17 error"?
18 MR. HYNES:
19 A. I mean, I took it that it meant a very
20 negligible change. I mean, in my view, I
21 remember taking this as good news at the time,
22 that it wasn't as bad as we had first thought,
23 to be honest.
24 CHAYTOR, Q.C.:
25 Q. And who used those words, "within margin of

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1 error"?
2 MR. HYNES:
3 A. Ms. Bonnell or Mr. Tilley when they were
4 describing the information.
5 CHAYTOR, Q.C.:
6 Q. Now Mr. Hynes, did anyone challenge that
7 calculation? For example, did you know that
8 28 or think that 2800 cases had been retested?
9 MR. HYNES:
10 A. Well, if you--you know, and again, you have to
11 appreciate, I'm seeing this information for
12 the first time, and I mean, if they're saying
13 the rough numbers, there's 2800 cases and only
14 100, and I guess they're looking at the--
15 you're correct, it's probably a misspell on my
16 behalf. It's the change in results and
17 requires treatment change was 104. I mean,
18 I'm writing down--I'm trying to follow the
19 conversation and writing down what I'm being
20 told.
21 CHAYTOR, Q.C.:
22 Q. Okay.
23 MR. HYNES:
24 A. But I mean, I don't remember, you know, doing
25 the math in my head to figure out if that was

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1 the correct number, but the three percent was-
2 -you know, it was told of 2800, 109, all that
3 was factually told to me, so I recorded it.
4 CHAYTOR, Q.C.:
5 Q. Okay, and within the margin of error -
6 MR. HYNES:
7 A. I just want to be clear on that point, that's
8 not my analysis.
9 CHAYTOR, Q.C.:
10 Q. That's not yours?
11 MR. HYNES:
12 A. No, that's not my three percent, in my own
13 mind, because you know, that's what I was
14 told, ma'am.
15 CHAYTOR, Q.C.:
16 Q. That's what you were being told, yes, and I'm
17 just wondering if anyone asked any further
18 questions around that or how the calculation
19 of three percent had come to be.
20 MR. HYNES:
21 A. It was purely just that the three percent was
22 the 109 divided into 2800. You know, for 109
23 people, it's the only ones this really
24 mattered or affected severely.
25 CHAYTOR, Q.C.:

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1 Q. And by being given the three percent figure
2 then, that was also said in the context of
3 this is within the margin of error?
4 MR. HYNES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. So did you take that to mean that this was
8 within an acceptable margin of error for ER/PR
9 tests?
10 MR. HYNES:
11 A. Oh, clearly, that's how it was meant, that
12 this was--you know, it was within the margin
13 of error. It was within acceptable range,
14 acceptable standards, and again that's why, to
15 be honest, I took it to be--as a layperson, I
16 took it to be good news.
17 CHAYTOR, Q.C.:
18 Q. So no better or no worse than anywhere else?
19 MR. HYNES:
20 A. No, that's right. That's exactly right.
21 CHAYTOR, Q.C.:
22 Q. Was there any discussion around the term "rate
23 of error"?
24 MR. HYNES:
25 A. I don't specifically recall. I mean, the

1 three percent, in my mind, was the rate of
2 error. That's what they were--you know, the
3 whole 109 changes, recommendations, the three
4 percent, you know, this is our mistake, this
5 is our rate of error, and it's within the
6 margin of error. That's certainly what I
7 recall being told and that's my recollection.
8 CHAYTOR, Q.C.:
9 Q. And was there any indication given that they
10 would not be speaking to the total number of
11 patients who had had a change in their test
12 results?
13 MR. HYNES:
14 A. No, because I mean, you know, if you look at
15 the numbers, there were, you know,
16 approximately 200 people that had a change,
17 but it didn't impact them or there was no
18 change in their course of treatment, but I
19 mean, you know, we were always told that this
20 was the information going forward as it was.
21 CHAYTOR, Q.C.:
22 Q. And Mr. Hynes, is that what was said in the
23 meeting that those other 200 people had not
24 been impacted?
25 MR. HYNES:

1 A. That's certainly the conversation around the
2 109, that this is where the three percent
3 arrived from, you know, the recommendations on
4 what to do for the people that are affected,
5 and I mean these are people that had a
6 dramatic change in their health event, that
7 this is how they arrived at the three percent
8 number.
9 CHAYTOR, Q.C.:
10 Q. Okay, and if we could go back, please, for a
11 moment to P-0125, page 42? Under change in
12 results, but does not require treatment
13 change, 213 people, and then they're broken
14 down into a number of categories, including
15 "no recommendation because they are previously
16 treated with Tamoxifen or another aromatase
17 inhibitor, 148. This group includes a group
18 identified as being potentially impacted.
19 Those not placed on Tamoxifen for their
20 original disease but for subsequent metastatic
21 disease (13)." Was there any discussion about
22 those people, the people who were actually on
23 Tamoxifen or a similar medication because of
24 metastatic disease?
25 MR. HYNES:

1 A. No. I mean, when I--in my own mind, I was
2 doing some math, you know, towards the end of
3 the meeting, thinking that's 213 that had a
4 change. So 104, so you had--you know, there
5 was more people--the total changes were more
6 than what was presented as three percent,
7 because that's how I--you know, when I looked
8 at the number on the bottom that I circled,
9 101 were retested and results received.
10 Again, if they knew the results, then those
11 numbers could have been broken down and put in
12 the appropriate category, whether, you know,
13 it was some change to their treatment plan or
14 not, you know.
15 CHAYTOR, Q.C.:
16 Q. So in your mind, because you'd had a prior
17 conversation with Dr. Laing, there were more
18 people impacted, because she had told you that
19 some of the deceased were likely impacted?
20 MR. HYNES:
21 A. Well, that's why I remember making the note to
22 Minister Osborne. What were the results?
23 Because I knew that would be significant, and
24 I knew the media would question that issue. I
25 mean, I viewed that to be a paramount point in

1 my mind. I mean, there was more information
2 here that they had, or you know, they weren't
3 going to explain.
4 CHAYTOR, Q.C.:
5 Q. And this issue of those who were still alive,
6 but at this point in time did not require a
7 change in treatment because their disease had
8 spread and they were now being treated with
9 those drugs, that wasn't the subject of
10 discussion and how they may have been
11 impacted?
12 MR. HYNES:
13 A. No. I think it was more that for 109 people,
14 this was a dramatic, significant impact in
15 their lives and that was the one, you know, we
16 obviously focused on.
17 CHAYTOR, Q.C.:
18 Q. Was there any discussion of a number 22 or 22
19 people being greatly impacted?
20 MR. HYNES:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. Okay, and was there any discussion at all
24 about what was contained in the August 18th
25 briefing note?

1 MR. HYNES:
2 A. No, because I mean, I never saw the August
3 18th briefing note and it was never raised at
4 that table at that meeting.
5 CHAYTOR, Q.C.:
6 Q. It wasn't raised at this meeting?
7 MR. HYNES:
8 A. No.
9 CHAYTOR, Q.C.:
10 Q. By anyone in attendance?
11 MR. HYNES:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. Eastern Health, Mr. Abbott, nobody raised what
15 had come forward in August?
16 MR. HYNES:
17 A. No.
18 CHAYTOR, Q.C.:
19 Q. So Mr. Hynes, what information was it that you
20 understood, leaving that meeting, that Eastern
21 Health would not be discussing?
22 MR. HYNES:
23 A. Causation, that would--anything to do that
24 would jeopardize their legal defence, and
25 again, it's noted here in my notes, but

1 anything that would jeopardize their legal
2 defence, causation, because again there was
3 the talk of "we're going to stand behind the
4 lab, stand behind our people, and that will be
5 our defence." I mean, that's what they would
6 not talk about. Because again, when we
7 challenged on numbers, we were never told
8 what--you know, "don't worry about that,
9 Darrell, because we're not going to release
10 that part" or "we're not going to, you know,
11 go forward with that piece."
12 CHAYTOR, Q.C.:
13 Q. Okay.
14 MR. HYNES:
15 A. What I was reading, I understood, was going to
16 be released to the public in two or three
17 weeks time.
18 CHAYTOR, Q.C.:
19 Q. And what about the number of the deceased with
20 changed results, was that going to be
21 released?
22 MR. HYNES:
23 A. That's my understanding.
24 CHAYTOR, Q.C.:
25 Q. That would be released?

1 MR. HYNES:
2 A. Yeah, because again, that's why I pressed "you
3 should be able to"--you know, try to explain
4 it or have some explanation on what the
5 results were.
6 CHAYTOR, Q.C.:
7 Q. And if we could go back, please, then to your
8 notes and finish up with the notes at 1628?
9 We continue on with "now pathologists
10 centralized who will review them, working on
11 accreditation." What did you understand that
12 to be referring to?
13 MR. HYNES:
14 A. That this was a new development, and that's
15 why I think the "now" is capitalized that
16 pathologists are centralized. I mean, I think
17 I understood that to mean that there would be
18 less people, less different individuals
19 reviewing the slides and that would mean more
20 consistency in testing, and that the lab was
21 working on national accreditation, which they
22 viewed as a significant, you know, quality
23 improvement, I guess.
24 CHAYTOR, Q.C.:
25 Q. And those were new measures, I take it?

1 MR. HYNES:
2 A. Yes, yeah.
3 CHAYTOR, Q.C.:
4 Q. And "issues due to turnover of staff?" and
5 you've got a question mark, and then a sub-
6 bullet, "lack of specialists?" with a question
7 mark. What was that referencing?
8 MR. HYNES:
9 A. There was discussion around the table about,
10 you know, over the years, the various issues
11 the lab had had with turnover of staff and
12 recruitment/retention issues, how much of a
13 variable that could have been in the process,
14 how much it could have been impact, I guess.
15 CHAYTOR, Q.C.:
16 Q. And in terms of lack of specialists, was it
17 lack of specialists in subspecialties, such as
18 breast pathology? Lack of specialists in IHC
19 testing? What types of specialists were
20 lacking?
21 MR. HYNES:
22 A. Just I took to be very macro, just lack of
23 pathologists in general, not--I don't remember
24 any discussion about subspecialties or broken
25 down in any more definitive way.

1 CHAYTOR, Q.C.:
2 Q. And the turnover of staff was referencing the
3 medical staff?
4 MR. HYNES:
5 A. Yeah, and I guess, you know, there could be
6 clinicians, support staff perhaps that were
7 working in the lab as well.
8 CHAYTOR, Q.C.:
9 Q. And what was being done to address those
10 issues?
11 MR. HYNES:
12 A. I think, you know, they were trying to work to
13 stabilize the situation. I'm not entirely
14 sure, but I believe by this time the
15 Government had agreed to give pathologists a
16 stipend. I may stand to be corrected on that,
17 but a stipend to their salary to help, you
18 know, with recruitment/retention and so that
19 may have been in play by that time as well.
20 CHAYTOR, Q.C.:
21 Q. And then it says "legal defence: will be
22 probability of tests. Ches Crosbie will
23 argue, no paperwork to confirm." "The legal
24 defence will be probability of tests," what
25 did that mean?

1 MR. HYNES:
2 A. When Eastern Health explained what they were
3 going to go forward with, I guess, the
4 crucible of their defence for Court would be
5 that the system was unreliable and because it
6 was multi-stepped, you know, and again I'm a
7 layperson to try to explain it, but it was 40
8 plus steps, a lot of manual manipulation, that
9 the test, there was a certain amount of
10 inherent error in it, and this whole
11 probability of how many are correct all the
12 time and how many are error, that would be
13 their legal defence.
14 CHAYTOR, Q.C.:
15 Q. And ultimately they're within the margin of
16 error at three percent?
17 MR. HYNES:
18 A. And that would be their argument, that you
19 know, based on, I guess, whatever national
20 research they had done or looked at other labs
21 that the amount of error they had was within
22 an acceptable range, so it was okay.
23 CHAYTOR, Q.C.:
24 Q. So Eastern Health, in this meeting, had no
25 difficulty talking to the Department and

1 disclosing to the Department their strategy on
2 defending the class action and that the
3 defence would concentrate on the probability
4 of the tests and that the errors were within
5 an acceptable range of error?
6 MR. HYNES:
7 A. Well, and I think this may have been because--
8 the previous two points may have been the
9 Minister or someone raising, "look, you know,
10 is this because of staff and specialists, and
11 you know, how are you going to go forward?"
12 And I mean, you know, the probability of the
13 tests, that they were within an acceptable
14 margin of error would be what they would put
15 forward, and ultimately, we were told the
16 courts are going to have to decide.
17 CHAYTOR, Q.C.:
18 Q. And in being told this information as to what
19 the legal defence would be, the Department
20 wasn't told what the external reviewers had
21 found?
22 MR. HYNES:
23 A. No, at least at this meeting.
24 CHAYTOR, Q.C.:
25 Q. To your knowledge, were they told at any

1 meeting?
2 MR. HYNES:
3 A. Not that I'm aware of.
4 CHAYTOR, Q.C.:
5 Q. And you think you would be aware?
6 MR. HYNES:
7 A. I think I'd remember.
8 CHAYTOR, Q.C.:
9 Q. And then the next bullet says "of 176
10 deceased, Eastern have no idea of results,
11 only reviewed at request of family." So this
12 is saying "of the 176 deceased, Eastern have
13 no idea of results." What were you referring
14 to there?
15 MR. HYNES:
16 A. That's perhaps not entirely correct, because
17 the 176--on the note that was passed out, the
18 176 is the top number on the very bottom, but
19 of course, you know, the second bullet was
20 "101 were retested and results received." So
21 Eastern Health did, in fact, know, but again,
22 it's still that they were only going to be
23 released, I guess, to the family at the family
24 request.
25 CHAYTOR, Q.C.:

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1 Q. Was it that they had not--even though the
2 results had been received, perhaps they had
3 not been reviewed?
4 MR. HYNES:
5 A. 101?
6 CHAYTOR, Q.C.:
7 Q. Yes.
8 MR. HYNES:
9 A. Yeah, I'm not clear if the board that they had
10 established had reviewed those. I mean, like
11 you said, you make a good point. Just because
12 they're sent away and received back doesn't
13 mean that they've been, I guess, processed or
14 assessed by the board that they had
15 established.
16 CHAYTOR, Q.C.:
17 Q. Analyzed by Eastern Health once they were
18 received back.
19 MR. HYNES:
20 A. Yeah.
21 CHAYTOR, Q.C.:
22 Q. And then is says "media issue". What's that
23 in relation to?
24 MR. HYNES:
25 A. Just that, I guess, there was recognition that

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1 because this had been such a long issue, such
2 a big issue for health care and patients and
3 their families, that there was going to be
4 significant media interest in the issue,
5 perhaps even nationally, you know, that this
6 had gone on for a long time and there was
7 going to be significant issue, media interest.
8 CHAYTOR, Q.C.:
9 Q. And then it says "1.5 year wait - delays at
10 Mount Sinai." What was that referencing?
11 MR. HYNES:
12 A. I guess there was--you know, our recognition
13 and frustration, I guess, that it had been a
14 1.5 year turnaround by the time the first
15 samples, I think, were sent to Mount Sinai, by
16 the time they all got done, and that was going
17 to be attributed to delays at Mount Sinai in
18 getting stuff turned around and returned to
19 the province.
20 CHAYTOR, Q.C.:
21 Q. So the year and a half wait is being
22 attributed to delays at Mount Sinai?
23 MR. HYNES:
24 A. That's correct.
25 CHAYTOR, Q.C.:

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1 Q. Is there any discussion of any delays within
2 Eastern Health or the other health
3 authorities?
4 MR. HYNES:
5 A. No, just Mount Sinai.
6 CHAYTOR, Q.C.:
7 Q. Is there any indication given as to whether
8 there was any difficulty in receiving the
9 samples in from the other health authorities?
10 MR. HYNES:
11 A. Not at this meeting, no.
12 CHAYTOR, Q.C.:
13 Q. Was that ever discussed with the Department?
14 MR. HYNES:
15 A. I remember in one meeting in the fall of '05
16 perhaps that it was raised that, I believe
17 maybe Dr. Cook at the time said that he was
18 calling his colleagues around the province to
19 get some idea about what numbers they had or
20 what they may have had to get some retesting
21 done and begin that process.
22 CHAYTOR, Q.C.:
23 Q. Was there any indication that any of the
24 delays may have been due to once the results
25 were received from Mount Sinai, they then had

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1 to go through a panelling process at Eastern
2 Health?
3 MR. HYNES:
4 A. I'm sorry, I missed -
5 CHAYTOR, Q.C.:
6 Q. Was there any indication or discussion around
7 any further delay due to once the results were
8 received back from Mount Sinai, they then had
9 to go through a panelling process at Eastern
10 Health?
11 MR. HYNES:
12 A. I remember making that one connection once
13 myself because I remember reading a briefing
14 note or information and it seemed like they
15 got stuff back in January and the panel took
16 June, July or whatever, too two or three
17 months to review it, and I thought that was an
18 extraordinary amount of time, given the
19 circumstances.
20 CHAYTOR, Q.C.:
21 Q. And given that it's already January?
22 MR. HYNES:
23 A. Well, and whatever it was, you know, it was
24 time to get on with it and -
25 CHAYTOR, Q.C.:

1 Q. Yes.
2 MR. HYNES:
3 A. But now, I don't know internally what may have
4 caused that delay, so I just remember noting
5 it in my mind.
6 CHAYTOR, Q.C.:
7 Q. Your next note here is "John Abbott". And I
8 take it these are comments then attributed to
9 Mr. Abbott, is that correct?
10 MR. HYNES:
11 A. Yes, two comments to Mr. Abbott.
12 CHAYTOR, Q.C.:
13 Q. "How to position issues?" What was that
14 referencing?
15 MR. HYNES:
16 A. I can honestly say I'm not sure what he meant
17 by that and I have no general recollection or
18 definitive about what he may have been saying.
19 I imagine it may have been something that, you
20 know, Eastern Health are going to go out and
21 make this announcement and release this
22 information, we may have to be ready for the
23 minister to have some role or to be able to
24 respond based on what they release, that it
25 may have been some discussion like that. But

1 unfortunately, ma'am, I can't -
2 CHAYTOR, Q.C.:
3 Q. Well, Mr. Hynes, what does it mean to position
4 an issue?
5 MR. HYNES:
6 A. I guess be able to explain and be prepared to
7 explain.
8 CHAYTOR, Q.C.:
9 Q. Does it mean to be able to not just explain
10 it, but put it forward in a certain light?
11 MR. HYNES:
12 A. No. I mean, I think if you're going to
13 position it, you've got to be able to, you
14 know, define it and articulate clearly what
15 your position is on it. Obviously some
16 positions, some issues are positive and some
17 are, you know, negative.
18 CHAYTOR, Q.C.:
19 Q. So the word "position" to you simply means
20 explain?
21 MR. HYNES:
22 A. I mean, again, I'm not--I made that note and
23 Mr. Abbott said it. If he was thinking about
24 positioning of the minister or positioning of
25 Eastern Health on this issue vis-a-vis, I

1 mean, how we would couch the issue, so to
2 speak, I'm not sure.
3 CHAYTOR, Q.C.:
4 Q. Was there -
5 MR. HYNES:
6 A. But you could certainly, you could certainly
7 make that reference.
8 CHAYTOR, Q.C.:
9 Q. Was there any discussion within the department
10 on that?
11 MR. HYNES:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. So was there any concern expressed within the
15 department as to what the fallout of this
16 media briefing might be?
17 MR. HYNES:
18 A. Well, I mean, I can only say after the media
19 briefing on December, you know, 11 or 12th,
20 the only other recollection I have is me and
21 Ms. Mundon and Minister Osborne in his office
22 and I remember were collectively surprised by
23 the lack of media interest in this story,
24 because I thought it would be much more
25 significant and in depth, I guess.

1 CHAYTOR, Q.C.:
2 Q. Okay. And I'll take you to that in a moment.
3 The last note you have here on your list is
4 "Peter Dawe to be debriefed closer to actual
5 launch." What did you understand was going to
6 happen there?
7 MR. HYNES:
8 A. I think because Eastern Health had been
9 keeping Mr. Dawe in the loop and had periodic
10 sessions with him over the past year and a
11 half that now that they were ready to go
12 forward with the information and the full set
13 of numbers, that they were perhaps as a
14 courtesy and to make sure, you know, the
15 Canadian Cancer Society as a key stakeholder
16 was given the heads up ahead of time. Because
17 undoubtedly when this information was released
18 to the public, the first person who the media
19 would go to would be Mr. Dawe and the Canadian
20 Cancer Society for their views and interest on
21 what, you know, what it all meant and their
22 reaction, that kind of thing.
23 CHAYTOR, Q.C.:
24 Q. And was that Mr. Abbott's idea, that Peter
25 Dawe be debriefed before the actual launch?

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1 MR. HYNES:
2 A. I think so, because I remember another point
3 in the meeting there was some resistance to
4 doing it.
5 CHAYTOR, Q.C.:
6 Q. And who was resisting?
7 MR. HYNES:
8 A. Eastern Health.
9 CHAYTOR, Q.C.:
10 Q. Any particular individuals?
11 MR. HYNES:
12 A. It was either Mr. Tilley or Ms. Bonnell. And
13 again, I think the--I got the sense, anyway,
14 and this is my perception, but I got the sense
15 that the relationship between Eastern Health
16 and the Canadian Cancer Society had soured
17 and, you know, they weren't exactly excited by
18 having to give him a briefing.
19 CHAYTOR, Q.C.:
20 Q. Okay. And what made you form that impression,
21 that their relationship had soured?
22 MR. HYNES:
23 A. I think this whole issue of a briefing was
24 raised earlier in the meeting and I remember
25 there was some comment or some eye roll or

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1 something that I picked up on that they
2 weren't--you know, I think there had been some
3 issue with a briefing or some information had
4 been given to Mr. Dawe at some point
5 previously that he had, you know, either gone
6 out with or something that clearly Eastern
7 Health were not, not excited about having to
8 deal with him again. And again, now, you
9 know, that's my perception of, you know,
10 reactions at the meeting and what I recall.
11 CHAYTOR, Q.C.:
12 Q. Okay. And do you know whether or not in this
13 instance Mr. Dawe got his pre-briefing?
14 MR. HYNES:
15 A. I know we wanted it to happen, but I'm not
16 entirely sure it did.
17 CHAYTOR, Q.C.:
18 Q. And so did anyone inform you or the minister
19 that, in fact, Mr. Dawe had not been given
20 that pre-briefing?
21 MR. HYNES:
22 A. I believe I remember hearing after that it was
23 attributed to a scheduling conflict or
24 something.
25 CHAYTOR, Q.C.:

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1 Q. At any point -
2 MR. HYNES:
3 A. Or, no, I apologize, Ms. Chaytor, my
4 recollection would be I believe he was to be
5 told that if he wanted a briefing, he could
6 come to the technical briefing like everyone
7 else and that would be the position of Eastern
8 Health, that's what I remember.
9 CHAYTOR, Q.C.:
10 Q. And was that the position at the end of this
11 meeting or did you--when the meeting ended,
12 you understood he was still going to be given
13 -
14 MR. HYNES:
15 A. No, I still think at the end of this meeting
16 they were still going to go forward. But now,
17 it very well could have been that when Eastern
18 Health were packing and leaving the room, they
19 may have said, look, we don't think this is a
20 good idea, we're just going to bring him in to
21 the main meeting with everyone else and he can
22 get the information from there.
23 CHAYTOR, Q.C.:
24 Q. And was it their concern that he may go out
25 with the information prematurely and not allow

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1 them an opportunity to go out with their own
2 technical briefing, was that the concern?
3 MR. HYNES:
4 A. No, I don't remember any explanation about why
5 they were having these reservations. I just
6 remember, I mean, getting a clear impression
7 that, you know, there was some, I don't know
8 if it was mistrust or dislike, but there was
9 just, you know, they weren't, they weren't
10 prepared to--they weren't excited about John
11 Abbott's suggestion to do it.
12 CHAYTOR, Q.C.:
13 Q. Okay. At any point prior, then, to the
14 December 11th, 2006 briefing did you learn
15 that all of the numbers given to the
16 department on November 23rd would not be
17 released?
18 MR. HYNES:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. After the meeting were there any discussions,
22 the November 23rd meeting, were there any
23 discussions in the department around the
24 issue, did you all get together then and
25 caucus about what had happened?

1 MR. HYNES:
2 A. No, because I remember the minister had to go
3 back into the house for a meeting, or sorry,
4 for a vote, I apologize, in the House of
5 Assembly, and the Eastern Health officials
6 left and, excuse me, I believe myself and Ms.
7 Mundon and Mr. Abbott just walked back to the
8 office and went on with the rest of our--with
9 our day. I don't remember ever having a
10 debrief or anything like that, no.
11 CHAYTOR, Q.C.:
12 Q. And did you contact anyone else within
13 government and share the information and the
14 update?
15 MR. HYNES:
16 A. No, I believe again I'd seen the numbers for
17 the first time. I believe I may have went
18 back to my office and just sat down and looked
19 at them again, because again, I hadn't seen
20 the August notes, so this was all fairly new
21 to me.
22 CHAYTOR, Q.C.:
23 Q. When you went back to your office and sat down
24 and looked at the note and looked at the
25 numbers, did you do any other calculations

1 with the numbers?
2 MR. HYNES:
3 A. No, just the one I referenced earlier that, I
4 mean, you know, you could look at--even though
5 there was no required treatment change, there
6 was still, you know, 213, plus 104 that
7 Eastern Health said it really affected, so
8 that was two hundred and, you know, seventeen,
9 plus you had another 176 that it was -
10 CHAYTOR, Q.C.:
11 Q. No, 317.
12 MR. HYNES:
13 A. Sorry, I apologize. That there was another
14 176 people on the bottom that it's unclear if
15 it--you know, what their status may have been.
16 So in my mind, you know, the overall rate of
17 change could have been--well, it was
18 significantly higher.
19 CHAYTOR, Q.C.:
20 Q. And the total results obtained and reviewed,
21 according to this document at this point in
22 time was 763, not 2800, it's 763 results
23 obtained and reviewed?
24 MR. HYNES:
25 A. Um-hm.

1 CHAYTOR, Q.C.:
2 Q. Did that catch your eye at the time?
3 MR. HYNES:
4 A. No.
5 CHAYTOR, Q.C.:
6 Q. So it didn't occur to you at that point in
7 time, well, results were obtained and
8 reviewed, 763, and the bit of mental math that
9 you did do, 317, you didn't do anything with
10 those numbers?
11 MR. HYNES:
12 A. No, because, I mean, they were, you know, what
13 I took away from the meeting was it was only
14 109 changes, and that's a typo, but 100 plus
15 changes out of 2800, so the margin of error
16 was only three percent, which was within an
17 acceptable range. That's what I took away.
18 CHAYTOR, Q.C.:
19 Q. Even though all the 2800 were not retested?
20 MR. HYNES:
21 A. No. You know, I guess I -
22 CHAYTOR, Q.C.:
23 Q. 939 retested, 763 results obtained and
24 reviewed?
25 MR. HYNES:

1 A. No, Ms. Chaytor, I wrote down what I was told
2 and I guess that's what I came away to
3 believe.
4 CHAYTOR, Q.C.:
5 Q. Okay. And I take it the department didn't ask
6 anyone else with any expertise in this area to
7 have a look at these numbers and provide any
8 feedback?
9 MR. HYNES:
10 A. No, not that I'm aware of.
11 CHAYTOR, Q.C.:
12 Q. In the next two weeks, then, coming up to the
13 technical briefing on the 11th is there any
14 further discussion in the department around
15 this issue?
16 MR. HYNES:
17 A. Not that I was party to or have any
18 recollection of.
19 CHAYTOR, Q.C.:
20 Q. Okay. And on December 4th, we've heard from
21 others, there was a meeting between Mr.
22 Abbott, Mr. Tilley, Ms. Mundon and Ms.
23 Bonnell. Were you aware that that meeting had
24 taken place?
25 MR. HYNES:

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1 A. I was aware, yes.
2 CHAYTOR, Q.C.:
3 Q. Okay. And what did you hear about that
4 meeting, what was the purpose of the meeting
5 and what was told to you about the outcome of
6 the meeting?
7 MR. HYNES:
8 A. I think that was the meeting to address
9 communication protocols between Eastern Health
10 and the department.
11 CHAYTOR, Q.C.:
12 Q. And what was the issue, what needed to be
13 discussed around communication protocols?
14 MR. HYNES:
15 A. That I guess Eastern Health were not always
16 giving the department a heads up or
17 information about potential issues at Eastern
18 Health that, you know, could have, I guess,
19 larger, larger political or Pan-Provincial
20 consequences.
21 CHAYTOR, Q.C.:
22 Q. And we understand from the e-mail exchanges
23 that happened that was concerning ER/PR. Did
24 you understand that one of the communications
25 issues, at least, was around the issue of ER

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1 and PR?
2 MR. HYNES:
3 A. I don't remember that being a specific topic,
4 but again, I think I testified yesterday that
5 there was recurring issues and if, you know,
6 if there was another issue that Ms. Mundon
7 felt here we go again. And again, you know,
8 my only recollection was I knew it took place
9 and I, you know, remember feeling that it was
10 significant that the deputy minister would
11 meet with the CEO over, you know, a kind of a
12 line department between us and Eastern Health.
13 CHAYTOR, Q.C.:
14 Q. Okay. And in terms of that, who did you
15 understand had requested the meeting or was
16 this brought forth because of Ms. Mundon's
17 concerns?
18 MR. HYNES:
19 A. That was my understanding, yeah, that's my
20 recollection.
21 CHAYTOR, Q.C.:
22 Q. And did Ms. Mundon talk to you about that and
23 what her concerns were?
24 MR. HYNES:
25 A. Just that she viewed over a period of time

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1 that Eastern Health were not exactly
2 forthcoming with information and giving an
3 appropriate heads up to the department and the
4 minister's office on issues that they were
5 about to release or decisions that they were
6 about to make.
7 CHAYTOR, Q.C.:
8 Q. And did Ms. Mundon express to you any sense of
9 conflict between what she was being asked to
10 get in terms of information from the minister
11 or others in the department and what was
12 forthcoming from her contact at Eastern
13 Health, being Ms. Bonnell?
14 MR. HYNES:
15 A. I don't remember that level of detail. I
16 remember just, I mean, general frustration
17 with getting information and getting, you
18 know, information is one piece, and then a
19 heads up and appropriate notifications when
20 issues were about to go public or Eastern
21 Health were doing various things in the media
22 or other public announcements, even.
23 CHAYTOR, Q.C.:
24 Q. And to your knowledge what role was Ms. Mundon
25 asked to play in eliciting information from

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1 Eastern Health regarding the ER/PR issue?
2 MR. HYNES:
3 A. Do you mean in a specific case or in a
4 general?
5 CHAYTOR, Q.C.:
6 Q. Throughout the whole piece, was she asked to
7 get just information around communications and
8 what Eastern Health may or may not be going to
9 communicate on the issue or was Ms. Mundon
10 being asked to obtain more information than
11 that?
12 MR. HYNES:
13 A. I'm not--you know, that would be outside my
14 role. I mean, she may very well have been
15 assisting with the preparation of briefing
16 notes, so if she had to go t her colleagues at
17 Eastern Health to get information in the
18 preparation of a briefing note for the house
19 or the minister, that would be part of perhaps
20 her role in assisting Ms. Hennessey and the
21 deputy in preparing that information.
22 CHAYTOR, Q.C.:
23 Q. And to your knowledge did Minister Osborne
24 ever ask Ms. Mundon to get information around
25 the issue and to go through the channel of Ms.

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1 Mundon through Ms. Bonnell to get information
2 on the issue?
3 MR. HYNES:
4 A. He very well may have, but I'm not--I wasn't
5 party to that discussion.
6 CHAYTOR, Q.C.:
7 Q. Do you know whether in the meeting of December
8 4th, 2006 the issue of ER/PR was further
9 discussed and what might happen at the
10 upcoming technical briefing?
11 MR. HYNES:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. So nobody relayed any discussion around that
15 to you afterwards?
16 MR. HYNES:
17 A. No, I -
18 CHAYTOR, Q.C.:
19 Q. If such a discussion, in fact, took place, it
20 wasn't told to you?
21 MR. HYNES:
22 A. No. I mean, I knew they were planning to meet
23 and I had some idea what it was about, but I
24 don't remember ever being told the outcomes or
25 how it went or anything like that.

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1 CHAYTOR, Q.C.:
2 Q. Okay. So did Ms. Mundon come back to you and
3 speak to you at all about the meeting at any
4 point in time to say whether or not her
5 concerns had been alleviated?
6 MR. HYNES:
7 A. No, I don't remember ever having that
8 conversation with her.
9 CHAYTOR, Q.C.:
10 Q. So no feedback at all on that?
11 MR. HYNES:
12 A. No, no.
13 CHAYTOR, Q.C.:
14 Q. Okay. And was there any sense within the
15 department after that meeting that things had
16 changed in terms of the communications with
17 Eastern Health?
18 MR. HYNES:
19 A. How do you mean changed?
20 CHAYTOR, Q.C.:
21 Q. Well, if there's a concern that Eastern Health
22 may not have been forthcoming on certain
23 things going out into the public, after that
24 did that meeting appear to improve that
25 situation?

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1 MR. HYNES:
2 A. I have no--not directly involved in that, so I
3 wouldn't have any ability to measure. I could
4 only rely on what I was told.
5 CHAYTOR, Q.C.:
6 Q. Okay. So you don't recall hearing any further
7 complaints after that point?
8 MR. HYNES:
9 A. No, but, you know, I left the department in
10 January of '07, so.
11 CHAYTOR, Q.C.:
12 Q. If we could look at, please, P-0196? And it's
13 page 3 of that exhibit, please? This is an e-
14 mail from Ms. Mundon to yourself, amongst
15 others, including the minister. And it's
16 December 11th, 2006 at 10:36 in the morning.
17 And "Materials for ER/PR briefing". This is
18 the morning of the technical briefing. And
19 she writes, "As promised, please see attached.
20 Minister, I have printed off a copy for you."
21 And this was Ms. Mundon forwarding to you and
22 the others what had been forwarded to her by
23 Eastern Health. And we understand this
24 included slide presentation, copies of the
25 slides, as well as Q and A document, news

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1 release, amongst other thing. Do you remember
2 getting that on December 11th?
3 MR. HYNES:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. Okay. And what did you do when you received
7 this?
8 MR. HYNES:
9 A. I remember printing it off. I don't know if I
10 did that immediately or not, but I remember
11 printing it off and it was a fairly lengthy
12 package of materials, and I remember putting
13 it in an ER/PR file I had.
14 CHAYTOR, Q.C.:
15 Q. Did you read it?
16 MR. HYNES:
17 A. No.
18 CHAYTOR, Q.C.:
19 Q. And why not?
20 MR. HYNES:
21 A. I was busy, I believe, at that time, with
22 other things and I just put it in a file with
23 the anticipation of reading it later in the
24 day, maybe.
25 CHAYTOR, Q.C.:

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1 Q. Okay. At any point did you go back and read
2 it?
3 MR. HYNES:
4 A. No.
5 CHAYTOR, Q.C.:
6 Q. So to this day you've never read it?
7 MR. HYNES:
8 A. I've read it after.
9 CHAYTOR, Q.C.:
10 Q. Okay. When did you read it?
11 MR. HYNES:
12 A. Back when I was asked--I guess when I was
13 scheduled to go meet with you and Mr. Coffey
14 in April, I got the information out and -
15 CHAYTOR, Q.C.:
16 Q. Okay. And having read it, did anything in the
17 material stand out in terms of what Eastern
18 Health had indicated on November 23rd would be
19 going forward at the technical briefing, how
20 did that compare to what you read in the
21 documents that were forwarded on December
22 11th?
23 MR. HYNES:
24 A. Well, there was no, there was no numbers. I
25 mean, you know, there was some wishy washy

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1 answer about we're not going to get into a
2 numbers game or something to that effect, but
3 it was, you know, they didn't get into numbers
4 of patients that--you know, they never
5 released this information as we expected.
6 CHAYTOR, Q.C.:
7 Q. And, Mr. Hynes, if you had read that document
8 back on December 11th, would that have stood
9 out to you?
10 MR. HYNES:
11 A. Yes, because I would have realized the change.
12 CHAYTOR, Q.C.:
13 Q. And what would you have done about it?
14 MR. HYNES:
15 A. I would have went to the minister immediately.
16 CHAYTOR, Q.C.:
17 Q. For what purpose?
18 MR. HYNES:
19 A. I would have give him strong advice that this
20 is not what we were told three weeks ago and I
21 got concerns that the water on the beams has
22 changed and this is not what we, this is not
23 what we thought.
24 CHAYTOR, Q.C.:

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1 Q. Within the department after either after
2 receiving this documentation on December 11th,
3 did anyone raise that concern with the
4 minister?
5 MR. HYNES:
6 A. No, not that I'm aware of. They never raised
7 it with me and he never raised it with me.
8 CHAYTOR, Q.C.:
9 Q. Do you have any reason to think anyone raised
10 it with him?
11 MR. HYNES:
12 A. I don't think they did because if they did,
13 I'm sure he would have said, Darrell, did you
14 see this and what, you know, what's going on.
15 CHAYTOR, Q.C.:
16 Q. Okay. If we could have, please, P-0104? And
17 this is the documentation, Mr. Hynes. So it
18 has a chronology, then it has an embargo news
19 release. We're told those are key messages
20 and then the PowerPoint. And here's the Q and
21 A document. And I believe what you may have
22 been referring to is question nine in this
23 document. "How many people converted?" "What
24 is the rate of error? How many people
25 converted?" And there is reference in here to

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1 a "numbers game," in quotation marks. "The
2 numbers of individual conversions are not
3 relevant and turn the process into a numbers
4 game. What is relevant is the number of
5 people whose care may change as a result of
6 the process, and that was 117." And the
7 numbers in the news release, the numbers
8 referred to are the 2760 total tests, 939 of
9 those originally negative and 117 requiring
10 treatment change. So those are -
11 MR. HYNES:
12 A. Which were the ones, I guess, they focused on
13 when they met with us in November.
14 CHAYTOR, Q.C.:
15 Q. But in having focused on those numbers in
16 November, you didn't understand that would
17 also be the focus of the media technical
18 briefing?
19 MR. HYNES:
20 A. No, I mean, I thought all the information
21 would be released.
22 CHAYTOR, Q.C.:
23 Q. Okay.
24 MR. HYNES:
25 A. Including the, how the, you know, the three

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1 percent of 2800 is the rate of error.
2 CHAYTOR, Q.C.:
3 Q. You thought that would happen, they would be
4 saying that three percent was the rate of
5 error?
6 MR. HYNES:
7 A. Absolutely.
8 CHAYTOR, Q.C.:
9 Q. And on December 11th we know that the briefing
10 went ahead. I take it you didn't attend?
11 MR. HYNES:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. And nobody from the department attended?
15 MR. HYNES:
16 A. Not that I'm aware, no.
17 CHAYTOR, Q.C.:
18 Q. Did you receive any feedback on how it went,
19 did you hear anything in the department after
20 that day? You said that there was some
21 discussion between yourself and the minister
22 and Ms. Mundon, that you were surprised by the
23 limited amount of media coverage, is that
24 correct?
25 MR. HYNES:

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1 A. Yeah. That's, honestly, that's my only
2 recollection, me and Ms. Mundon and the
3 minister having a brief discussion in his
4 office and we were on our way to a meeting and
5 it was just, you know, I think we were
6 collectively surprised that there hadn't been
7 more media interest in the story based on, you
8 know, the numbers as we understood were going
9 to be released.
10 CHAYTOR, Q.C.:
11 Q. So I take it you were aware of the media
12 coverage that followed?
13 MR. HYNES:
14 A. You know, I mean, I guess, well, I was aware
15 that there was very little of it.
16 CHAYTOR, Q.C.:
17 Q. Did you read the media coverage?
18 MR. HYNES:
19 A. No, not -
20 CHAYTOR, Q.C.:
21 Q. Or listen to it. You listen to the news as
22 part of your job?
23 MR. HYNES:
24 A. Yeah. Well, you know, sometimes you get a
25 chance and sometimes you don't. I mean, I may

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1 have saw the media clippings for that day
2 because there's a staff in the department that
3 would prepare media clippings. And if I
4 thumbed through them and there was only one or
5 two passing references to the issue, I mean, I
6 would have expected something like this would
7 have been on the front page of the Telegram
8 with this, with the November 23rd sheet front
9 page, here are the numbers, after a year and a
10 half, here they are and, you know.
11 CHAYTOR, Q.C.:
12 Q. So you were surprised by how little media
13 coverage there was?
14 MR. HYNES:
15 A. Right.
16 CHAYTOR, Q.C.:
17 Q. So there's not a lot of media coverage. Did
18 you pay attention then to the little coverage
19 that there was?
20 MR. HYNES:
21 A. Oh I'm sure I probably did, I mean -
22 CHAYTOR, Q.C.:
23 Q. And did it occur to you then or was it--did it
24 come to your attention that not all the
25 numbers had been released?

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1 MR. HYNES:
2 A. No, I don't remember making that linkage.
3 CHAYTOR, Q.C.:
4 Q. And if the media in fact were reporting that,
5 that Eastern Health were refusing to say, not
6 only what went wrong, but how many people had
7 changed results, that didn't come to your
8 attention?
9 MR. HYNES:
10 A. No, I don't remember making that connection.
11 CHAYTOR, Q.C.:
12 Q. Was there any discussion in the department
13 around that?
14 MR. HYNES:
15 A. There was none to my knowledge.
16 CHAYTOR, Q.C.:
17 Q. If we could look, please, at P-1455? And this
18 is a story which followed the media briefing,
19 it's a CBC story, "117 Newfoundland and
20 Labrador cancer patients received the latest
21 hormone treatment, Monday, December 11th,
22 2006." And this appears to come from their
23 website at 5:33 p.m. And it refers to "more
24 than 100 patients in Newfoundland and Labrador
25 failed to receive their hormone treatment for

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1 breast cancer because of a screening problem,
2 health officials said Monday." And you'll see
3 this news story, Mr. Hynes, was forwarded to
4 you from Ms. Mundon and was also forwarded to
5 Mr. Abbott and Ms. Hennessey and the Minister.
6 And if we come down towards the bottom,
7 there's a couple of quotes from Mr. Dawe.
8 "Because of a potential lawsuit, provincial
9 health officials refuse to explain if the
10 discrepancy resulted from human error or from
11 new methods of interpreting test results." So
12 you understood they weren't going to speak to
13 that, that would be a causation issue.
14 MR. HYNES:
15 A. That's correct.
16 CHAYTOR, Q.C.:
17 Q. So I take it that wouldn't have surprised you.
18 "Officials also would not say if any patients
19 who were mistakenly denied hormone treatment
20 had died or were needlessly given mastectomies
21 when they could have been treated with drugs."
22 And Peter Dawe is quoted as saying "Not
23 receiving this treatment could very well mean
24 a life and death issue for people going
25 through the process. The lack of disclosure

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1 raises questions, said Dawe, about what the
2 problem is and how it can be fixed. Health
3 officials in Newfoundland and Labrador hope to
4 resume their own hormone testing in the near
5 future." And you reply back to Ms. Mundon
6 later that evening, so I take it you've read
7 the story, you say, "I hate to say it, but
8 Peter has a point." First of all, what point
9 was it that Mr. Dawe was making?
10 MR. HYNES:
11 A. I think that not receiving a treatment, you
12 know, could have had life and death issue for
13 these people, because again, I still think
14 back to what Dr. Laing told myself and the
15 Minister and I think that still resonates with
16 me.
17 CHAYTOR, Q.C.:
18 Q. And what about his point that "the lack of
19 disclosure raises questions about what the
20 problem is and how it can be fixed". Was that
21 also noteworthy?
22 MR. HYNES:
23 A. I mean, I'm sure I read it, obviously, but to
24 me, you know, I guess that would have been
25 tangled up in the whole litigation issue that

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1 they could not discuss, so I don't know if
2 that would have been a new point that I would
3 have agreed with.
4 CHAYTOR, Q.C.:
5 Q. And the only numbers referenced in this story
6 are the 900 patients and 117 patients who have
7 been denied treatment and no other reference
8 to any other numbers.
9 MR. HYNES:
10 A. No, but unfortunately, I, you know, if the
11 media only picked one, I mean the media might
12 rightly have just said, well how many people
13 in this issue are deeply affected and 117
14 number may have been the story for the media,
15 you know, like there's no numbers here were
16 talked about changed rates, or anything like
17 that, so that's why it probably wouldn't have
18 tweaked my interest any more than that.
19 CHAYTOR, Q.C.:
20 Q. Okay. Mr. Hynes, why would you hate to say
21 that Mr. Dawe has a point?
22 MR. HYNES:
23 A. I'm not sure I understand your question.
24 CHAYTOR, Q.C.:
25 Q. You say, "I hate to say it, but Peter has a

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1 point". Why would you be reluctant to give
2 any credit to Mr. Dawe for raising a point?
3 MR. HYNES:
4 A. I don't know what I may have meant, I mean, we
5 had a good relationship with Mr. Dawe and the
6 ministers I worked for, sometimes we agreed to
7 disagree, but on this point, I mean, I agreed
8 with him.
9 CHAYTOR, Q.C.:
10 Q. But why would you be reluctant to acknowledge
11 that?
12 MR. HYNES:
13 A. Perhaps in a prior meeting we agreed to
14 disagree on something else, I mean, I had a
15 number of meetings with Mr. Dawe and Dr. West
16 who is chair of the board, with both ministers
17 over the years and in my mind it may have been
18 reflected on something else that before we
19 agreed to disagree on and this is one where he
20 called it right.
21 CHAYTOR, Q.C.:
22 Q. And the attitude that you sense that Eastern
23 Health had towards Mr. Dawe, did you share
24 that attitude?
25 MR. HYNES:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. Do you know whether or not it was shared by
4 others in the department?
5 MR. HYNES:
6 A. No, not that it was ever expressed to me
7 because I can still remember, I believe the
8 first time John Ottenheimer met with Mr. Dawe,
9 during the meeting Mr. Dawe kept referring to
10 him as John, and I thought that was very
11 unusual because I would always call him
12 Minister and the Deputy would and other
13 officials in the department and it just seemed
14 like a very warm cordial relationship, so I
15 mean, that kind of personalness was unusual in
16 my circles because it was always, you're the
17 Minister and you know, you didn't deviate from
18 that, but Mr Dawe and him were quite
19 comfortable and seemed to have that good
20 personal rapport, in my view.
21 CHAYTOR, Q.C.:
22 Q. If we could have, please, P-0196, page 16?
23 Okay? This is an e-mail here which was
24 forwarded to you by Ms. Mundon and again, it's
25 in the aftermath of the technical briefing on

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1 December 11th and this is sent from Ms. Mundon
2 to yourself, Mr Abbott, Ms. Hennessey and
3 Minister Osborne, and the subject is a night
4 line caller ER/PR, 8:24 p.m. that evening.
5 It's December 11th, so it's the evening of the
6 briefing. "Minnie is a breast cancer patient,
7 in fact, she is one of the 117 patients whose
8 tests were conducted incorrectly. To find out
9 last February that she was tested for positive
10 receptors and realized she should have been on
11 a drug for the past 8 years was very hard to
12 hear. She's not getting any answers from the
13 doctors. Minnie does not even know how her
14 chemo helped her. The problem that she has
15 with the health care system is that the
16 doctors do not know why the problem occurred.
17 How can they correct something when they
18 cannot pinpoint the problem, questions Minnie.
19 Something went awfully wrong if for several
20 years people were being treated incorrectly
21 for the breast cancer. Minnie says she may
22 have to enter the hospital again for her
23 breast cancer and how can she be certain that
24 things will be dealt with in a correct and
25 adequate manner." And the Minister comes back

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1 to Ms. Mundon and says "We need to be ready
2 for this as well." So I take it, Mr. Hynes,
3 at this point in time Minnie is also concerned
4 about well what happened and if they can't
5 tell me what happened, how can I have any
6 comfort that they fixed it? The news report
7 from CBC that I showed to you, Mr. Dawe is
8 asking the same question, what happened? What
9 was done in the department after receiving
10 this, Minister Osborne says we need to be
11 ready for this as well. What was done to be
12 able to support Mr. Osborne and give him the
13 necessary information he would need to answer
14 that question?
15 MR. HYNES:
16 A. I would suspect Ms. Mundon would have talked
17 to the Deputy because this is certainly the
18 direction I read from the Minister's e-mail,
19 but she would have talked to the Deputy or
20 Assistant Deputy Minister to get an up-to-date
21 note, but ultimately I guess the answer at
22 this point would have to be that because this
23 matter was before litigation and before the
24 courts, that we could not comment on what had
25 happened. We could not provide that answer.

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1 CHAYTOR, Q.C.:
2 Q. So the plan was, Minister Osborne is going to
3 go into the House the next day, December 12th,
4 without that answer because of the pending
5 litigation?
6 MR. HYNES:
7 A. That would be my understanding.
8 CHAYTOR, Q.C.:
9 Q. So four months before when Minister Osborne
10 was asking what is the root cause, the answer
11 given when the briefing of the Minister took
12 place on November 23rd was that Eastern Health
13 is not going to comment on that because of the
14 pending litigation. So on December 11th, the
15 department accepted that position and were not
16 going to speak as to what went wrong.
17 MR. HYNES:
18 A. Yeah, I don't know if we could say otherwise,
19 because if it was before the courts, I guess
20 our, the position of government would be we
21 would not comment.
22 CHAYTOR, Q.C.:
23 Q. Even though that's what the patients wanted to
24 hear, that's what stakeholders like Mr. Dawe
25 wanted to hear, the department would not

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1 comment?
2 MR. HYNES:
3 A. Yeah, I mean, I'm not saying that's the right
4 approach, but I mean, our--we would always,
5 anytime, Ms. Chaytor, government was being
6 sued or a government agency was being sued,
7 the understanding certainly across government
8 was you didn't go out and say anything, and I
9 can't be more definitive than that.
10 CHAYTOR, Q.C.:
11 Q. If we could look, please, at P-1629? Mr.
12 Hynes, this is an e-mail to yourself from Mr.
13 Abbott and it's now January 18th, 2007, so
14 shortly before, I take it, you leave the
15 department?
16 MR. HYNES:
17 A. That's correct.
18 CHAYTOR, Q.C.:
19 Q. And it's forwarded, the subject is "Forward
20 Dr. Ganguly." And he's sending you a copy of
21 an e-mail that went from Mr. Tilley directly
22 to the Minister. If you just want to take a
23 moment and look at this and tell us what you
24 recall about this e-mail and the subject
25 matter of the e-mail?

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1 MR. HYNES:
2 A. Yes, Ms. Chaytor, this would certainly seem to
3 build on the meeting I accompanied with the
4 Minister in the May, there's some of the same
5 issues about, you know, the pay thresholds,
6 compensation issues, Dr. Ganguly's role, I
7 remember a lot of this was some of the same
8 issues that we had, I guess, talked about some
9 months before.
10 CHAYTOR, Q.C.:
11 Q. Okay, and so I take it this was the oncology
12 issues and Dr. Ganguly still wasn't satisfied
13 with how it had been dealt with from his point
14 of view or with respect to him personally in
15 any event?
16 MR. HYNES:
17 A. No, and I recall Mr. Tilley was correct that
18 that Dr. Ganguly, there was some reference
19 here that he would go, his next step would be
20 to go to the Minister, I think. I recall some
21 conversations he had with the Minister
22 directly during that period of time.
23 CHAYTOR, Q.C.:
24 Q. Around this issue?
25 MR. HYNES:

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1 A. Yes, because I remember he was not satisfied,
2 I believe, with the department's response and
3 how Dr. Bradbury had gone back with our
4 proposals in light of what they had submitted.
5 CHAYTOR, Q.C.:
6 Q. And do you recall any follow up discussions
7 then or meetings around this issue, the
8 oncology stipend, oncology pay?
9 MR. HYNES:
10 A. No, because again, two or three days later I
11 was moved, so -
12 CHAYTOR, Q.C.:
13 Q. And Mr. Hynes, we understand that the ER/PR
14 testing resumed in early February, 2007, so
15 shortly after. Up to the time that you left
16 the department, what inquiries had been made
17 and what information provided to the
18 department to assure itself that the problem
19 had in fact been identified and the
20 appropriate measures had been taken to solve
21 the problem?
22 MR. HYNES:
23 A. The department would have been aware of the
24 various improvements, Eastern Health I guess
25 had made in the lab, in staffing, new model of

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1 who actually would review the slides, working
2 towards accreditation of the centre of
3 excellence concept, additional training, I
4 remember was a fairly significant piece of it,
5 and I, you know, I guess the department took
6 some comfort in whatever, all these
7 improvements and investments, et cetera, all
8 these internal processes and the consultants
9 subsequently reviewing what had taken place,
10 et cetera, that that had addressed whatever
11 the underlying issues were and they were ready
12 to move forward again.
13 CHAYTOR, Q.C.:
14 Q. So additional training for whom?
15 MR. HYNES:
16 A. Staff, I'll say staff. I don't know if that
17 meant the pathologists or the actual -
18 CHAYTOR, Q.C.:
19 Q. So Minnie's concern that if you don't know
20 what the problem is, how can you fix it, the
21 department was assured enough that it could go
22 forward without being told what the original
23 problem had been?
24 MR. HYNES:
25 A. Well I guess I don't remember a discussion,

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1 any discussion of we can't let them do this
2 because we don't know, I mean, you know,
3 presumably they were comfortable enough and
4 the consultants or whoever they had engaged
5 were comfortable enough to say, to recommend
6 to them to go ahead again, so -
7 CHAYTOR, Q.C.:
8 Q. And you recall no discussion around that?
9 MR. HYNES:
10 A. No, this issue, of course, after you've left
11 the department in May becomes a significant
12 issue for discussion in the public forum, were
13 you contacted at that point in time to ask
14 what you knew about the issue?
15 MR. HYNES:
16 A. No, I remember Minister Osborne coming to me
17 after the Cabinet meeting where he first saw
18 the briefing note of August and asking--and
19 inquiring of me if I had known at the time, et
20 cetera, and that led to our conversation.
21 CHAYTOR, Q.C.:
22 Q. Did anyone else, other than Minister Osborne,
23 contact you?
24 MR. HYNES:
25 A. No, I think my first contact was sometime, I

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1 believe in January of this year when Mr.
2 Robert Thompson contacted me to see if I had
3 any notes or recollections or e-mails dealing
4 with this issue in my role as, you know,
5 executive assistant to Minister Ottenheimer
6 and a policy advisor to Minister Osborne.
7 CHAYTOR, Q.C.:
8 Q. And was there any difficult in retrieving your
9 e-mail?
10 MR. HYNES:
11 A. I wasn't part of that process, I was never
12 told to search my e-mail myself, I just--I
13 went back through all my manuals, old books I
14 had, working books and old files and tried to
15 go through everything.
16 CHAYTOR, Q.C.:
17 Q. And nobody alerted you to any difficulty with
18 your e-mail, I take it?
19 MR. HYNES:
20 A. No, not that I'm aware of.
21 CHAYTOR, Q.C.:
22 Q. And in moving on beyond the department, there
23 was no problem with the archiving of your e-
24 mail?
25 MR. HYNES:

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1 A. I have had problems because I moved a fair bit
2 and my understanding of the technology is when
3 you move, you change servers or technologies
4 because I think I've had to re--you know,
5 start from scratch. I've lost contacts, for
6 instance, that normally I could type into a
7 system and, you know, and I've also changed
8 whole e-mail systems. I used to be on
9 GroupWise, now I'm on Outlook and I don't
10 understand the difference, but government
11 converted and I've gone from one department
12 that had one, to something new and then back
13 to the old one, because I had moved again a
14 number of times.
15 CHAYTOR, Q.C.:
16 Q. Well we certainly have e-mail from you -
17 MR. HYNES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. And I don't think we're alerted to any
21 difficulty, but do you, in reviewing what we
22 have, do you have any reason to believe
23 there'd be anything additional around the
24 ER/PR issue that we don't have?
25 MR. HYNES:

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1 A. No, because again I don't remember a whole lot
2 of contacts from individuals, but I mean,
3 you'd have to talk to the computer folks to
4 see if there was some, some issue that there's
5 more, you know, somewhere else.
6 CHAYTOR, Q.C.:
7 Q. Nothing significant that you've had a fairly
8 good recall around your discussions on the
9 issue, nothing significant stands out that's
10 missing from the written documentation?
11 MR. HYNES:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. Mr. Hynes, looking back on this, do you find
15 it rather remarkable that the department did
16 not ask to be provided with the external
17 review reports?
18 MR. HYNES:
19 A. Absolutely.
20 CHAYTOR, Q.C.:
21 Q. Is there anything else, Mr. Hynes, that I
22 haven't covered with you that you know about
23 or think may be of significance to the
24 Commissioner as she moves forward with her
25 mandate?

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1 MR. HYNES:
2 A. No, I think I've covered or you have covered,
3 sorry, anything I may have had -
4 CHAYTOR, Q.C.:
5 Q. Well thank you, thank you for your time and
6 some of my learned friends may have some
7 questions for you.
8 THE COMMISSIONER:
9 Q. Why don't we take the morning break and then
10 proceed.
11 (RECESS)
12 THE COMMISSIONER:
13 Q. Mr. Simmons.
14 MR. DARRELL HYNES, EXAMINATION BY MR. DANIEL SIMMONS
15 MR. SIMMONS:
16 Q. Thank you, Commissioner. Good morning, Mr.
17 Hynes. My name is Dan Simmons, I'm the lawyer
18 here for Eastern Health. I have a few
19 questions for you coming out of some of the
20 things that you said in your evidence
21 yesterday afternoon and also this morning.
22 And I'm going to try to take it pretty much in
23 the same order that Ms. Chaytor did, although
24 I won't be asking you about everything that
25 she has covered off. A couple of questions

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1 for you about the meeting on the 21st of July,
2 2005, which was concerning the Minister
3 attending. One of the things that you told us
4 at that meeting was that it was clear to you
5 that Eastern Health had sought some advice and
6 I understood you to say of their insurance
7 company or lawyer. And can you tell us
8 whether you have any clearer recollection than
9 that or whether that's just a general
10 recollection that it was one or the other?
11 MR. HYNES:
12 A. No, I seem to recall that there was
13 recollection that they had talked to their
14 legal department, who in turn had talked to
15 their insurance company and again, you know,
16 the information coming back was to be very
17 cautious with any patient notification letters
18 in light of what had happened in Labrador
19 Grenfell Health Authority.
20 MR. SIMMONS:
21 Q. Right, so the extent of what you understood
22 then was to exercise some caution in the way
23 that was handled?
24 MR. HYNES:
25 A. Well, I mean, Eastern Health certainly had

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1 their legal advice engaged in the process.
2 MR. SIMMONS:
3 Q. Right, okay. I think you also told us that at
4 that meeting Dr. Cook was present at that one?
5 MR. HYNES:
6 A. Yes, that's correct.
7 MR. SIMMONS:
8 Q. And that he gave some explanation of the
9 testing process for the ER and the PR testing
10 -
11 MR. HYNES:
12 A. That's correct.
13 MR. SIMMONS:
14 Q. - that had been in use at, I guess it was
15 Health Care Corporation really before these
16 events occurred, and you told us that he
17 described it, I think, as a complex process
18 with a number of steps involving various
19 manipulation, and I think you said an
20 opportunity for error to occur at different
21 steps in the process.
22 MR. HYNES:
23 A. That sounds like an accurate statement, yes.
24 MR. SIMMONS:
25 Q. That's pretty much--okay, and was this just a

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1 very brief explanation he gave or did he give
2 some actual detail of what these tests were,
3 what the manipulation that was done, what--
4 detail the technical side of it?
5 MR. HYNES:
6 A. I believe he got into some of the detail,
7 technical side, Mr. Simmons, but again, you
8 know, as a layperson it was quickly lost on me
9 in the explanation, once he got past step two
10 or three in the forty-step process, I, you
11 know, it was lost on me, sir, I have to admit.
12 MR. SIMMONS:
13 Q. Right, okay. Because you were asked if there
14 was any suggestion that there could have been
15 any human error involved in the process, and
16 I'm just wondering if you would have taken out
17 of that that some of those steps did involve
18 actions by people, they weren't all carried
19 out by machinery, that there were steps in
20 that process that involved people manipulating
21 and doing things in order to bring it to a
22 completion, did you have that impression?
23 MR. HYNES:
24 A. Yes, because the Ventana system, of course,
25 because it was more automated removed many of

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1 that variable.
2 MR. SIMMONS:
3 Q. Right, because one thing that I've heard is
4 that the Ventana system removed opportunity
5 for human error that had existed previously
6 with the previous system. Is that something
7 you would have taken out of that early
8 meeting?
9 MR. HYNES:
10 A. I don't remember being told the Ventana system
11 would have removed all the human component,
12 but just that -
13 MR. SIMMONS:
14 Q. No, just the opportunity for -
15 MR. HYNES:
16 A. I don't remember hearing that language, again,
17 I remember it being described as a very manual
18 system and Ventana was semi-automated, that
19 there was still some human component.
20 MR. SIMMONS:
21 Q. Right, but less than there had been with the
22 previous system?
23 MR. HYNES:
24 A. Oh yes, again, because you were going from a
25 manual system to a semi-automated system.

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1 MR. SIMMONS:
2 Q. So to the extent that the earlier system
3 involved more human intervention, it would
4 seem to make sense that by moving from one to
5 the other, you'd reduce the opportunity for
6 error to occur in the things that people had
7 to do in carrying out the tests?
8 MR. HYNES:
9 A. Yes.
10 MR. SIMMONS:
11 Q. Right, so say that there's, you know, no
12 suggestion that there might have been human
13 error involved, would seem to me that the
14 explanation that you were given of the change
15 from one system to the other, would--could
16 suggest that there had been the removal of
17 some opportunity for human error in the
18 testing process?
19 MR. HYNES:
20 A. I remember more the linkage that the Ventana
21 was a newer system and the sensitivity of the
22 newer system; I don't remember the linkage of
23 it had to do with removing the human
24 component. I don't remember that getting the
25 emphasis you're giving it now.

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1 MR. SIMMONS:
2 Q. Okay, so that's not the way you understood the
3 explanation, but you've told us that as a
4 layperson you didn't understand all the
5 intricacies of what was being explained to
6 you.
7 MR. HYNES:
8 A. No, I mean, I understood you're going from a
9 manual system with multi steps and going to a
10 more automated system.
11 MR. SIMMONS:
12 Q. Now I want to bring you to the meeting of
13 August 15th which you actually didn't attend,
14 but you've told us that you did get some
15 report on that, after the fact. Who did you
16 talk to to learn about what had happened on
17 the 15th of August, '05 when there was a
18 meeting with the Minister and that's the one
19 that the oncologists attended also.
20 MR. HYNES:
21 A. I believe I would have talked to, perhaps the
22 Minister, other officials maybe in the
23 department.
24 MR. SIMMONS:
25 Q. Do you know if you talked to Ms. Hennessey or

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1 Mr. Abbott about it?
2 MR. HYNES:
3 A. Not that I can be definitive about.
4 MR. SIMMONS:
5 Q. Okay. And the impression you were left with
6 from those conversations about what if any
7 decisions had been made at that meeting again
8 was about notification of patients, again was
9 what?
10 MR. HYNES:
11 A. The oncologists strongly urged to hold off.
12 MR. SIMMONS:
13 Q. Right, and to hold off until when or until
14 what happened?
15 MR. HYNES:
16 A. In my view they had more information which
17 included having test results back, sent away
18 and returned.
19 MR. SIMMONS:
20 Q. Okay. So if what they wanted to do was to
21 hold off until test results were back, that
22 would mean going through the testing process,
23 getting results back for individual patients
24 and notifying them of their test results,
25 right? And you were asked yesterday about,

1 what about notification of patients that
2 testing was going to occur? What was your
3 understanding about whether there was any
4 decision made at the August 15th meeting about
5 whether that would happen before test results
6 came back?
7 MR. HYNES:
8 A. Again, it's still to hold off, was my
9 understanding.
10 MR. SIMMONS:
11 Q. Okay, so that was your understanding, that
12 there would not be any--as of August 15th, it
13 had been decided that there was not going to
14 be any contact made with patients to tell them
15 in advance that testing was going to happen,
16 the contact would be after the test results
17 came back for those patients?
18 MR. HYNES:
19 A. Yes, based on the expert medical advice we
20 were given from the oncologists. Again, now
21 that was my understanding.
22 MR. SIMMONS:
23 Q. Right, because I didn't quite understand it
24 when you explained it that way yesterday, but
25 that's your recollection of what you learned

1 the decision was on the 15th of August, is it?
2 MR. HYNES:
3 A. Is to hold off.
4 MR. SIMMONS:
5 Q. Good, okay. You were asked some questions
6 concerning the lead up to a meeting--I'm going
7 to jump ahead a bit now, on December 4th of
8 '06, which was a meeting among Mr. Tilley, Mr.
9 Abbott, Tansy Mundon and Susan Bonnell. And I
10 believe you've told us that you understood
11 that the purpose of that meeting was to sort
12 out communications protocols between Eastern
13 Health and the Department of Health, and that
14 you had understood that the reason for
15 organizing that meeting was that there had
16 been some experience with problems getting
17 information from Eastern Health on and off?
18 MR. HYNES:
19 A. Part of it, yes.
20 MR. SIMMONS:
21 Q. Okay, and your source of that information was
22 what? How did you know there had been any
23 problems like that?
24 MR. HYNES:
25 A. I recall very early on when I got to the

1 Department of Health having a conversation
2 with Ms. Chaplin and I think this was spurned
3 by something, I was driving to work and I
4 heard something on the radio and we hadn't
5 been aware of it and I remember talking to Ms.
6 Chaplin and Ms. Chaplin saying that this is a
7 problem, trying to, you know, build a rapport
8 with Susan, but from time to time Eastern
9 Health will go out and issue statements and do
10 things without giving us a heads up.
11 MR. SIMMONS:
12 Q. Okay, so was the concern that Eastern Health
13 was making public statements or issuing press
14 releases that the department didn't have a
15 heads up on, as opposed to being concerned
16 that Eastern Health was operationally making
17 decisions about the things that were going to
18 do without involving the department?
19 MR. HYNES:
20 A. Well operational decisions we would not
21 normally be directly involved in. I'm talking
22 about if Eastern Health were going shutdown a
23 wing of Bonavista Hospital for the summer, I
24 mean, I would sense even though that's an
25 operational decision, we would be given a

1 heads up because of the political overtones of
2 a decision like that.
3 MR. SIMMONS:
4 Q. Right, so before the announcement of anything
5 like that, that's what you'd expect the
6 department would be notified on.
7 MR. HYNES:
8 A. Even a courtesy heads up, yes.
9 MR. SIMMONS:
10 Q. It would be Eastern Health's decision to make,
11 but it was the public announcement that was of
12 interest and that the department would want to
13 know beforehand.
14 MR. HYNES:
15 A. And the information, what exactly are we going
16 to go out and say, obviously, I mean, the
17 Minister may have to--just in case he's
18 questioned on it coming out of the House, he
19 would have to have some understanding of what
20 the issue was and what was going on.
21 MR. SIMMONS:
22 Q. Okay. Much of what you talked about this
23 morning was the meeting with Minister Osborne
24 on the 23rd of November, 2006. You've told us
25 that there had been an inquiry from him, I

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1 think in August of '06, about wanting to know
2 something more about the root cause here, and
3 that you had passed that request on to Mr.
4 Abbott just before you went on vacation with
5 the anticipation that Mr. Abbott would arrange
6 something to assist the Minister in answering
7 that question.
8 MR. HYNES:
9 A. That's correct.
10 MR. SIMMONS:
11 Q. Now how long were you on vacation?
12 MR. HYNES:
13 A. Just two weeks, I believe.
14 MR. SIMMONS:
15 Q. Just two weeks. Did you do any follow up when
16 you came back to see if anything had happened
17 or if Mr. Abbott had done anything about that?
18 MR. HYNES:
19 A. Not that I can recall.
20 MR. SIMMONS:
21 Q. Do you know if any request ever got passed on
22 to anyone at Eastern Health to say the
23 Minister wants a meeting to be told about the
24 causes of the problem?
25 MR. HYNES:

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1 A. I don't know, I don't know what Mr. Abbott
2 actioned on the request. I know it was
3 mentioned a number of times during that spring
4 and summer and I don't know what, if anything,
5 he might have done with it.
6 MR. SIMMONS:
7 Q. Okay, you didn't have any contact with Eastern
8 Health and you didn't know if anyone else
9 contacted Eastern Health -
10 MR. HYNES:
11 A. No.
12 MR. SIMMONS:
13 Q. - specifically to say the Minister wants that
14 information.
15 MR. HYNES:
16 A. Now it wouldn't be my role to contact Eastern
17 Health directly on something like that.
18 MR. SIMMONS:
19 Q. Right, and then in the lead up to the November
20 23rd meeting, you didn't have any role in
21 arranging that meeting either, did you?
22 MR. HYNES:
23 A. No, just that I was to attend and -
24 MR. SIMMONS:
25 Q. Did you renew your request to Mr. Abbott at

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1 any time to say we need to get that meeting
2 organized with Eastern Health so that they
3 could talk to the Minister about root cause?
4 MR. HYNES:
5 A. No, I seem to recall that fall there was a
6 number of scheduling things with the Minister
7 out of town at national meetings, et cetera,
8 that I think November was the earliest
9 opportunity and I believe the recommendation
10 from Eastern Health was that they wanted to
11 hold off until they had all the information
12 ready and this is why this date was selected.
13 We were going to be briefed just before the
14 public release of the information.
15 MR. SIMMONS:
16 Q. Okay. Was there any kind of agenda given to
17 Eastern Health as to what they were to address
18 at the meeting on the 23rd or what questions
19 were to be answered for the Minister on that
20 date?
21 MR. HYNES:
22 A. Not that I'm aware of, sir.
23 MR. SIMMONS:
24 Q. Could we have P-0177 please? Now this is a
25 document that you probably haven't seen

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1 before, Mr. Hynes. It is an e-mail message on
2 November 22nd, 2006. I'll go down through the
3 first one in the chain so you can just go
4 through it here. This is the day before, of
5 course, that meeting actually took place. And
6 there was an e-mail at 1:43 in the afternoon
7 from Tansy Mundon to Leona Barrington and
8 Susan Bonnell at Eastern Health. These are
9 the communications people communicating with
10 each other.
11 MR. HYNES:
12 A. Sure.
13 MR. SIMMONS:
14 Q. And it says, "In light of this request, can
15 you please ask that a status report is sent to
16 the Minister this week." And the subject
17 matter is "forward, breast cancer screening".
18 So there's a request here from Ms. Mundon for
19 a status report for the Minister that week.
20 You move up to the next message in the chain
21 at 2:54 in the afternoon, Ms. Bonnell replied,
22 asking what the Minister would want, would a
23 verbal briefing be helpful. Then the next one
24 in the chain in Tansy Mundon back to Susan
25 Bonnell, 2:59, "Waiting on the Minister to

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1 come out of the House of Assembly and I'll
2 call you." And then, if we go up to the last
3 message in the chain at 3:55, Ms. Mundon to
4 Ms. Barrington and Ms. Bonnell, "Susan, the
5 Minister doesn't need a briefing today, but we
6 would like to set up a briefing for him as
7 soon as possible. I will advise you once I
8 have discussed with John Abbott and we can
9 find a time." And then the briefing actually
10 takes place, the one that you went to the next
11 day, outside of the House of Assembly. So
12 from this exchange here, were you aware of any
13 of these discussions going on between Ms.
14 Mundon and the staff at Eastern Health to
15 arrange the meeting on the 23rd.
16 MR. HYNES:
17 A. No.
18 MR. SIMMONS:
19 Q. Because I don't see anything here about this
20 being a follow up to a long outstanding
21 request for a meeting to come in and tell us
22 about causes or root cause of the problem.
23 MR. HYNES:
24 A. But unfortunately, Mr. Abbott's not e-mailed
25 on any of this or neither am I, so I don't

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1 know if they may not have been aware of the
2 other meeting ahead of time or the other
3 process that--because no doubt if there was a
4 meeting to be set up, Mr. Abbott would have
5 called Mr. Tilley directly.
6 MR. SIMMONS:
7 Q. And when they came in on the 23rd, the only
8 material they had to provide was the handout
9 with the retest numbers on it, the numbers in
10 the retest program. Did Mr. Abbott or someone
11 convene the meeting at the outset and say,
12 well we're finally here to talk about the
13 causes of the problem? Or was that put on the
14 agenda or on the table at the outset of the
15 meeting as being the reason why that meeting
16 was being convened?
17 MR. HYNES:
18 A. I don't remember any statement at the
19 beginning. I remember, you know, we sat down
20 and Mr. Tilley led us through a discussion of
21 the document that was to be released publicly
22 and that's what, you know, my notes follow.
23 MR. SIMMONS:
24 Q. Led through the discussion of the document
25 that I think we've seen at P-0125, page 42.

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1 Because there's certainly nothing here about
2 causes, this is just a statistical review of
3 the results of getting the retests done and
4 analyzed by the panel, the information that
5 was known at that time.
6 MR. HYNES:
7 A. No, but they told us, I mean, they wouldn't
8 talk about causation because of the legal,
9 outstanding lawsuit.
10 MR. SIMMONS:
11 Q. Okay, but my point is that it was way back in
12 August that that request was made by the
13 Minister and a lot of time has gone by and I
14 don't see anything in the record here to link
15 that request that was made back in August to
16 you about wanting a briefing on root cause and
17 what actually happened here on the 23rd of
18 November. Can you tell me anything about
19 whether the Eastern Health people came to this
20 meeting knowing that the purpose of it was to
21 follow up on this request back from August.
22 MR. HYNES:
23 A. I can't speak to what day he may have known or
24 not known about what the request in the
25 conversation was in August, I mean -

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1 MR. SIMMONS:
2 Q. Okay. You told us about the discussion that
3 happened at that meeting about the results for
4 the deceased patients and the handout
5 identifies 176 patients who were known to be
6 deceased and 111 were retested and results
7 received. And I just want to clarify, did you
8 understand at that meeting whether the
9 Physician Review Panel, the physicians who had
10 looked at the results for the living patients,
11 whether they had looked at these results for
12 the deceased patients at all by this time?
13 MR. HYNES:
14 A. No, I believe I told Ms. Chaytor I was unclear
15 if, even though the results were back, I was
16 unclear for unknown--I mean, I don't know why
17 they wouldn't have, but I'm unclear that the
18 panel hadn't, you know -
19 MR. SIMMONS:
20 Q. Okay, would you have understood the importance
21 for treatment of patients, the clinical
22 reasons for reviewing the retests for all the
23 patients who were living in that they could
24 benefit still from a change in treatment if
25 one was to be recommended, but that that same

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1 clinical imperative wouldn't exist for
2 reviewing retests of patients who were
3 deceased.
4 MR. HYNES:
5 A. No, and I think that was borne out in Dr.
6 Laing's comment.
7 MR. SIMMONS:
8 Q. Yes, okay, and that was essentially the point
9 she was making, was it, that there was not a
10 clinical reason now existing in order to carry
11 out that the review be done?
12 MR. HYNES:
13 A. Well I mean, there was not much you could do
14 for them people, that's why her concern was
15 for the living and not the deceased.
16 MR. SIMMONS:
17 Q. Did you have any idea or gather anything from
18 that meeting about the type of resources that
19 would be required, the time required of the
20 limited number of people who were available to
21 carry out that kind of a review?
22 MR. HYNES:
23 A. I don't think we were given any information on
24 that, it was just that it could take some time
25 and they were ready to go forward in short

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1 order with a public announcement.
2 MR. SIMMONS:
3 Q. Did you understand at that point that there
4 were significant work loads on the oncologists
5 and pathologists as well within Eastern Health
6 at that time for their regular duties that
7 they were carrying out?
8 MR. HYNES:
9 A. Oh no question, I mean, I had attended some of
10 their meetings and heard their frustrations
11 about workload and I mean, no question that
12 was a recognition.
13 MR. SIMMONS:
14 Q. You had mentioned and you reiterated a moment
15 ago that on the issue of cause and talking
16 about it, it was made fairly clear that
17 because there was pending litigation that
18 there wasn't going to be any public discussion
19 of the media briefing about causation issues,
20 I think that's the way you understood it.
21 You've told us as well that that was pretty
22 well standard operating procedures, as far as
23 you knew in government for when there was any
24 litigation involving government as well.
25 MR. HYNES:

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1 A. That's correct.
2 MR. SIMMONS:
3 Q. So did anyone on the government side take
4 issue with that approach in this case?
5 MR. HYNES:
6 A. Not that I remember at the meeting, no, sir.
7 MR. SIMMONS:
8 Q. Now on the handout, P-0125, page 42, there's
9 numbers here in different categories. There's
10 no attempt on this sheet to do any analysis
11 about rates of change, rates of error, margins
12 of error, no percentages at all calculated
13 here on this sheet, are there?
14 MR. HYNES:
15 A. No, sir.
16 MR. SIMMONS:
17 Q. When Mr. Tilley made his presentation, did he
18 go through each of these categories and use
19 this sheet as a guide to explain what these
20 numbers were?
21 MR. HYNES:
22 A. I don't believe, sir, you know, he actually
23 physically read every line, but just reviewed
24 the headings and subheadings in a very broad -
25 MR. SIMMONS:

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1 Q. Yes. Can you remember anything about the
2 structure of the meeting, whether it started,
3 as you said, with Mr. Tilley giving a
4 presentation and that there was then
5 discussion among the parties or was it more or
6 less structured than that?
7 MR. HYNES:
8 A. I would think, I mean, he was the CEO and he
9 was there with his officials to brief the
10 Minister, so he would lead discussion about
11 here, at the end of the day here's what we
12 found and here's what we're ready to release.
13 MR. SIMMONS:
14 Q. Right. Did he make any kind of a statement of
15 presentation about whether or not Eastern
16 Health was comfortable that they could
17 calculate any kind of rate of error or margin
18 of error, as you've termed it here--Mr.
19 Tilley, in his presentation?
20 MR. HYNES:
21 A. No, because--well, I mean, no, because Eastern
22 Health's position, as they put forward it was
23 only three percent within a margin of error.
24 MR. SIMMONS:
25 Q. Mr. Tilley made his presentation first. Did

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1 he, in his presentation on these numbers, take
2 the position that Eastern Health's position
3 was there was a three percent rate of error?
4 MR. HYNES:
5 A. No, he never mentioned that.
6 MR. SIMMONS:
7 Q. He did not.
8 MR. HYNES:
9 A. No.
10 MR. SIMMONS:
11 Q. That came out in the discussion that followed,
12 did it?
13 MR. HYNES:
14 A. Yeah, Ms. Bonnell made that point.
15 MR. SIMMONS:
16 Q. From Ms. Bonnell, who is the director of
17 communications. Did Mr. Tilley ever put
18 forward that as being in any way any kind of
19 official position or conclusion that Eastern
20 Health had reached that that was a rate?
21 MR. HYNES:
22 A. No, I mean, Ms. Bonnell made the point and no
23 one corrected it, so we moved on.
24 MR. SIMMONS:
25 Q. She may have been in the course of the

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1 discussion, okay. Now are you aware if
2 Eastern Health or anyone from Eastern Health
3 ever publicly put forward three percent as a
4 rate which reflected anything from these
5 results of the retesting program? Was it ever
6 used -
7 MR. HYNES:
8 A. Not that I'm aware of, sir, no.
9 MR. SIMMONS:
10 Q. - in Eastern Health, never. Did you ever hear
11 it used anywhere other than in this discussion
12 at this meeting?
13 MR. HYNES:
14 A. No, sir, no.
15 MR. SIMMONS:
16 Q. Ever hear it raised by anyone other than Ms.
17 Bonnell?
18 MR. HYNES:
19 A. I seem to recall another health official,
20 another Eastern Health official at the
21 meeting, you know, was part of that joint
22 conversation, so I don't know if Dr. Laing or
23 someone else was also using the three percent,
24 I'm not sure. Again, they were at the other
25 end of the table and I know Ms. Bonnell was

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1 leading the discussion, but, you know, it's
2 entirely possible someone else--I don't recall
3 Dr. Howell saying much, but Dr. Laing may have
4 offered her comment to that as well.
5 MR. SIMMONS:
6 Q. Now you didn't read the materials that were
7 used at the December 11th media briefing until
8 much after, but when you did read them much
9 after, you did determine, from looking at
10 that, that Eastern Health did not release any
11 kind of a rate of error?
12 MR. HYNES:
13 A. No, or any numbers.
14 MR. SIMMONS:
15 Q. Or did not take any position on what a rate of
16 error was?
17 MR. HYNES:
18 A. No, or any of the numbers that were given to
19 us, no.
20 MR. SIMMONS:
21 Q. Okay. Now on that point, you've told us that
22 it was your understanding, when you left the
23 meeting, that all the numbers on this handout
24 here, or all this information, would be
25 released in the media briefing that was coming

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1 up?
2 MR. HYNES:
3 A. That's correct.
4 MR. SIMMONS:
5 Q. In a couple of weeks time. Now did anyone
6 from Eastern Health make the positive
7 statement that "we are going to release all
8 this to the media"?
9 MR. HYNES:
10 A. No, it was certainly assumed to us.
11 MR. SIMMONS:
12 Q. Okay. Did anyone make the positive--did
13 anyone from Eastern Health make the statement
14 that "we are not going to release any of these
15 numbers to the media"?
16 MR. HYNES:
17 A. No.
18 MR. SIMMONS:
19 Q. No. Did anyone from the Department side ask
20 "are you going to release all these numbers to
21 the media?"
22 MR. HYNES:
23 A. I don't know if that was asked in a definitive
24 way.
25 MR. SIMMONS:

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1 Q. Okay. Did anyone from the Department side ask
2 "is there anything here you're not going to
3 release to the media?"
4 MR. HYNES:
5 A. No, because I think we collectively had the
6 assumption that this was going forward.
7 MR. SIMMONS:
8 Q. Okay, right.
9 MR. HYNES:
10 A. And again, when I did question some of the
11 numbers, I was never told that this is not
12 going to be part of the final document or
13 released to the public.
14 MR. SIMMONS:
15 Q. Okay. You told Ms. Chaytor this morning that
16 when you did read the media materials that
17 were used by Eastern Health on December 11th,
18 when you did get around to reading them, it
19 did stand out to you that there were only
20 limited retest results included in it, and
21 that all the other numbers weren't there? You
22 had no trouble recognizing that when you read
23 those materials?
24 MR. HYNES:
25 A. No, quite clear.

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1 MR. SIMMONS:
2 Q. Quite clear. Ms. Mundon attended the meeting
3 on the 23rd of November, did she?
4 MR. HYNES:
5 A. Yes.
6 MR. SIMMONS:
7 Q. She did, and so would she have been in the
8 same position as you, having heard everything
9 at the meeting of November 23rd, that if she
10 had read those materials that the same
11 conclusion should have jumped out to her?
12 That she should have recognized -
13 MR. HYNES:
14 A. I mean, the -
15 MR. SIMMONS:
16 Q. - that there's limited information there?
17 MR. HYNES:
18 A. - you know, the original press release only
19 had the 117 number, which of course, was
20 highlighted by Eastern Health as what they
21 based their margin of error on, on the
22 November 23rd meeting, and you know, I guess
23 if you read the rest of the background
24 information and the Q and A's, you would come
25 to the realization that there was no other

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1 numbers mentioned.
2 MR. SIMMONS:
3 Q. Yes.
4 MR. HYNES:
5 A. But I don't know, I mean, what her--I mean,
6 you'd have to ask her, sir.
7 MR. SIMMONS:
8 Q. Sure.
9 MR. HYNES:
10 A. I don't know. She never shared anything with
11 me.
12 MR. SIMMONS:
13 Q. Okay, and just one final point, you were asked
14 a little bit about the external review reports
15 that had been done early on for Eastern Health
16 there, and I know you weren't really directly
17 involved in this, so I can only ask you your
18 impression of it, I guess, from talking to
19 other people in the Department, but did you
20 have any understanding of what it was the
21 external consultants had been brought in to
22 do, what the purpose of bringing them in was
23 to Eastern Health at first?
24 MR. HYNES:
25 A. My understanding was to look at the lab.

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1 MR. SIMMONS:
2 Q. Yes.
3 MR. HYNES:
4 A. Part of that was to review the operation of
5 the technology that was in place.
6 MR. SIMMONS:
7 Q. Yes.
8 MR. HYNES:
9 A. And that included, you know, the talk back
10 from the 21st about sensitivity.
11 MR. SIMMONS:
12 Q. Yes.
13 MR. HYNES:
14 A. And I guess it was also, in a broad way, to
15 look at processes, I guess, operational
16 processes in the lab. I guess to look at the
17 operation of the lab with respect to ER/PR.
18 MR. SIMMONS:
19 Q. So if I were to suggest that--it sounds like
20 what you're telling me is that you understood
21 that the purpose was for them to come in and
22 look at the operation as it existed at the
23 time they were there and try to identify if
24 there were any deficiencies in that that
25 needed to be rectified?

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1 MR. HYNES:
2 A. Sure, and to make recommendations that could
3 be, you know, measured and acted upon, I
4 guess.
5 MR. SIMMONS:
6 Q. And did you understand that recommendations
7 had been made and that Eastern Health's
8 position was that they were acting or had
9 acted on those recommendations?
10 MR. HYNES:
11 A. Well, I would have assumed if they were
12 resuming testing that they were--Eastern
13 Health were satisfied if they were resuming
14 testing in the lab, because that would have
15 been their--that would have been an
16 operational decision that they had made.
17 MR. SIMMONS:
18 Q. Good. Thank you very much, Mr. Hynes.
19 MR. HYNES:
20 A. Thank you.
21 THE COMMISSIONER:
22 Q. Mr. Browne?
23 MR. DARRELL HYNES, EXAMINATION BY MR. PETER BROWNE
24 MR. BROWNE:
25 Q. Thank you, Commissioner. Good morning, Mr.

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1 Hynes. My name is Peter Browne. I represent
2 a number of the individual physicians who have
3 been requested to give evidence here,
4 including Dr. Laing, and I just have a few
5 questions I want to canvas with you this
6 morning. First of all, am I correct in the
7 note I made yesterday that early in
8 questioning by Ms. Chaytor, you agreed that
9 your role in a number of the meetings that you
10 participated around the ER/PR issue, you came
11 to these meetings with what we've--the
12 Commissioner has heard various terminology and
13 nomenclature, a political lens. Is that a
14 fair description?
15 MR. HYNES:
16 A. Yes.
17 MR. BROWNE:
18 Q. Because you were, I think, at various points,
19 first of all, an executive assistant and then
20 latterly, a policy analyst?
21 MR. HYNES:
22 A. Yes.
23 MR. BROWNE:
24 Q. Okay, and can I assume from that that others
25 in the room had different lenses as well?

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1 MR. HYNES:
2 A. Sure, absolutely. I mean, if there was--if
3 the Deputy Minister was there, he would
4 certainly bring the departmental lens. If
5 there was communications people in the room,
6 they would bring that lens. If we were
7 meeting with a respective group and they were
8 doctors, they would bring the clinician lens
9 to the table.
10 MR. BROWNE:
11 Q. Precisely. Now if we look at Dr. Laing, she
12 would bring the oncology medical lens to the
13 meeting and offer views from that perspective?
14 MR. HYNES:
15 A. Yes, and that's why I think, sir, in the
16 August meeting, her view was so highly
17 regarded.
18 MR. BROWNE:
19 Q. Okay, but in fairness, to go back on that,
20 your observation is a good one that was it
21 well understood that everybody in this meeting
22 was coming at the issue with different lenses?
23 MR. HYNES:
24 A. Sure.
25 MR. BROWNE:

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1 Q. Sure, okay. So the purpose is to have
2 everybody's lens offer a perspective and then
3 to come out with a consensus?
4 MR. HYNES:
5 A. Yes, which was the best medical expert advice
6 we had at the time, I guess.
7 MR. BROWNE:
8 Q. But a consensus of everybody's point of view
9 that was in that room?
10 MR. HYNES:
11 A. But, sir, you'd have to--I mean, the reality
12 is if it's a communications issue, I would
13 give most weight to our communications people.
14 If it's a medical lens, you'd give most weight
15 to your doctors, what they're saying.
16 MR. BROWNE:
17 Q. Fair enough. Now can we see P-0138, please?
18 Thank you, Registrar. You were shown this
19 exhibit yesterday, Mr. Hynes, and this is
20 notes from Dr. Williams' meeting. Now I
21 appreciate you weren't at this meeting. I
22 think your evidence was, if you were, you may
23 have just been there temporarily.
24 MR. HYNES:
25 A. Yeah.

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1 MR. BROWNE:
2 Q. Because your recollection is fairly vague on
3 it. You have more of a recollection about a
4 post discussion surrounding this meeting. Is
5 that fair?
6 MR. HYNES:
7 A. Yeah.
8 MR. BROWNE:
9 Q. Okay. The note there, and I'll just scroll
10 down, you'll see the second last bullet,
11 "Minister will accept best advice for now.
12 Wishes to meet again within the next two
13 weeks." Were you made aware of that after the
14 meeting in any discussion with the Minister?
15 MR. HYNES:
16 A. Well, the Minister would have certainly
17 relayed to me that based on, you know, the
18 medical opinion of Eastern Health, that they
19 recommended to hold off.
20 MR. BROWNE:
21 Q. No, no, no, that's not what I'm asking you.
22 The second part of that, it says "wishes to
23 meet again within the next two weeks." Did
24 the Minister convey that sentiment to you?
25 MR. HYNES:

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1 A. There was a number of ongoing expectations for
2 meetings on this in short order because the
3 Minister wanted almost ongoing briefings. So
4 I don't know if he might have mentioned two
5 weeks, but there would have been an
6 expectation he would have been updated in
7 short order.
8 MR. BROWNE:
9 Q. But do you agree that this is--if I'm reading
10 this correctly, is that what Dr. Williams has
11 recorded here is a sentiment by the Minister
12 to meet again in two weeks. Is that fair?
13 MR. HYNES:
14 A. That's his statement, I guess.
15 MR. BROWNE:
16 Q. And my question is--yes, fair enough, but what
17 I'm asking you is did the Minister ever convey
18 that information to you that he--after the
19 August 15th meeting that he wanted to still
20 have a further meeting within two weeks?
21 MR. HYNES:
22 A. I can't be definitive if he--I mean, again,
23 there was an ongoing expectation to be briefed
24 continually.
25 MR. BROWNE:

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1 Q. Okay, and then again, assuming that this is an
2 accurate reflection, whose responsibility
3 would it have been to arrange this meeting?
4 MR. HYNES:
5 A. It would have been, I guess, the Deputy
6 Minister to advise the CEO of Eastern Health
7 to make the necessary arrangements.
8 MR. BROWNE:
9 Q. Now going--again, I appreciate that you
10 weren't around for this August 15th meeting,
11 but going back, you were involved in the
12 initial meeting with the Minister back on July
13 21st, correct?
14 MR. HYNES:
15 A. That's correct, yeah.
16 MR. BROWNE:
17 Q. Would it be fair to say that the
18 representatives from Eastern Health, at that
19 time, in discussing that issue with the
20 Minister, expressed a point of view that had
21 the best interest of the patient in mind?
22 MR. HYNES:
23 A. I would, you know, like to think that they
24 expressed that at all times, you know, the
25 interest of the patients was first and

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1 foremost in everyone's mind.
2 MR. BROWNE:
3 Q. And you never ever, at any point, had any
4 concern that that was not the case, in the
5 meetings that you participated in?
6 MR. HYNES:
7 A. No, I mean.
8 MR. BROWNE:
9 Q. Now, I want to ask you about your evidence
10 yesterday of the November 9th, 2005 meeting
11 with Dr. Laing. I think that was around the
12 issue of Herceptin and the introduction of
13 that drug, which is a breast cancer drug, to
14 the provincial formulary, and that happened in
15 November 2005.
16 MR. HYNES:
17 A. That's right.
18 MR. BROWNE:
19 Q. And if we can, just for a moment, Registrar,
20 if we could show the witness that portion of
21 his transcript? Mr. Hynes, I've asked that
22 that be put in, and just so we're clear on
23 that. You'll just see that, if we can go down
24 there, and you can probably, if you want--your
25 mouse is not working, is it?

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1 MR. HYNES:
2 A. Yeah.
3 MR. BROWNE:
4 Q. Okay. It must have been given some
5 antibodies. I don't think it was working
6 earlier. If you could turn -
7 THE COMMISSIONER:
8 Q. The Registrar has been on the case, so it's
9 working.
10 MR. BROWNE:
11 Q. Well, found some good antibodies, I think,
12 Registrar. Let's look at--I think the essence
13 of what I want to deal with this morning is on
14 page 381 and 382 and that's around this whole
15 Herceptin. I think because what you testified
16 was that Dr. Laing was there to review a
17 portion of a press release that contained
18 statements attributed to her, and while she
19 was there, you took the opportunity of
20 discussing with her, I guess, where things
21 were with ER/PR.
22 MR. HYNES:
23 A. That's correct.
24 MR. BROWNE:
25 Q. And there were two points that came up. I

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1 think one, you sort of asked her "well, how
2 are things going?" and she sort of said "look,
3 it's a big challenge. We're working through
4 it."
5 MR. HYNES:
6 A. That's correct.
7 MR. BROWNE:
8 Q. The second thing was about, regarding whether
9 or not people who had died could have been
10 helped?
11 MR. HYNES:
12 A. Yes.
13 MR. BROWNE:
14 Q. And she responded to you yes, they could have
15 been. Is that right?
16 MR. HYNES:
17 A. Yes.
18 MR. BROWNE:
19 Q. Did you--what was your understanding about, at
20 that time, what drugs were available to help
21 cancer patients? Did you know anything about
22 Tamoxifen, how Tamoxifen could help?
23 MR. HYNES:
24 A. I mean, I know it was a leading drug across
25 the country, and I remember, sir, that at

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1 another meeting with our oncologists, at some
2 point, that they even indicated that they were
3 pleased with some of the drugs Government had
4 offered, because we were viewed as a leading
5 jurisdiction across the country with respect
6 to the treatments we could offer, medications
7 and other things that were available.
8 MR. BROWNE:
9 Q. I guess I'm focused more on the fact of your
10 understanding of Tamoxifen and how Tamoxifen
11 may help breast cancer patients. Did you have
12 any understanding at that point in time?
13 MR. HYNES:
14 A. I did.
15 MR. BROWNE:
16 Q. I mean, when--can you tell me what your
17 understanding was about how Tamoxifen helps
18 breast cancer patients?
19 MR. HYNES:
20 A. It would determine what was the appropriate
21 follow-up treatment.
22 MR. BROWNE:
23 Q. But I guess I'm more focused on the mechanism,
24 how--does it extend life? Does it help their
25 quality of life? Any sorts of those things,

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1 would you know that level of detail, how it
2 would help?
3 MR. HYNES:
4 A. My understanding is it would help determine
5 your likelihood for recurrence, sir. That's
6 my limited understanding.
7 MR. BROWNE:
8 Q. And you had it that--that was your
9 understanding at around that time?
10 MR. HYNES:
11 A. Yes, sir.
12 MR. BROWNE:
13 Q. Thank you. Now the last area I want to ask
14 you about, Mr. Hynes, is in relation to the
15 meeting on November 23rd. Now Mr. Simmons has
16 covered some of the questions I have for you,
17 but could the witness be shown P-0145? I
18 think this exhibit you've been shown, there's
19 a number of--this exhibit shows up in a number
20 of different exhibits. Oh no, well then
21 perhaps--I know it's at P-0125, page 42.
22 Sorry, Registrar. And this is the document
23 that was shown at the meeting in November, Mr.
24 Hynes. And you had mentioned this morning
25 that you recalled, at this meeting, your

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1 previous discussion from November of 2005 with
2 Dr. Laing. Is that right?
3 MR. HYNES:
4 A. Yes.
5 MR. BROWNE:
6 Q. Okay. Did you remind her of that discussion
7 during this meeting?
8 MR. HYNES:
9 A. No, that was just a quiet reflection to
10 myself, sir.
11 MR. BROWNE:
12 Q. Okay.
13 MR. HYNES:
14 A. When I was looking at the number of deceased
15 people, in that context.
16 MR. BROWNE:
17 Q. Sure, sure, and is it fair to say that at this
18 meeting, and I think you sort of touched on
19 this with some answers to Mr. Simmons just a
20 few moments ago, but is it fair to say that
21 the focus, again using the lens approach here,
22 of the oncologists and Dr. Laing was that they
23 were trying to priorize the patients, the
24 living patients, and help deal with them and
25 that was the focus that they were doing with

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1 the tumor panel at that time?
2 MR. HYNES:
3 A. Yeah, no question that, I mean, their time and
4 efforts, I guess, I mean, you know, were again
5 focused on the people who could still be
6 helped with this treatment or with this test.
7 MR. BROWNE:
8 Q. And that the results that were received, if we
9 can scroll down here, at the bottom here, the
10 101 retested and results received, was it your
11 understanding that those results were not
12 reviewed by the tumor panel at that point?
13 MR. HYNES:
14 A. That was my understanding, and that became, I
15 guess, a question, why bother retesting if
16 you're not going to send them to the tumor
17 panel.
18 MR. BROWNE:
19 Q. Okay. Now lastly, Mr. Hynes, I just want you
20 to sort of run through, if we could, please,
21 Registrar, the second transcript, and this is
22 a transcript, Mr. Hynes, of Minister Osborne's
23 testimony surrounding the meeting, and perhaps
24 just you can start perhaps with the bottom of
25 page 278, and just tell me, and take your

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1 time, sir, if this accords with your
2 recollection of the dynamic--this is of Mr. -
3 MR. HYNES:
4 A. Okay.
5 MR. BROWNE:
6 Q. This is Mr. Simmons' cross-examination of Mr.
7 Osborne, Minister Osborne, concerning his
8 recollections of the, I guess, discussion
9 surrounding the deceased patients and your
10 discussion with Dr. Laing and the responses
11 from Dr. Laing.
12 MR. HYNES:
13 A. So what page did you want me to -
14 MR. BROWNE:
15 Q. Well, I think it starts at page 278 and it's
16 fairly--there are a series of questions there.
17 MR. HYNES:
18 A. Okay.
19 MR. BROWNE:
20 Q. And let me just walk you through it a bit
21 then, if it may help. You see at 279, line
22 22, that the response there from Mr. Osborne
23 was that when you raised this issue, Dr. Laing
24 indicated that given the resources available,
25 they would prefer to spend their time focusing

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1 on the living patients.
2 MR. HYNES:
3 A. That would be a simple way of saying what she
4 said.
5 MR. BROWNE:
6 Q. Okay, and then further on 280, that there was
7 concerns that in addition to doing--and this
8 is lines 12 to 17, that in addition to doing
9 normal lab work and normal pathology, oncology
10 work and seeing patients, they were doing this
11 on top of their regular workload. Again, does
12 that accord with your recollection?
13 MR. HYNES:
14 A. I know, again, you know, Mr.--I apologize,
15 I've lost your name, but -
16 MR. BROWNE:
17 Q. Browne.
18 MR. HYNES:
19 A. Browne, I apologize, Madam Commissioner. You
20 know, I had the sense in the conversation that
21 Dr. Laing became--you know, I won't say
22 emotional, but she certainly got very flush in
23 the face because--and I had the understanding
24 that this had been an onerous emotional task
25 on her, that I had some respect for, because

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1 she was the one, and I had appreciated from
2 prior meetings, that she had a caseload of
3 probably 200 plus patients. She had
4 administrative duties as the clinical chief,
5 etcetera, etcetera, and aside from all that,
6 they were taking on this extra piece of
7 business, and this had been a very emotional,
8 almost draining experience for them as a team,
9 because again, I mean, I appreciated, sir,
10 that she was the one, at the end of the day,
11 having to meet with some of these people and
12 give them this information, which is, I'm
13 sure, the worst thing she would have wanted to
14 do. So I mean, I had some appreciation for
15 that.
16 MR. BROWNE:
17 Q. And that sort of, I guess, led to sort of the
18 emotion that may have been in that room that
19 day between you and Dr. Laing?
20 MR. HYNES:
21 A. No question. I mean, I think she was
22 probably, you know, coming at it from that
23 perspective that I respected, but my political
24 lens was just that "well, look, you've got
25 these numbers out here. You're going to be

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1 able to answer the question?" And I mean, the
2 media will want a better answer than, you
3 know, "well, I'm concerned with the living
4 than the"--you know, I mean, I just thought
5 that was a point that would definitely need to
6 be answered.
7 MR. BROWNE:
8 Q. You wanted to weigh in on that perspective?
9 MR. HYNES:
10 A. Yes.
11 MR. BROWNE:
12 Q. Okay, thank you. That's all the questions I
13 have. Thank you, Mr. Hynes. I appreciate it.
14 THE COMMISSIONER:
15 Q. Ms. O'Dea?
16 MS. O'DEA:
17 Q. No questions, Commissioner.
18 THE COMMISSIONER:
19 Q. Ms. Newbury?
20 MR. DARRELL HYNES, EXAMINATION BY MS. JENNIFER NEWBURY
21 MS. NEWBURY:
22 Q. Good afternoon, Mr. Hynes. Jennifer Newbury
23 for the Canadian Cancer Society. I just have
24 a couple of areas to cover with you today. It
25 was your evidence yesterday that, with regard

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1 to what was happening in July of 2005, I
2 understand, that the reality was once you
3 started to get test results back and notifying
4 people, that it was inevitable that the news
5 about the ER/PR test would be out in the
6 public. Did I understand your evidence?
7 MR. HYNES:
8 A. Yeah, that's based on that there had been a
9 number of people contacted already when they
10 met with us on July 21st of 2005, yes.
11 MS. NEWBURY:
12 Q. And I believe the number at that point in time
13 was 12 patients had been notified.
14 MR. HYNES:
15 A. That's what I noted, yeah.
16 MS. NEWBURY:
17 Q. Okay, and was it your view then that it could
18 public any day, as of July 21st, or any week
19 or -
20 MR. HYNES:
21 A. Yes.
22 MS. NEWBURY:
23 Q. - what sort of time frame were you looking at?
24 MR. HYNES:
25 A. I would have to say that's a safe statement.

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1 MS. NEWBURY:
2 Q. Okay, and did the Minister and others in the
3 Department of Health share this particular
4 viewpoint?
5 MR. HYNES:
6 A. Well, yes. I think that's why the Minister
7 was so concerned about getting out public
8 notification immediately, because he knew
9 that, you know, it was only a matter of time,
10 I think, before it was raised publicly, either
11 by a family member or someone who had gotten a
12 letter or had gotten information that their
13 test had changed and then, you know, if they
14 went public or called their MHA or went to an
15 open line show that it would be raised in a
16 very public way.
17 MS. NEWBURY:
18 Q. Okay. Was the Minister's concern to go public
19 as soon as possible or was he focusing on
20 notifying the patients before it went public?
21 MR. HYNES:
22 A. I think the Minister wanted to get it out
23 there publicly, but certainly, I mean, you
24 know, there was a certain respect for we
25 should make sure the patients are notified

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1 first.
2 MS. NEWBURY:
3 Q. Right.
4 MR. HYNES:
5 A. In an appropriate and caring way, before we
6 make a broader public statement. I think, you
7 know, the view of the Minister was we owed it
8 to individual people to communicate with them
9 directly, and you know, I think that was
10 shared around the table.
11 MS. NEWBURY:
12 Q. Okay, by people from the Department of Health
13 or from both Department of Health and Eastern
14 Health?
15 MR. HYNES:
16 A. I think that was--well, I know that was
17 certainly the Department's view. I mean, the
18 Minister spoke for the Department. I think
19 that was a consensus.
20 MS. NEWBURY:
21 Q. Okay, and ultimately, it was the advice of
22 Eastern Health, and in particular the--I think
23 you had described it as medical advice or
24 professional advice that they would hold off
25 on the patient notification until they had

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1 something to tell the patients, and more
2 particularly, the retest results?
3 MR. HYNES:
4 A. Yes.
5 MS. NEWBURY:
6 Q. And the medical--so this you described as best
7 advice. So that was the advice of the
8 oncologists?
9 MR. HYNES:
10 A. That would have been after, you know, the
11 August meeting when the oncologists were at
12 the table, but certainly, and I think I
13 alluded to it earlier, at the July meeting,
14 George Tilley's role as a senior chief
15 executive officer with a very long and
16 distinguished career in Eastern Health of 30
17 plus years and Dr. Williams' career as a
18 former deputy minister of Health with 30- 40
19 plus years, I mean they're--when they spoke,
20 we certainly listened.
21 MS. NEWBURY:
22 Q. Okay. But on the July 21st meeting, were they
23 leaning towards holding off on notifying the
24 patients or were they just waiting to see what
25 they oncologists had to say?

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1 MR. HYNES:
2 A. Oh, I think the--well, the meeting ended
3 certainly we need to bring the oncologists on
4 board, and certainly, I think, there was a
5 realization that until they had a better
6 handle on the numbers, what years were
7 involved, what exactly we were dealing with,
8 and that's why, I think, they had a number of
9 internal processes under way at Eastern Health
10 to try to work through that.
11 MS. NEWBURY:
12 Q. So they wanted more information, not just
13 necessarily the retest results, but also more
14 information about the problem and the scope of
15 the problem?
16 MR. HYNES:
17 A. Yes, and I think that's reflected in Mr.
18 Tilley's e-mail to Mr. Abbott that was shared
19 with me on the 25th of July.
20 MS. NEWBURY:
21 Q. Do you know if the oncologists or others,
22 especially the medical people at Eastern
23 Health, have any experience with dealing with
24 the media and having issues going public and
25 whether they can control an issue going

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1 public?
2 MR. HYNES:
3 A. I missed the first part of your question, I
4 apologize.
5 MS. NEWBURY:
6 Q. Do you know if the oncologists or other
7 medical professional at Eastern Health would
8 have any experience with dealing with media
9 and dealing with issues going public or being
10 able to control an issue going public?
11 MR. HYNES:
12 A. Certainly, I mean, I don't know if anyone has
13 any control, but I mean, I know Dr. Laing was
14 quoted in a story in October, I believe, when
15 it broke and I assume that was Eastern
16 Health's internal recommendation to who they
17 would have as their spokesperson, whether it
18 be Mr. Tilley, Dr. Williams, and in this case
19 they chose the oncologist.
20 MS. NEWBURY:
21 Q. Okay. But I guess my question is this, you
22 have a viewpoint and others at the Department
23 of Health have a viewpoint that 12 people, at
24 least, know about a problem with ER/PR
25 testing. This can go public at any minute.

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1 Ultimately within that couple of week period
2 of time, by August 15th, it was decided to
3 defer to the advice of oncologists and not to
4 notify patients until more information was
5 available. My question is whether the
6 oncologists would know, was it explained to
7 them that you can't control when this goes
8 public, so even in an ideal world if it's
9 better to wait to have more information to go
10 to patients with, that you can't control that?
11 MR. HYNES:
12 A. Yeah, I don't know what their background would
13 be and what they would bring from an
14 experience factor to that decision. But, I
15 mean, I guess there's certain, I guess, mind
16 sets around how you would publicly disclose a
17 fairly large patient issue like this, so I
18 assume they would have brought that to the
19 table, and as well as the clinical part about
20 the practicality of, I mean, they had
21 practices and how logistically this would
22 operate. Because, I mean, there was also some
23 concern, too, that, I mean, if you made a mass
24 statement, you could have, you know, fairly
25 widespread concern and discourse and people

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1 would flood their--flood offices with
2 inquiries and information and looking for
3 clarification. And of course, all these
4 doctors, you know, admittedly, are already
5 quite busy now.
6 MS. NEWBURY:
7 Q. Right. But there was, I think you had
8 indicated that resources could have been made
9 available by the Department of Health, if
10 necessary, to deal with that end of it?
11 MR. HYNES:
12 A. Well, I mean, the offer was made by the
13 minister a number of times because, you know,
14 my experience in most things in Department of
15 Health you could fix with enough resources.
16 MS. NEWBURY:
17 Q. Sure.
18 MR. HYNES:
19 A. At least short-term. But in this case, you
20 know, Mr. Tilley, I assume, felt he didn't
21 need any additional resources or any--because,
22 you know, we offered and he certainly felt he
23 could manage it.
24 MS. NEWBURY:
25 Q. I guess, you know, they might have experience

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1 in how to deal, interact with patients or
2 public notification. But my question really
3 is focusing on was it realistic for the
4 oncologists to think they could actually have
5 control over the timing of when this went
6 public? Is that something that you think that
7 the oncologists would have any experience
8 dealing with?
9 MR. HYNES:
10 A. I don't know. I mean, you know, the one thing
11 with this story, I don't know if anyone in
12 country, except now in New Brunswick, would
13 have any experience with how to deal with a
14 massive issue involving this. So I don't know
15 if that's a fair question to the oncologists,
16 if they would have any--because, I mean, the
17 scope and the depth of this issue was
18 something that perhaps there's not another
19 health authority in the country has ever gone
20 through.
21 MS. NEWBURY:
22 Q. But it's not so much the particular problem
23 that I'm talking about, it's--I mean, you're
24 coming here, you deal with, you know,
25 political issues all the time, you deal with

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1 media all the time. You in your own heart, I
2 think, had the impression that this can go
3 public at any minute?
4 MR. HYNES:
5 A. Yes.
6 MS. NEWBURY:
7 Q. You're used to dealing with that in your day-
8 to-day life?
9 MR. HYNES:
10 A. Yes.
11 MS. NEWBURY:
12 Q. I'm wondering whether you had relayed that or
13 someone else from the Department of Health had
14 relayed that particular viewpoint to the
15 oncologists and said point blank, you know,
16 ideally maybe you would rather that you had
17 all the information to go to the patients,
18 that you had the retest results, but you can't
19 control this. Twelve people know about it,
20 they're going to go public and the worse case
21 scenario is that they hear about it in the
22 media?
23 MR. HYNES:
24 A. Yeah. I certainly did not. And I can't,
25 again, I don't specifically recall being at

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1 the, you know, August 15th meeting -
2 MS. NEWBURY:
3 Q. I appreciate that.
4 MR. HYNES:
5 A. - Ms. Newbury so, I mean, I don't know. I
6 wouldn't be surprised if that was a topic of
7 discussion, knowing some of the past
8 discussions around this issue, but I can't
9 confirm.
10 MS. NEWBURY:
11 Q. So you don't know, then, whether the
12 oncologists fully understood the risk of
13 holding off or postponing notification of the
14 patients, in particular?
15 MR. HYNES:
16 A. I mean, you know, I can only surmise that that
17 would have been a topic of significant
18 discussion within Eastern Health.
19 MS. NEWBURY:
20 Q. But that was never, ever relayed to you?
21 MR. HYNES:
22 A. Not that--no, sir--no, ma'am.
23 MS. NEWBURY:
24 Q. Okay. And in hindsight do you think, looking
25 back at it, because there was some time,

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1 August came and went, September came and went,
2 and maybe you didn't know what was going on
3 behind the scenes at Eastern Health, but in
4 hindsight do you think Department of Health
5 could have pushed this point a bit more, just
6 to say, listen, if you're going to try to hold
7 off on notifying the patients to get more, you
8 know, results, you have to recognize that this
9 is going to go public at any minute and, you
10 know, govern yourself accordingly? Maybe they
11 could have put a push on trying to get patient
12 notification out?
13 MR. HYNES:
14 A. Well, I mean, you know, we certainly, at least
15 early on it was the view, and, you know, I
16 believe sincerely Eastern Health believed
17 this, that this could be done and turned
18 around, this whole process to be turned around
19 and the information could come back and people
20 could be notified, the individual patient
21 contacts could be done in fairly short order.
22 MS. NEWBURY:
23 Q. Um-hm.
24 MR. HYNES:
25 A. And unfortunately as the months moved along in

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1 the fall, I mean, that process got away from
2 us.
3 MS. NEWBURY:
4 Q. Right.
5 MR. HYNES:
6 A. And ultimately, I mean, you know, these people
7 weren't contacted in our way in an appropriate
8 way, I guess, and then it went, as you say,
9 went public in October.
10 MS. NEWBURY:
11 Q. Do you think if there was a better
12 appreciation by Eastern Health as to the
13 ability for things to leak out there and to go
14 public and be picked up by the media, do you
15 think if they had a better appreciation for
16 that angle, that they might have been dealing
17 with it in a bit more of an urgent fashion,
18 particularly in terms of the patient
19 notification?
20 MR. HYNES:
21 A. Yeah, I don't know if I'm comfortable
22 commenting on what Eastern Health may or may
23 not. I mean, all I can tell you is, I mean,
24 we--it was certainly the minister's strong
25 view that individual patient notification

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1 would be done. Unfortunately, that process
2 dragged on for some period of time and
3 ultimately just, you know--and when the issue
4 went public in October, I mean, I think, you
5 know, the minister was relieved and I think we
6 all were.
7 MS. NEWBURY:
8 Q. Right. And I think it was, I mean, you stated
9 that you were relying upon the best advice of
10 Eastern Health and, in particular, the medical
11 professions. And it was your understanding
12 that the minister, even though his reaction
13 was to go public right away and to get the
14 patient notification out there right away, but
15 defer to the best advice of medical
16 professionals. But would it not be the best
17 advice of the Department of Health, if you
18 were acting in an advisory capacity to Eastern
19 Health, to say this is the world that we're
20 operating in, you know, you're going to have
21 to take that into account even though in an
22 idea world you might want it to go forward in
23 this manner, this is the world that we're
24 operating in and you really should take that
25 into account?

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1 MR. HYNES:
2 A. I think I understand what you're trying to
3 say. I mean, again, you know, the minister was
4 quite strong in advocating and I think that's
5 reflected in his, you know, his testimony and
6 the notes of that file that, I mean, he wanted
7 public disclosure done, wanted to get the
8 information out. And you know, if the
9 Department of Health should have, you know,
10 taken more of a direct role or somehow ordered
11 Eastern Health to go ahead, because in my
12 view, especially early on, without full
13 information from Eastern Health and, you know,
14 cooperation, I don't know what you could go
15 out and say, because again, you know, you have
16 to remember that we weren't sure for periods
17 of time what exactly the errors were, what
18 exactly the tests were and, you know, could
19 you go out and make a broad statement that we
20 have a, you know, without knowing exactly what
21 you're talking about. I don't know, I guess,
22 and it's for others to decide if that would be
23 a greater public service.
24 MS. NEWBURY:
25 Q. But how about that patient notification, I

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1 mean, obviously there's some--there is a group
2 of patients that have had tests done that are
3 now cause--you know, there's some reason to
4 believe that they may not be accurate. How
5 about at least notifying that group of
6 patients, that they don't have to hear about
7 it through the media when it goes public?
8 MR. HYNES:
9 A. Oh, and I think that's why the minister kept
10 pushing that individual patient notification
11 should have been, should have been, because
12 again, some of these stories that people are
13 getting the letters addressed to the wrong
14 people and something all this time later, I
15 mean, these are, you know, dreadful,
16 heartbreaking stories that I think all of us
17 would find unacceptable and just, you know,
18 sad. I mean -
19 MS. NEWBURY:
20 Q. So you think then that the minister did, in
21 fact, push this issue and it was Eastern
22 Health's decision not to, I guess, follow the
23 minister's advice in that regard -
24 MR. HYNES:
25 A. You know, the -

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1 MS. NEWBURY:
2 Q. - and rather to pursue the wrong approach?
3 MR. HYNES:
4 A. Yeah, I mean, the minister urged, and you
5 know, quite strongly, in my view, and you
6 know, his view is still that we should have
7 gotten individual patient notifications out
8 ASAP. And I remember discussions and I
9 remember even seeing an e-mail, perhaps a part
10 of testimony, back, up into September, that
11 Moira Hennessey or someone in the department
12 was still inquiring of Eastern Health about
13 the status of the letters.
14 MS. NEWBURY:
15 Q. Um-hm.
16 MR. HYNES:
17 A. And again, I'm not sure if that was because
18 they were still trying to put together their
19 database to identify these people or whatever.
20 But, I mean, the minister's opinion in that
21 never changed, so unfortunately the issue
22 broke in October and the issue of the letters
23 just never seemed to--it never got done.
24 MS. NEWBURY:
25 Q. Okay. So was it your understanding that

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1 behind the scenes, during the month of August,
2 for example, Eastern Health was actually
3 working towards sending that letter of
4 notification to patients or did you rather
5 think that they had decided to postpone that
6 notification of patients?
7 MR. HYNES:
8 A. No, I mean, I would think the letter was still
9 being worked on, but the problem was you were
10 going to do patient notifications first.
11 MS. NEWBURY:
12 Q. Um-hm.
13 MR. HYNES:
14 A. And the problem was is the, you know, the
15 testing and retesting, getting results back
16 just, you know, it went far longer, I guess.
17 I mean, we were originally told it would
18 probably be a couple of weeks and, you know, I
19 mean, ultimately I think it took a year and a
20 half to get done.
21 MS. NEWBURY:
22 Q. Okay. So it was getting the information about
23 which patients to notify that you thought was
24 delaying the process of patient -
25 MR. HYNES:

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1 A. I'm not clear on that. I mean, you know,
2 whether--I mean, obviously the samples never
3 went away and got back quick enough, and that
4 became such a point that, I mean, Mr. Tilley
5 even at one point, I think, made a direct
6 appeal to the director of the lab to try to
7 see if there was any way to put pressure on to
8 speed up things.
9 MS. NEWBURY:
10 Q. But wasn't -
11 MR. HYNES:
12 A. I mean, I don't--put it this way, I think--I
13 don't recall the department ever ordering
14 them, irregardless, I mean, you know, send out
15 a letter because, again, in a very real way I
16 don't think Eastern Health, and I believe I
17 made this point at my deposition or whatever
18 that I don't remember having a comfort level
19 that Eastern Health could press a button and
20 print out the 1000 to 2000 names of people
21 they were talking about that were affected.
22 MS. NEWBURY:
23 Q. Right. Now, a couple of points there. Number
24 one, the letter that you're talking about, the
25 delays in Mount Sinai testing and getting the

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1 samples done, that would explain a delay in
2 notifying the patients about the result of
3 their retesting. But I had understood from
4 your evidence that the letter contemplated by
5 the minister was to advise that retesting will
6 take place, so you wouldn't have to wait until
7 the samples had gone to Mount Sinai and come
8 back?
9 MR. HYNES:
10 A. The letter, I mean, was still in, very much in
11 play certainly after the August meeting when
12 we found out, you know, the oncologists
13 recommended holding off. But, I mean, I think
14 it just became a mute point after everything
15 went public in October because it was out
16 there and -
17 MS. NEWBURY:
18 Q. So they were holding off, they were, from your
19 perspective, suggesting that you hold off on
20 any notification to patients, whether it's to
21 advise of retesting or to advise -
22 MR. HYNES:
23 A. Until they had more information, yeah.
24 MS. NEWBURY:
25 Q. Okay. And I guess my question is in

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1 hindsight, given that the Department of Health
2 has a certain perspective, and I appreciate
3 that you may not have felt that you could
4 direct them to do it at that time, in
5 hindsight do you think that the Department of
6 Health could have offered its best advice from
7 the political perspective that you cannot
8 control when the media finds out about this
9 and produces a story, because you said
10 yourself that this could go public at any
11 moment, any day after July 21st, was that not
12 best advice that you could have offered from
13 the Department of Health perspective to the
14 oncologists just so that they know what
15 they're dealing with?
16 MR. HYNES:
17 A. I mean, Eastern Health have a number of
18 professional people in house and I'm sure that
19 would have certainly been the discussion
20 internally and it would have been a discussion
21 around the department that, I mean, the
22 reality is time wasn't with us because as
23 tests were going away and coming back and
24 people were being notified, it was only a
25 matter of time before it went public.

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1 MS. NEWBURY:
2 Q. Sure. And you're not aware if that was
3 specifically relayed to the Eastern Health
4 decision makers by the Department of Health
5 officials, that you're personally aware of?
6 MR. HYNES:
7 A. No, not that I'm personally aware of, no.
8 MS. NEWBURY:
9 Q. Okay.
10 COMMISSIONER:
11 Q. Mr. Hynes, I'm not sure I understood one point
12 raised in the question you just answered, and
13 that was the nature of the letter contemplated
14 by the minister. Did you agree with Ms.
15 Newbury that the letter that the minister was
16 contemplating would be one to those who had
17 been tested to tell them there was going to be
18 a retesting?
19 MR. HYNES:
20 A. My recollection, Madam Commissioner, was the
21 letter, because again, we were operating under
22 the premise that the tests would come back,
23 the letter would essentially tell people the
24 definitive, their definitive situation, you
25 would tell them that there's been a change and

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1 here's the situation. Please contact, you
2 know, Dr. X for -
3 COMMISSIONER:
4 Q. Okay.
5 MS. NEWBURY:
6 Q. So there would be no letter in advance to tell
7 people that they would be retested, it would
8 only be upon receipt of the results from Mount
9 Sinai?
10 MR. HYNES:
11 A. That's my recollection.
12 MS. NEWBURY:
13 Q. Okay. And would it only be those patients who
14 had a change in their results? Would there be
15 any letter to patients whose results remained
16 the same?
17 MR. HYNES:
18 A. No, because I don't know if there'd be a need
19 for that. You know, if there was no change,
20 why would you alarm people if they weren't
21 affected, I guess?
22 MS. NEWBURY:
23 Q. Okay. At the November 23rd, 2006 meeting,
24 briefing, there was some discussion. You had
25 indicated in your evidence that John Abbott

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1 wanted an advance, I think it was an advance
2 briefing for Mr. Dawe, for the Canadian Cancer
3 Society?
4 MR. HYNES:
5 A. Yes.
6 MS. NEWBURY:
7 Q. Okay. And is the purpose of such an advance
8 briefing for someone like Peter Dawe for the
9 Canadian Cancer Society, is that just to
10 provide information to the Canadian Cancer
11 Society or is there any opportunity for
12 information or input to be sought from Mr.
13 Dawe on behalf of the Canadian Cancer Society?
14 MR. HYNES:
15 A. I'm not sure I understand. I mean, he would
16 certainly, I guess, be free to ask questions.
17 But I mean, his--you know, presumably the text
18 is set and the format is set, so I mean, he
19 was certainly free to ask questions and seek
20 clarification. But I mean, by this point it
21 would be -
22 MS. NEWBURY:
23 Q. It would be a done deal -
24 MR. HYNES:
25 A. - materially done.

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1 MS. NEWBURY:
2 Q. Okay. I thought you had said this morning
3 that you would go--as part of this debriefing,
4 they would go to the Canadian Cancer Society
5 for their views and reaction. Did I
6 misunderstand what -
7 MR. HYNES:
8 A. No. It would be--well, I mean, what I meant
9 by that, Ms. Newbury, was the media would
10 certainly, I mean, I assume as soon as the
11 press conference was over, they'd go right to
12 Mr. Dawe, probably immediately, and say what
13 is your view point, so it would be beneficial
14 to have know ahead of time.
15 MS. NEWBURY:
16 Q. So that he can think about what his viewpoints
17 -
18 MR. HYNES:
19 A. That's right. So he'd have some courtesy heads
20 up to try to get his mind around this
21 information and formulate, I guess, the
22 Canadian Cancer Society's response and
23 viewpoint on it at that time.
24 MS. NEWBURY:
25 Q. So you don't think that there would

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1 necessarily be any role, say, if something was
2 confusing to Mr. Dawe for the Canadian Cancer
3 Society or he didn't understand something that
4 was being presented, would there be any role
5 for Eastern Health to say, well, if he doesn't
6 understand it, then, you know, maybe we ought
7 to clarify this?
8 MR. HYNES:
9 A. Well, he should certainly raise flags with
10 them. I mean, if he couldn't, if he couldn't
11 understand what was being presented and had
12 significant concerns, maybe, you know, it
13 might be too late, but I mean, they may have
14 to rethink their strategy.
15 MS. NEWBURY:
16 Q. Or they can add something verbally, I guess?
17 MR. HYNES:
18 A. Or you can add clarification or some caveat,
19 yeah.
20 MS. NEWBURY:
21 Q. And what if there was some sort of omissions
22 from his point of view or questions that
23 Eastern Health hadn't thought to address in
24 their briefing?
25 MR. HYNES:

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1 A. That might be a harder thing because obviously
2 it's ultimately Eastern Health's process,
3 Eastern Health's information, so to have a
4 third party, I guess, suggest or dictate to
5 you what you should or should not have in your
6 material might not, you know, be something
7 that's going to take place.
8 MS. NEWBURY:
9 Q. Well, not to dictate, but just to give Eastern
10 Health a heads up that, you know, this
11 question might be posed at some point in time
12 and for our benefit it's better that we know
13 this in advance of the briefing.
14 MR. HYNES:
15 A. Sure. And that's why I think the minister
16 thought it was a good idea on November 23rd.
17 MS. NEWBURY:
18 Q. The minister or the deputy minister or both?
19 MR. HYNES:
20 A. I think the minister agreed, certainly.
21 MS. NEWBURY:
22 Q. Okay. And were you surprised by the reaction
23 of, I guess, Eastern Health to the suggestion
24 that he get an advance briefing?
25 MR. HYNES:

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1 A. I can't say I was surprised, no.
2 MS. NEWBURY:
3 Q. No. And why is that?
4 MR. HYNES:
5 A. Because I believe I may have been copied or
6 had some knowledge of the e-mails prior to
7 that. One of them had Ms. Bonnell about some
8 connotation about fool me once, this kind of
9 thing, I remember seeing that earlier. But,
10 you know, I certainly had some understanding
11 that there was a strained relationship between
12 Eastern Health and the Canadian Cancer
13 Society.
14 MS. NEWBURY:
15 Q. Now, I thought that that e-mail came
16 subsequently, but you had -
17 MR. HYNES:
18 A. And it might have, but, I mean, I certainly--
19 it was understood by me.
20 MS. NEWBURY:
21 Q. Okay.
22 MR. HYNES:
23 A. Whether it was that e-mail or another e-mail
24 that was shared to me.
25 MS. NEWBURY:

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1 Q. Okay.
2 MR. HYNES:
3 A. With me during my time, but I certainly
4 remember.
5 MS. NEWBURY:
6 Q. And was this viewpoint shared by anyone at the
7 Department of Health about -
8 MR. HYNES:
9 A. No, not that it was ever expressed to me.
10 MS. NEWBURY:
11 Q. Okay. And did you consider the, John
12 Abbott's--was it a direction or a suggestion
13 or a request that Mr. Dawe get the briefing in
14 advance?
15 MR. HYNES:
16 A. Again, I don't know if the deputy could
17 direct, but it was Mr. Abbott's certainly
18 suggestion that he thought it was a good idea.
19 And I think that was shared at least among the
20 Department of Health officials because just on
21 the nature of the information, Mr. Dawe would
22 be keenly interested and would perhaps be the
23 very first person the media and, you know,
24 would want to go to to get his reaction to
25 this information.

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1 MS. NEWBURY:
2 Q. Okay. And is this a fairly standard approach
3 to give special interest groups or
4 stakeholders advance notice of a briefing?
5 MR. HYNES:
6 A. Absolutely, seeing--I mean, we do it for--when
7 I was in the Department of Finance we do it
8 for budget day, I mean, you bring in your
9 various individual stakeholders and give them
10 a heads up or if you're announcing new
11 legislation or new technical legislation, you
12 know, for instance, when we did the mental
13 health legislation, we brought in the various
14 Canadian Mental Health group, various advocacy
15 groups and walked through the legislation with
16 them so they had a clear understanding of what
17 we were doing and what we were announcing.
18 MS. NEWBURY:
19 Q. Okay. And when you left the meeting on the
20 23rd of November, did you have any reason to
21 believe that Mr. Dawe would not be getting
22 that advance briefing?
23 MR. HYNES:
24 A. Except a hesitation expressed by Eastern
25 Health, but I was never clearly told this is

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1 definitely not on.
2 MS. NEWBURY:
3 Q. Okay. Thank you, Mr. Hynes. Those are all
4 the questions I have.
5 MR. HYNES:
6 A. Thank you.
7 COMMISSIONER:
8 Q. Mr. Crosbie?
9 CROSBIE, Q.C.:
10 Q. No questions, thank you.
11 MR. PIKE:
12 Q. No questions.
13 COMMISSIONER:
14 Q. Mr. Pike?
15 MR. PIKE:
16 Q. Commissioner, thank you.
17 COMMISSIONER:
18 Q. Mr. Pritchard?
19 MR. DARRELL HYNES, EXAMINATION BY MR. ROLF PRITCHARD
20 MR. PRITCHARD:
21 Q. Thank you, Commissioner. Mr. Hynes, I want to
22 take you back to a remark that you'd been
23 asked about, your remark regarding Mr. Dawe,
24 that you hated to admit it, but Peter Dawe has
25 a point. When you said you hate to admit it,

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1 am I correct in assuming that's just a turn of
2 phrase, it's completely innocuous?
3 MR. HYNES:
4 A. Yeah, I mean, it didn't mean nothing to me at
5 the time or I don't remember having any
6 definitive thought about it or -
7 MR. PRITCHARD:
8 Q. Sure. And you were questioned towards the end
9 of your questioning by Ms. Chaytor, you were
10 asked about the resumption of ER/PR testing at
11 Eastern Health. Who made the decision to
12 resume ER/PR testing at Eastern Health in
13 February of 2007?
14 MR. HYNES:
15 A. It would have been, I guess, the senior,
16 senior team of Eastern Health.
17 MR. PRITCHARD:
18 Q. Okay. And there was no decision made at the
19 department, that you're aware of, to resume
20 testing?
21 MR. HYNES:
22 A. No, that wouldn't be. An operational matter
23 like that, it wouldn't be our decision to
24 make.
25 MR. PRITCHARD:

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1 Q. And going back now to 2005, are you aware of
2 who made the original decision to stop ER/PR
3 testing at the lab at Eastern Health?
4 MR. HYNES:
5 A. I understood, sir, we were told, so it would
6 have been Eastern Health making the decision
7 and simply informing us.
8 MR. PRITCHARD:
9 Q. Thank you, Mr. Hynes. Those are all my
10 questions. I don't know if Ms. Chaytor has
11 any more questions for you.
12 COMMISSIONER:
13 Q. Ms. Chaytor, do you have anything arising?
14 CHAYTOR, Q.C.:
15 Q. Nothing arising.
16 COMMISSIONER:
17 Q. Thank you. Mr. Hynes, thank you, very much
18 for your contribution. We'll adjourn for the
19 luncheon break and resume at 2 with the next
20 witness. Thank you.
21 (LUNCH BREAK)
22 COMMISSIONER:
23 Q. Please be seated. Mr. Coffey.
24 COFFEY, Q.C.:
25 Q. Thank you, Commissioner. The next witness is

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1 Rick Singleton, at least that's the name he
2 goes by. I shouldn't presume that's his--go
3 ahead.
4 MR. RICHARD SINGLETON (SWORN) EXAMINATION BY BERNARD
5 COFFEY, Q.C.
6 REGISTRAR:
7 Q. And would you please state and spell your
8 complete name for the Commission?
9 MR. SINGLETON:
10 A. R-i-c-h-a-r-d, Richard, Singleton, S-i-n-g-l-
11 e-t-o-n.
12 REGISTRAR:
13 Q. Thank you.
14 COFFEY, Q.C.:
15 Q. Commonly referred to as Rick?
16 MR. SINGLETON:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. You call yourself Rick, okay. If we could,
20 please, Commissioner, I have some exhibits I'm
21 going to ask be entered, please?
22 COMMISSIONER:
23 Q. Yes.
24 COFFEY, Q.C.:
25 Q. They are Exhibits P-1687 through 1694,

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1 inclusive. 1687 through 1694.
2 COMMISSIONER:
3 Q. All right, then. Entered.
4 EXHIBITS P-1687 THROUGH P-1694, INCLUSIVE, ENTERED INTO
5 EVIDENCE.
6 COFFEY, Q.C.:
7 Q. Thank you, Commissioner. If we could, please,
8 Registrar, when you're ready, Exhibit P-1694?
9 Mr. Singleton, I take it that this is your CV?
10 MR. SINGLETON:
11 A. Yeah.
12 COFFEY, Q.C.:
13 Q. Okay. And this was provided to the
14 Commission, I take it, relatively recently, so
15 it's a current one?
16 MR. SINGLETON:
17 A. Um-hm, yes, yeah, yeah.
18 COFFEY, Q.C.:
19 Q. Okay, sir, could you please give us an
20 overview, a brief overview of your education
21 and professional background?
22 MR. SINGLETON:
23 A. Okay. Well, in the university years, of
24 course, Bachelor of Arts in Philosophy and
25 Religious Studies, I did a Master's of

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1 Divinity in at Western in London, Ontario and
2 did a Doctorate of Ministry program in
3 Graduate Theological Foundation in Indiana.
4 And I also did certificate programs and the
5 like, diploma programs in Health
6 Administration and also accomplished a
7 certificate in Thanatology through the
8 International Association of Death Education
9 and Counselling. And so that's the -
10 COFFEY, Q.C.:
11 Q. That's your education. Before we pass off
12 that, what is thanatology?
13 MR. SINGLETON:
14 A. Thanatology is kind of a word to describe the
15 area in the study of death-related matters.
16 It's kind of the emerging discipline now, I
17 suppose, that kind of brings together studies
18 related to grief and bereavement, counselling
19 related to death and dying and health care
20 ethics, matters related to death and dying and
21 those types of things. So it's kind of rooted
22 in the Greek word for death.
23 COFFEY, Q.C.:
24 Q. And you're then work history?
25 MR. SINGLETON:

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1 A. My work history, well, that's kind of a
2 mixture, but anyway, I'll -
3 COFFEY, Q.C.:
4 Q. And overview?
5 MR. SINGLETON:
6 A. I guess my earliest kind of professional role
7 was in ministry, I was a Roman Catholic Priest
8 for about ten years. And subsequent to that I
9 started work at the Janeway Hospital as
10 Director of Pastoral Care. And well, right
11 back from my university days I did studies in
12 the area of ethics as well as the broader area
13 of philosophy and then ethics within theology,
14 as well. And in my time as a priest, I got
15 involved in the area of health care ethics and
16 so continued to kind of develop that area of
17 interest, the study and what have you and kind
18 of really facilitated my professional
19 development and career when I left the
20 priesthood. And when I started work at the
21 Janeway, one of the areas that I was asked to
22 take a lead role in was the development of
23 ethics and ethics committees and so on within
24 the Janeway structure.
25 COFFEY, Q.C.:

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1 Q. When did you begin at the Janeway?
2 MR. SINGLETON:
3 A. In 1988.
4 COFFEY, Q.C.:
5 Q. Okay, sir. And you were there for how long?
6 MR. SINGLETON:
7 A. I was, well, kind of as the system changed, I
8 changed, as well, but I continued to be part
9 of it. I moved from being the Director of
10 Pastoral Care or Pastoral Care and Counselling
11 it was called at the Janeway into the position
12 of being Director of Pastoral Care in the
13 Health Care Corporation. One of the roles
14 that came about in that position was to take a
15 kind of a lead role in the development of an
16 ethics structure in the ethics programs and
17 services for the Health Care Corporation. And
18 then when the Health Care Corporation was
19 folded into the new entity that we are now,
20 Eastern Health, I became the Director of
21 Pastoral Care and Ethics within Eastern
22 Health. In that restructuring the role of--
23 the place of ethics was identified with the
24 department and that came about, I suppose, for
25 practical reasons, largely because for my work

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1 and the work of others working with me as
2 managers and in other roles in the department
3 we were giving a lot of the lead role to the
4 activities in the area of ethics, or at least
5 the structural supports need to sustain it.
6 COFFEY, Q.C.:
7 Q. I'm sorry, the structural supports to sustain
8 what?
9 MR. SINGLETON:
10 A. Well, you know, the organizing of meetings and
11 development of the ethics consultation process
12 and those types of things that are needed.
13 The ethics activities within Eastern Health
14 are very interdisciplinary and very
15 collaborative and so we engaged with people
16 from all over the place, but what we found is
17 that there was certainly a need to have--it
18 was built into the structure so that there was
19 someone, you know, accountable for the
20 activities and to assist with the ethics
21 education and to lead the ethics education and
22 those types of matters.
23 COFFEY, Q.C.:
24 Q. So, I'm sorry, with the formation of Eastern
25 Health you became, subsequent to the formation

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1 of Eastern Health you became the Director of -
2 MR. SINGLETON:
3 A. Director of Pastoral Care and Ethics, yeah.
4 COFFEY, Q.C.:
5 Q. And in that capacity whom did you report to?
6 MR. SINGLETON:
7 A. Louise Jones while she was the COO for acute
8 care.
9 COFFEY, Q.C.:
10 Q. And before that with the Health Care
11 Corporation, you had been--what was your
12 position?
13 MR. SINGLETON:
14 A. Director of Pastoral Care.
15 COFFEY, Q.C.:
16 Q. Okay. Simpliciter, I take it, there was no
17 "and ethics" at that time?
18 MR. SINGLETON:
19 A. No. Yeah, yeah.
20 COFFEY, Q.C.:
21 Q. Okay. And as the Director of Pastoral Care
22 for the Health Care Corporation you had held
23 that position since when?
24 MR. SINGLETON:
25 A. Well, throughout the whole life of the Health

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1 Care Corporation.
2 COFFEY, Q.C.:
3 Q. Okay.
4 MR. SINGLETON:
5 A. Whatever that was.
6 COFFEY, Q.C.:
7 Q. Back to the mid '90s, then, that would have
8 been?
9 MR. SINGLETON:
10 A. Yeah, yeah.
11 COFFEY, Q.C.:
12 Q. And at that time you reported to whom?
13 MR. SINGLETON:
14 A. Louise Jones.
15 COFFEY, Q.C.:
16 Q. In the same--she held the equivalent position
17 -
18 MR. SINGLETON:
19 A. Well she held -
20 COFFEY, Q.C.:
21 Q. - COO -
22 MR. SINGLETON:
23 A. Vice president for -
24 COFFEY, Q.C.:
25 Q. Acute care?

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1 MR. SINGLETON:
2 A. - patient services -
3 COFFEY, Q.C.:
4 Q. Be acute -
5 MR. SINGLETON:
6 A. Yeah.
7 COFFEY, Q.C.:
8 Q. - care? Okay. So could you tell us--I'm
9 sorry, go ahead, sorry.
10 MR. SINGLETON:
11 A. No, sorry.
12 COFFEY, Q.C.:
13 Q. I was about to interrupt you. Go ahead.
14 MR. SINGLETON:
15 A. No, I was just going to say other ethics
16 activities that I've been involved in are the
17 area of research ethics that I've been quite
18 involved because I'm on the board of one of
19 the institutes of CIHR, the Canadian Institute
20 for Health Research and through that I was
21 designated or in a position called Ethics
22 Designate. Each institute board has a person
23 designated to take a lead role on ethics on
24 behalf of that advisory board, so I have that
25 position on the board that I am a member of,

1 but as well as that then I am the chair of the
2 committee of ethics designates for CIHR and
3 I'm on the standing committee on ethics for
4 CIHR, SO.
5 COFFEY, Q.C.:
6 Q. And how long have you been involved with CIHR?
7 MR. SINGLETON:
8 A. Almost five years.
9 COFFEY, Q.C.:
10 Q. So that would be now going back to 2003, I
11 take it, roughly?
12 MR. SINGLETON:
13 A. Yeah, about that, yeah.
14 COFFEY, Q.C.:
15 Q. Okay. Now, sir, what, if anything, changed
16 when your position went from being director of
17 pastoral care to the director of pastoral care
18 and ethics?
19 MR. SINGLETON:
20 A. Well, I guess we have, there are really three
21 areas that I am involved in in addition to
22 being the, you know, having the administrative
23 role within the department, but the main areas
24 of our service would be obviously the
25 pastoral, spiritual care, supports,

1 counselling, that type. We've take a very
2 significant lead role within our system prior
3 to Eastern Health, but continuing and we've
4 developed it somewhat since Eastern Health was
5 created in the area of grief and bereavement
6 and some of that is because that was my own
7 area of focus and concentration in my studies
8 and research and what have you, at last for a
9 large part of it. And then we've also been
10 quite involved in the development of the
11 ethics structures and programs and what have
12 you.
13 COFFEY, Q.C.:
14 Q. And -
15 MR. SINGLETON:
16 A. So as we moved into Eastern Health, we
17 continued on with a lot of the same types of
18 services but we've certainly been growing
19 them, we might say, expanding them into the
20 areas that were not as well developed in those
21 services. As Eastern Health, as you know,
22 takes in the seven previous boards, but the
23 geographical areas are the Avalon, Burin and
24 Bonavista Peninsulas and some of the services
25 that we offer wouldn't have been very much

1 available outside of the former Health Care
2 Corporation, certainly to a great extent not
3 available very much in the rural portfolios
4 that are part of Eastern Health now. And so
5 one of the challenges, but also one of the
6 really worthwhile opportunities we've had has
7 been to kind of develop those services to
8 greater and lesser degrees throughout the
9 entire region.
10 COFFEY, Q.C.:
11 Q. Now, and other than, I gather, that the "and
12 ethics" was added.
13 MR. SINGLETON:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. And I appreciate the--you're saying, well,
17 Eastern Health, of course, covers a wider
18 geography and even within the same geography
19 different types of institutions?
20 MR. SINGLETON:
21 A. Yeah.
22 COFFEY, Q.C.:
23 Q. Even within the St. John's region, than the
24 Health Care Corporation used to?
25 MR. SINGLETON:

1 A. Yeah.
2 COFFEY, Q.C.:
3 Q. With respect to the matter of ethics and acute
4 care facilities, for example, within the St.
5 John's region.
6 MR. SINGLETON:
7 A. Right.
8 COFFEY, Q.C.:
9 Q. Has that really changed in the sense of the
10 approach to ethics from the Health Care
11 Corporation into Eastern Health?
12 MR. SINGLETON:
13 A. Well, the ethics work that we do is within
14 Eastern Health really has kind of three major
15 roles. One would be ethics education.
16 COFFEY, Q.C.:
17 Q. Okay.
18 MR. SINGLETON:
19 A. One is policy review and development. And the
20 other would be clinical consultations. And so
21 those are the three areas that typically, that
22 we do as services and that's pretty common to
23 most health care organizations. How they do
24 it, of course, varies, you know, on their
25 resources as well as other things. Since

1 we've been, become part of Eastern Health
2 we've continued to develop it and I think some
3 of the service that we offer within Eastern
4 Health have grown from and we have some kind
5 of broader services in addition to what we had
6 in the prior organization.
7 COFFEY, Q.C.:
8 Q. So -
9 MR. SINGLETON:
10 A. But generally speaking I would say, you know,
11 we still do the same types of things in that
12 we take the initiative to do a fair amount of
13 education to, for staff and some community
14 activities, as well. We sometimes are
15 consulted about policies that are being
16 developed because there's an ethics component
17 and there's a desire to have some ethics
18 analysis, we might say, ethics, you know,
19 discussions in the policy development.
20 Sometimes as a result of the ethics
21 consultations that we have it's identified
22 that there's a need to probably do education
23 or there might be a need for the development
24 of policy or review of current policies. And
25 so those three roles are very interconnected

1 with each other.
2 COFFEY, Q.C.:
3 Q. And from an organizational perspective is
4 there any relationship with Memorial
5 University?
6 MR. SINGLETON:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. And how has that worked over the years?
10 MR. SINGLETON:
11 A. Okay. The ethicists that resource our service
12 as ethicists employed by the medical school.
13 We have Daryl Pullman is with us longest, Fern
14 Brunger is an ethicist, Natalie Bandrauk is a
15 intensivist, physician intensivist as well as
16 an ethicist and Jennifer Flynn is an ethicist,
17 as well, so all four of those are part of the
18 medical school. And we have an arrangement
19 between Eastern Health and the medical school,
20 as we did with the Health Care Corporation
21 prior to that. When we have cases, when we're
22 working on policies, whatever undertakings we
23 have, the ethicists provide that professional
24 resource for us.
25 COFFEY, Q.C.:

1 Q. Okay. So that you--the Health Care
2 Corporation as it then was, before 2005, and
3 then more recently Eastern Health, as of now,
4 even, they utilize the services of ethicists
5 who are or have positions within Memorial
6 University's medical school?
7 MR. SINGLETON:
8 A. Yeah, yeah. And there's a contractual
9 arrangement.
10 COFFEY, Q.C.:
11 Q. Contractual arrangement.
12 MR. SINGLETON:
13 A. Yeah, yeah.
14 COFFEY, Q.C.:
15 Q. Now -
16 MR. SINGLETON:
17 A. And I would add that I know that they find and
18 we find, as well, that it works very well
19 because for us it provides us with the people
20 who have the credentials and the competency to
21 assist us in those discussions or whatever
22 activities we're into, but it also provides
23 them with the hands on, frontline clinical
24 situations that enhances both their teaching
25 and their writing and their academic pursuits.

1 COFFEY, Q.C.:
2 Q. Now sir, I take it in relation to with
3 Memorial University in that regard goes back
4 for a decade or so?
5 MR. SINGLETON:
6 A. Oh yeah, yeah, that's right, back to the
7 earliest days of the Health Care Corporation.
8 COFFEY, Q.C.:
9 Q. Now what is an intensivist?
10 MR. SINGLETON:
11 A. A physician who specializes in providing care
12 in the intensive care unit.
13 COFFEY, Q.C.:
14 Q. Okay, because you did describe one of the
15 ethicists in question as that, and I just
16 wanted to have that explained to the
17 Commissioner. An ethicist, what is an
18 ethicist?
19 MR. SINGLETON:
20 A. This week we have about 200 of them in town.
21 We have the annual meeting of Canadian
22 Bioethics Society, so I'm afraid if they're
23 watching now they'd probably be offended by my
24 description, but they're generally people who
25 come out of a discipline of one sort or

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1 another, it's one of the things about
2 ethicists, some are philosophers who have
3 specialized in the area of ethics and then
4 bioethics. Some are lawyers or physicians or
5 theologians, and they have kind of gone on to
6 focus in the area of ethics and then
7 bioethics. Some use the word ethicists. Some
8 call those same people bioethicists and what
9 have you. But generally speaking, what we're
10 talking about are people who have an academic
11 preparation and the credentials to participate
12 in the discussion of the ethical matters
13 relating to decision making, to policy
14 development and to the understanding of the
15 natures of the morality, we might say,
16 pertaining to, in the case of bioethics, to
17 matters pertaining to life.
18 COFFEY, Q.C.:
19 Q. Now what was--that leads to the next question
20 I wanted to ask you, and I hesitate, but I'm
21 going to do it anyway. Can you describe, in
22 this context, what you understand ethics to
23 mean and encompass?
24 MR. SINGLETON:
25 A. Well, I guess I can give a kind of formal and

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1 then probably a less formal description of it.
2 I mean, generally, it's about processes of
3 understanding and making decisions that are
4 principle based with a rationale that gives,
5 in most cases, and integration of values and
6 other significant, probably self-defining
7 features of individuals and of groups that
8 lead them to make decisions and to anticipate
9 directions and plan their lives.
10 I suppose in a more casual way, one of
11 the challenges of describing ethics or living
12 out ethics is to try and find that balance
13 between doing the right thing and doing the
14 thing right, and quite often that's the nature
15 of debate in health care ethics and in other
16 context as well, but in health care ethics,
17 there are no doubt many directives of how
18 things ought to be done, laws, rules,
19 regulations, guidelines, standards, and
20 procedures and policies and what have you that
21 say how things ought to be done, but quite
22 often, along with all of that, there may well
23 be gut feelings of what ought to be done, and
24 so there lies, I think, the tension or we
25 might say the life blood of ethics. It's that

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1 sorting and that balancing and it's the
2 dynamic really, I suppose, that we experience
3 in being part of the activities of ethics with
4 a health care organization.
5 COFFEY, Q.C.:
6 Q. Now sir, you used the word, just before I
7 asked you that question, you referred to
8 morality. How does, in the context you used
9 the word, how does that factor into this?
10 MR. SINGLETON:
11 A. Well, it's a word that I used in the
12 description, along with others, but it's a
13 consideration in how the values that an
14 individual has and where they come from,
15 whether--and those things are influenced by
16 many things, culture, context in many
17 situations, beliefs and what have you, that
18 lead one or groups to set standards for
19 themselves, and sometimes set expectations of
20 others as well.
21 COFFEY, Q.C.:
22 Q. Sir, do you know whether or not Eastern--well,
23 first of all, do you know whether or not the
24 Health Care Corporation of St. John's had any
25 policies concerning or dealing with when

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1 ethics or an ethics consultation might be
2 required?
3 MR. SINGLETON:
4 A. Yes, we had--well, I don't know if it's
5 required, but we certainly had materials
6 developed and we promoted it substantially to
7 indicate when people could request an ethics
8 consultation. Because it is a consultation,
9 and that's--you know, that's a piece that we
10 sometimes miss, and in fact, in our earliest
11 days we used the word "review" for some reason
12 or other, but we made a revision to it to call
13 it a consultation, because in fact, that's
14 what it was. I think one of the ways of
15 coming to that discovery is that we did not
16 want to be seen to be, nor expected to be,
17 what sometimes people call the ethics police,
18 where we would--I say we, or anyone would be
19 going about kind of interrogating or, you
20 know, monitoring the activities of others and
21 kind of requiring them to account for what
22 they are doing. There may well be activities
23 of that sort that take place at times, but
24 that wouldn't be the activity of the ethics
25 service. So it is an ethics consultation

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1 where people, for one reason or another, in
2 any position, can request to avail of the
3 service.
4 COFFEY, Q.C.:
5 Q. Okay, and that--so that the Commissioner
6 understands it, the service that you, as the
7 director, provide is upon request for a
8 consultation?
9 MR. SINGLETON:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. You organize it?
13 MR. SINGLETON:
14 A. Yes, yeah, and I or others would organize it.
15 I'm not the only one. We have--it's a
16 facilitated consultation. If you want to talk
17 about the consultation service now, I'll give
18 you a description of it.
19 COFFEY, Q.C.:
20 Q. Yes.
21 MR. SINGLETON:
22 A. And so it is a facilitated service. In some
23 organizations, and I suppose prior to the
24 Health Care Corporation, what we tended to do
25 locally and the other organizations that are

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1 now part of Eastern Health would do is that
2 they--some of them had ethics committees where
3 when matters came up, they were discussed by
4 the ethics committees and, you know, handled
5 that way. But generally speaking, the
6 committees are not an efficient way to handle
7 ethics consultations because there's no
8 guarantee that the people who were on the
9 committees would know very much about the
10 matter at hand, either the overall issue or
11 the specifics of the case, and my own
12 observation on it is that most times, after
13 the ethics committee would meet about
14 something, the most they would be able to do
15 is verify yeah, you have an ethics problem,
16 but they wouldn't really have much of a
17 solution or a recommendation or much to offer
18 to it.
19 So the more effective model for ethics
20 consultation is to use what we call it, a
21 facilitated model where we have people who
22 have been recruited and trained somewhat in
23 the area of ethics to be familiar with the
24 language of ethics discussions, health care
25 ethics and so on, and also they are people

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1 who, likely by their own training as
2 professionals, but also we have--offer
3 training in addition to that on the
4 facilitation skills needed for the role of an
5 ethics facilitator. So when a consult comes
6 forward, whether it's brought to the secretary
7 who handles the ethics consultations or
8 brought to my office or to someone else who's
9 involved in ethics, what happens usually on
10 the front end of it is that someone takes on
11 the role of being the facilitator for it to do
12 a bit of fact finding about the case in order
13 to determine who needs to be involved in the
14 discussion and those kinds of things.
15 COFFEY, Q.C.:
16 Q. And at Eastern Health, who was the person who
17 assigned, as it were, the request to any
18 particular facilitator?
19 MR. SINGLETON:
20 A. Well, there are several ways by which consults
21 come forward. On the pamphlets that we
22 distribute, and I think Mr. Simmons made one
23 available to you, there are several numbers
24 given, but the office number, our office
25 number, Pastoral Care and Ethics, is where a

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1 lot of them come, and a fair number of the
2 consults do come forward to me, as the
3 director of the department, and then I will
4 ask one of the designated facilitators to take
5 it, or I will handle it myself, whatever the
6 case might be.
7 COFFEY, Q.C.:
8 Q. Okay. So the clinical consultation process,
9 which I take it is you're involved in really
10 three things, ethics education, policy review
11 and development and clinical consultation?
12 MR. SINGLETON:
13 A. Well, ethics services, consultation is one of
14 the services within that, yeah.
15 COFFEY, Q.C.:
16 Q. Could you--is there anything then you can add
17 as to--well, perhaps you could just describe,
18 perhaps, you get a request for an ethics
19 consult.
20 MR. SINGLETON:
21 A. Yeah.
22 COFFEY, Q.C.:
23 Q. And you decide to do it yourself.
24 MR. SINGLETON:
25 A. Yeah.

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1 COFFEY, Q.C.:
2 Q. How do you go about it?
3 MR. SINGLETON:
4 A. Well, the first thing, we have a form that
5 was, I think, part of the document that I left
6 with Mr. Simmons, but it kind of lays out, you
7 know, some steps in the--or we kind of have
8 three phases to it. The first is kind of the
9 intake phase where the person makes the
10 request and then immediately someone follows
11 up to get some, you know, the facts of the
12 case you might say, and some of the facts are
13 who else needs to be involved and how soon a
14 turn around do you need on this, because those
15 things are really important, and one impacts
16 the other, as you can imagine.
17 If it's a situation where someone from
18 the intensive care unit calls and says we've
19 got a situation here, you know, and this is
20 what's happening, and that I say "well, when
21 do you need a--you know, how quick of a
22 turnaround do you need on it?" and they say
23 "well, we really need to have something by
24 tomorrow afternoon." Well, who is involved
25 then, in terms of participating in it, what I

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1 call the right mix of people, would probably
2 be a bit different than if they say "oh, gee,
3 anytime in the next couple of months." Well,
4 you know, that leaves you a lot more room to
5 kind of, you know, select people, arrange
6 things and so on. But with that said and
7 done, generally people are very cooperative of
8 meeting, especially in the real urgent cases,
9 because everyone who needs to be involved is
10 likely quite concerned about getting--you
11 know, gathering about it anyway.
12 So that's kind of the first phase of it,
13 is to sort out, you know, the logistics, we
14 might say. Part of the consideration then in
15 it is--in who that right mix of people is, is
16 what phase is this in the handling of the
17 case. If it's a situation where the request
18 is being made because the health care
19 providers are considering what options would
20 be appropriate to offer to the patient or to
21 the family, then the consult would likely
22 involve, you know, members of the team and
23 maybe other resource people, but to look at
24 the options and to rule out options that would
25 not be brought to the decision makers, we'll

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1 call them.
2 In other situations, the patient and the
3 family or you know, the like, may already be
4 involved in the discussions and that might be
5 part of the reason why an ethics consult is
6 requested, because there may be requests or
7 there might be options being considered or,
8 you know, tensions about the way things are
9 being handled, and so in those cases, the
10 right mix of people would need to include or
11 at least the family need to be offered the
12 option of--I say the family because quite
13 often, a patient might be in a condition where
14 they couldn't attend themselves, but it
15 basically means having the--giving them the
16 opportunity if they want to attend and to
17 participate.
18 So those are kind of some of the
19 considerations that happen and, you know,
20 that, as I call it, the right mix of people
21 consideration is impacted somewhat by the
22 time, but I would say more by the timing than
23 the time, because where it is and the kind of
24 communication dialogue process. What I'm
25 describing is, of course, situations that

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1 involve a particular case and a particular
2 issue and what have you.
3 COFFEY, Q.C.:
4 Q. Now if it involves more than one patient, the
5 ethics consult?
6 MR. SINGLETON:
7 A. We typically don't have ethics consults on
8 cases of that sort, at least on situations
9 that involve more than one patient, except the
10 one that you'll probably come to later on.
11 But other than that, they are typically about
12 a case. We do have consultation and
13 discussions about what I might call batches of
14 cases, but it's not quite the same then as it
15 is, because it's likely--that's usually mostly
16 about, you know, sorting out how to develop a
17 policy or, you know, adjust some activity and
18 so on.
19 But with that said and done now, actually
20 we have had a couple of incidents where we
21 did--that did involve more than one patient
22 and without giving very much detail on it,
23 I'll just make the mention that it involved
24 situations of--there were essentially a batch
25 of patients where--that involved some genetics

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1 testing and so on, and the same issue was
2 present in all of the cases where, you know,
3 the individual's decisions about what would be
4 done with their information kind of differed
5 from what the professionals felt the standard
6 practice ought to be, and so we had an ethics
7 consult and made some progress with that.
8 COFFEY, Q.C.:
9 Q. Now could you tell the Commissioner, please--
10 well, I'm going to come back to this and take
11 you through this particular matter, but what
12 is the general expectation, in terms of what
13 those consulted are supposed to do, and what
14 are they supposed to produce and what usage is
15 to be made of it, like the report, if there is
16 to be a report? What's to be done?
17 MR. SINGLETON:
18 A. Well, it's a consult.
19 COFFEY, Q.C.:
20 Q. Sure.
21 MR. SINGLETON:
22 A. So generally speaking, within the--and this
23 was interesting discussion we had when we were
24 in the process of developing the ethics
25 consultation service is that, you know, what

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1 is the status of an ethics consult and where
2 should it be documented and those types of
3 things, but anyway, after a fair amount of
4 discussion and legal opinion and other matters
5 pertaining to it, it would be handled like any
6 other consult. That it's a request for the
7 consultation is presented by someone connected
8 to the case and the consultation happens and
9 if there are specific recommendations then
10 they are added to the health record in
11 individual cases. That's what we're talking
12 about--you know, that's what I'm speaking
13 about at this moment. And then the people who
14 asked for the consult are free to follow the
15 recommendations or give them consideration and
16 set it aside because they see a different or
17 fuller picture.
18 But like with any other consultation, I
19 suppose if someone asks for an opinion and
20 they get the opinion or recommendations and
21 they set it aside, then they likely need to be
22 aware that, you know, if you have to account
23 for it later, then you know, be prepared to do
24 that, and that's reasonable, and I think most
25 do that. Generally speaking, in individual

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1 cases, the people who make the request attend
2 the consult and they participate in the
3 discussions. So when the recommendations are
4 generated, their participation and involvement
5 are part of the consensus that leads to the
6 recommendation. Generally speaking, in
7 individual cases, the recommendations are
8 generated mainly by consensus amongst the
9 people who participate.
10 THE COMMISSIONER:
11 Q. Are differences recorded in your report?
12 MR. SINGLETON:
13 A. Pardon me?
14 THE COMMISSIONER:
15 Q. If there is no consensus, would it be
16 reported--would it be recorded in your report?
17 MR. SINGLETON:
18 A. Yes, or sometimes if there isn't a consensus,
19 I mean, you know, the range of things that are
20 considered would be there, but yes, but
21 actually I don't really remember any situation
22 where we didn't--where we weren't able to come
23 to a consensus.
24 THE COMMISSIONER:
25 Q. Thank you.

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1 COFFEY, Q.C.:
2 Q. Now, and in relation to, at least your
3 experience with the Health Care Corporation of
4 St. John's and now Eastern Health, in your
5 role as director, for consultations that you
6 have arranged for, other than the one
7 involving the genetics matter, which you just
8 referred to, has there been any other
9 consultation that you recall involving a group
10 of patients? And you know, not just one or
11 two patients, but mass.
12 MR. SINGLETON:
13 A. Well, the matter that -
14 COFFEY, Q.C.:
15 Q. Yes, you just referred to.
16 MR. SINGLETON:
17 A. Yeah, but the one that we're -
18 COFFEY, Q.C.:
19 Q. And this one here, ER/PR issue.
20 MR. SINGLETON:
21 A. Right, yeah.
22 COFFEY, Q.C.:
23 Q. Anything else?
24 MR. SINGLETON:
25 A. Ah, gee -

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1 COFFEY, Q.C.:
2 Q. And if they don't immediately come to mind,
3 fine, but I take it the point is to the
4 Commissioner, this was a rarity, that event.
5 MR. SINGLETON:
6 A. Yes, that's right, yeah.
7 COFFEY, Q.C.:
8 Q. That was my point.
9 MR. SINGLETON:
10 A. And, you know, generally speaking the ethics
11 consultation service is set up to kind of
12 respond to these individual cases where teams
13 and individual professions are somewhat
14 perplexed by what they, you know, what's on
15 the go.
16 COFFEY, Q.C.:
17 Q. Now in relation to the ER/PR matter, I'm going
18 to ask you about, get into that now, but
19 bearing in mind its novelty, as it were, in
20 terms of this, the sheer size of the number of
21 patients involved, was any thought given by
22 yourself, as the person who was initially
23 consulted about it, to going elsewhere and
24 asking around, as it were, in Canada or US or
25 Euro, because this is different in the normal

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1 run of the mill, one patient consult.
2 MR. SINGLETON:
3 A. Yeah, that's right, yeah.
4 COFFEY, Q.C.:
5 Q. Was there any thought given to doing any kind
6 of canvassing in that regard as to how we
7 might handle this?
8 MR. SINGLETON:
9 A. No, I mean, I'm sure you understand the issue
10 that we had a consult on and the only matter
11 was the notification to families where the--
12 when the reports came back it was discovered
13 the patients were dead.
14 COFFEY, Q.C.:
15 Q. Yes.
16 MR. SINGLETON:
17 A. Right, so, but no, to answer your question,
18 no.
19 COFFEY, Q.C.:
20 Q. Now can you tell the Commissioner what you
21 recall about this ER/PR matter, I'll ask you
22 first of all before being approached about the
23 consult, were you aware that the matter was or
24 what were you aware about the matter? What
25 did you know about it?

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1 MR. SINGLETON:
2 A. I'd have to say nothing, you know, or next to
3 nothing. I might have heard that there were
4 issues going on, you know, something about
5 breast cancers and it didn't stand out to me,
6 I remember the first conversation that I--when
7 I received a copy of a note from Dr. Cook to
8 Dr. Young and then he wrote some--Dr.
9 Williams, he wrote some notes on it and, you
10 know, referring to, requesting an ethics
11 consult and when I received it and I called
12 Dr. Cook about it, you know, I knew the ER/PR
13 was something to do with the lab results and
14 so on, but he kind of gave me a condensed
15 Cole's notes version of it.
16 COFFEY, Q.C.:
17 Q. Okay, so on that you get asked and as you've
18 pointed out, you were first asked to organize
19 a consultation about in relation to ER/PR and
20 notifying the families of the deceased about
21 results, was that about as much as you knew
22 about it, initially?
23 MR. SINGLETON:
24 A. Yeah.
25 COFFEY, Q.C.:

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1 Q. And you contacted Dr. Cook.
2 MR. SINGLETON:
3 A. Yeah.
4 COFFEY, Q.C.:
5 Q. I suppose to even have him explain to you what
6 ER/PR meant?
7 MR. SINGLETON:
8 A. Yeah.
9 COFFEY, Q.C.:
10 Q. And put it in context.
11 MR. SINGLETON:
12 A. Yeah.
13 COFFEY, Q.C.:
14 Q. And I take it Dr. Cook did so. What did you
15 understand from Dr. Cook at the time? What
16 were you told by him, do you recall?
17 MR. SINGLETON:
18 A. Well, I guess I understood that there had been
19 at least complications with some testing with
20 this group of patients and that now there were
21 results coming back and really the focus of
22 our discussion and my attention to it was, you
23 know, where did the issue of notifying
24 families of deceased patients come into it, I
25 wasn't as focused on, you know, in the initial

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1 discussions or later, as far as that goes, but
2 especially the initial discussions with the
3 matters that caused all of this to come about
4 as the fact that there was information about
5 deceased patients and they had these health
6 records in the lab that they knew they needed
7 to do something with them, they couldn't just
8 file it away and ignore it, they needed to
9 consider what they would do with the
10 information. So that was kind of what I was
11 involved with.
12 COFFEY, Q.C.:
13 Q. If we could, please, exhibit P-1369. This is
14 a letter of May 3rd, 2006. It's addressed to
15 Dr. Williams, it's from Dr. Cook and he had
16 written to Dr. Williams saying, "Currently we
17 have documented ER/PR results from 17 deceased
18 patients on whom we have received results from
19 Mount Sinai and are currently in our hospital
20 information system. These patients have not
21 been signed out for release from the system.
22 I would appreciate direction on how to proceed
23 further with these cases. Sincerely yours,
24 Donald Cook." So I take it that sort of a
25 matter that, I appreciate it wasn't a sign

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1 out, it was the notification of the families
2 was the issue for yourself, but I take it that
3 Dr. Cook had something that he had to deal
4 with.
5 MR. SINGLETON:
6 A. Yeah.
7 COFFEY, Q.C.:
8 Q. You understood from him to move off--to move
9 ahead with.
10 MR. SINGLETON:
11 A. That's right, yes.
12 COFFEY, Q.C.:
13 Q. If we could, please, exhibit P-0778. And,
14 sir, at the bottom of the page here, there's
15 an e-mail from yourself, Friday, May 19th,
16 2006 at 11:20 a.m., to a number of
17 individuals, Dr. Williams, Louise Jones,
18 Heather Predham, Dr. Kara Laing, Nash Denic
19 and D. Pullman--and the D. Pullman in this
20 context is?
21 MR. SINGLETON:
22 A. Daryl Pullman, the ethicist.
23 COFFEY, Q.C.:
24 Q. The ethicist at Memorial. And the subject is,
25 "Ethics Consult Re: Disclosure of Info on

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1 Deceased Patients." And you've written, "Hi,
2 I've been asked to organize an ethics consult
3 to discuss the ethical issues regarding
4 disclosure of information (ER/PR results from
5 Mount Sinai) to families of deceased patients.
6 When organizing an ethics consult, we need to
7 get the right mix of people to have a
8 discussion and generate reasonable
9 recommendations. For this discussion we need
10 Dr. Pullman, ethicist; Dr. Cook and Dr. Denic,
11 lab; Dr. Laing, Cancer Program. We will
12 recruit others as needed, but getting a time
13 that works is usually the first challenge.
14 How is Monday, May 29th at 10:00 a.m.? If
15 this is not possible, how is June 13th or
16 16th? I suspect we will need about 1.5 to 2
17 hours for this case. Thanks, Rick." And
18 you've copied--well I suspect the copying is--
19 the copying subsequently is in relation to the
20 larger e-mail which I'll come to in a moment
21 or the one above. But, so you sent this off
22 and we have here at the top of the page on the
23 same date at 12:06 p.m., you sent an e-mail to
24 yourself and a number of other individuals and
25 you say "Hi, May 29th is not possible, so we

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1 are now looking at June 13th or 16th. How is
2 June 13th at 2 p.m. Rick." So I take it this
3 is the organizational phase.
4 MR. SINGLETON:
5 A. Oh yes, trying to get a time, yeah, it's
6 usually the front end of it, like over the
7 years my own experience on it is that there
8 are some who need to be there that are usually
9 difficult to get, you know, they have clinics,
10 they have those kinds of things, so my first
11 effort is usually to, you know, try and get
12 the attending physicians or whatever
13 physicians that need to be involved, their
14 schedules are very full and try to fill it out
15 from there.
16 COFFEY, Q.C.:
17 Q. If we could, please, exhibit P-0779.
18 MR. SINGLETON:
19 A. Another consideration in trying to put it
20 together and we've mentioned this, sometimes
21 there's some individuals who have to be there,
22 in other cases it's an individual who may
23 well, you know, have a colleague who would be
24 as informed on the matter and so it's not as
25 difficult, as is the case here, Dr. Laing, say

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1 for instance and Dr. McCarthy.
2 COFFEY, Q.C.:
3 Q. And here, in fact, this will illustrate for
4 the Commissioner your logistic's problem, the
5 same day, May 19th, at 1:12 p.m. Dr. Laing
6 responded to your earlier e-mail saying "I'm
7 away in P.E.I for an ACOG Cancer Conference
8 from June 13th to the 20th, '06." So getting
9 everybody in one spot, I take it, can be
10 problematic?
11 MR. SINGLETON:
12 A. Oh yeah, yeah.
13 COFFEY, Q.C.:
14 Q. Now, sir, can you tell the Commissioner,
15 please, in the context of this sort of matter,
16 I'm just looking at this e-mail, at the top of
17 the page here, P-0779, page 1, did you
18 anticipate at this point that you would
19 actually participate in this, the actual
20 consult itself?
21 MR. SINGLETON:
22 A. Yeah, well by this time I had taken--I was
23 taking the lead as facilitator on this one,
24 yeah.
25 COFFEY, Q.C.:

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1 Q. Is there any reason you got yourself involved
2 in this particular one?
3 MR. SINGLETON:
4 A. Don't ask me if I had my time back what I
5 would have done, but in the meantime, well I
6 knew this was complicated and I'm the lead
7 person in the department and we have the team
8 of facilitators and, you know, I figured that
9 I should--and I knew that eventually it would
10 be, first round was try to see if you can get
11 this during daytime hours, but I knew this
12 would be an after-hours events and it wasn't,
13 you like, it'd likely be a bit long and so I
14 was willing to, you know, participate in it
15 knowing that it would involve that type of
16 time and commitment.
17 COFFEY, Q.C.:
18 Q. Now why is Dr. Williams notified here?
19 MR. SINGLETON:
20 A. Because he was the one who made the original
21 note to me or asked his secretary to send it
22 along. And that is part of what we lay out is
23 in the routine is that whoever makes the
24 request, is kept in the loop on it and gets
25 the report at the end or the summary, whatever

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1 we'd call it.
2 COFFEY, Q.C.:
3 Q. Ms. Jones, why would she be involved? Why
4 would she be copied on the e-mail or involved
5 at all?
6 MR. SINGLETON:
7 A. I think she was--I'm not sure if--I don't
8 actually remember now whether, I think what I
9 received from Dr. Williams' office was just
10 probably a, I'm not sure if it came to me
11 electronically or in an envelope, but Louise
12 is the VP that I reported to or the COO that I
13 reported to and so that's why I have her in
14 the loop.
15 COFFEY, Q.C.:
16 Q. At this time, May 19th, was it anticipated Ms.
17 Jones would actually participate in the
18 consultation?
19 MR. SINGLETON:
20 A. No, she never did participate in any of the
21 consults, I don't think. There might have
22 been some meetings that we had on some policy
23 matters and so on that she'd be involved with,
24 but never on an ethics consult, no.
25 COFFEY, Q.C.:

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1 Q. Heather Predham is named here, why was Heather
2 Predham involved?
3 MR. SINGLETON:
4 A. Because when I was talking to Dr. Cook to kind
5 of get the first round of information from
6 him, I discovered this was, you know, had a
7 history to it and that Heather was quite
8 involved with it and so I contacted her, I had
9 been involved with, you know, we've had other
10 cases that Heather would have been involved
11 with as well.
12 COFFEY, Q.C.:
13 Q. So she had been involved and then Dr. Cook
14 told you that, but why would she be involved
15 in the actual consult?
16 MR. SINGLETON:
17 A. Because she would have had lots of information
18 about it to help us kind of move forward and
19 the whole issue of, you know, how we would
20 handle the--or how, you know, the information
21 pertaining to the communication and the
22 legalities and so on that might be relevant to
23 this stuff would be within her domain as in
24 the risk management area.
25 COFFEY, Q.C.:

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1 Q. So what was she going to bring, from your
2 perspective at that time, May 19th, what would
3 she bring to the table, as it were, to the
4 group?
5 MR. SINGLETON:
6 A. A lot of this history of what had gone on and
7 the scope of it and so on.
8 COFFEY, Q.C.:
9 Q. And in her capacity as risk manager, she'd
10 have some understanding, I gather, about the,
11 you understood about the legal ramifications?
12 MR. SINGLETON:
13 A. Yeah, well that there are laws that pertain to
14 this stuff that we need to be aware of at the
15 time.
16 COFFEY, Q.C.:
17 Q. Dr. Laing, why--and you've pointed out that
18 Dr. McCarthy would be the equivalent here, but
19 why were they -
20 MR. SINGLETON:
21 A. Well they were the oncologists involved in
22 the, you know, the care of the patients.
23 COFFEY, Q.C.:
24 Q. Okay, and Dr. Denic?
25 MR. SINGLETON:

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1 A. Because he was director of the lab--by that
2 time I think he was director of the lab, but
3 Dr. Cook had been the director, so I guess
4 there was an overlap--this issue overlapped
5 them.
6 COFFEY, Q.C.:
7 Q. Now what--at this point I notice that, you get
8 down at the bottom of the page here, the first
9 e-mail, the one at 11:20 a.m., you've
10 indicated "We need Dr. Pullman, Dr. Cook, Dr.
11 Denic, Dr. Laing. We will recruit others as
12 needed." So at that point in time, although
13 Ms. Predham is--this e-mail is sent to her, I
14 take it that as of that point, Ms. Predham had
15 not been identified as one of those as needed?
16 Not yet anyway, she wasn't in the list of
17 people. "For this discussion we need Drs.
18 Pullman, Cook, Denic and Laing."
19 MR. SINGLETON:
20 A. Yeah, I'm not sure why I would have listed her
21 or not, but -
22 COFFEY, Q.C.:
23 Q. Your thought process, I'm just trying to give
24 the Commissioner some sense of this, Dr.
25 Pullman's an ethicist, I understand that,

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1 would you be considered an ethicist too?
2 MR. SINGLETON:
3 A. No, no, others sometimes describe me that way
4 but I make it clear that I'm not because it's
5 not my primary discipline.
6 COFFEY, Q.C.:
7 Q. And so Dr. Pullman would be the ethicist, Dr.
8 Cook and Dr. Denic would be two
9 representatives from the laboratory.
10 MR. SINGLETON:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. The former clinical chief and the current
14 clinical chief.
15 MR. SINGLETON:
16 A. Yeah.
17 COFFEY, Q.C.:
18 Q. So they would certainly presumably bring the
19 history with them.
20 MR. SINGLETON:
21 A. Yeah.
22 COFFEY, Q.C.:
23 Q. And Dr. Laing would represent the treating
24 physicians as it were?
25 MR. SINGLETON:

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1 A. That's right.
2 COFFEY, Q.C.:
3 Q. The oncologists.
4 MR. SINGLETON:
5 A. Yeah.
6 COFFEY, Q.C.:
7 Q. Now, sir, any particular reason you had two
8 pathologists there?
9 MR. SINGLETON:
10 A. Well Dr. Cook had made the request to Dr.
11 Williams and Dr. Denic was current chief and
12 both were willing to attend.
13 COFFEY, Q.C.:
14 Q. Now, sir, what do you recall then about how
15 this unfolded? I can assist you by bringing
16 you to certain e-mails, if you like, but I'm
17 just going to ask -
18 MR. SINGLETON:
19 A. How the consult came about.
20 COFFEY, Q.C.:
21 Q. Yes, like how it went on from here. We're up
22 to, you're trying to set it up right now.
23 MR. SINGLETON:
24 A. Right, yeah. So getting a time to get the
25 people that you needed to have there and the

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1 others who needed, you know, to kind of round
2 out the table, we might say, involve making
3 the contacts that we needed to make in order
4 to make that happen. So once we eventually
5 got a time and I think I probably had three or
6 four stabs at it before we got a time, but I
7 think it was maybe June 19th or somewhere
8 around there at 5 in the evening that we set
9 the time. So by that time, Dr. Denic and Dr.
10 Cook were able to attend. Dr. Laing couldn't
11 attend but Dr. McCarthy was available and
12 willing to attend, so she did.
13 COFFEY, Q.C.:
14 Q. If we could, please, just on that point, P-
15 1131. Now this is an e-mail, sir, from
16 yourself, May 23rd, 2006, 8:39 a.m. to Dr.
17 Laing in fact, the subject is "Ethics Consult
18 Re: Disclosure of Info on Deceased Patients."
19 And it says, "Hi, is there anyone from your
20 service that may be able to attend this
21 session. We need someone who can speak to the
22 diagnosis and prognosis matters and what may
23 have been done differently if the test results
24 were accurate first time round. Thanks,
25 Rick." So this is you being persistent and as

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1 you just pointed out, asking Dr. Laing for
2 someone who could substitute for her.
3 MR. SINGLETON:
4 A. That's right, yeah.
5 COFFEY, Q.C.:
6 Q. And I'm sorry, I interrupted you, you were
7 about to tell the Commissioner -
8 MR. SINGLETON:
9 A. So the same thing kind of happened with regard
10 to Daryl Pullman wasn't available and what I
11 did there and it's probably not in the
12 tracking of the e-mails, but I would have sent
13 a similar note to the other ethicists asking
14 if either of them could be available for the
15 time that we were trying to set it up, and I
16 believe Natalie Bandrauk was available and
17 willing to participate and she did. So along
18 with that I had conversations with Heather
19 Predham about her being available for it and
20 as well, I asked about a lawyer available for
21 the case and sometimes and this is one of the
22 features that we've had up to relatively
23 recently, I suppose within Eastern Health, is
24 that in some ethics cases we would need a
25 legal opinion or want a legal opinion as well

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1 as the discussion by the ethicists and the
2 others who were involved, so occasionally the
3 lawyers would be a part of that right mix of
4 people. And what we would--and until recently
5 it wasn't clear where we would recruit the
6 lawyer from. There were several firms
7 available to Eastern Health that we would
8 sometimes, some were involved with different
9 types of matters and so on and they had a
10 history with the types of cases and so on, and
11 in some cases it was the lawyer who was
12 available through quality and risk management.
13 And in some cases, quality and risk management
14 would get the lawyer for us. Now,
15 incidentally, we have an in-house legal
16 service, so we go to the director of that
17 service and she will decide if the matter will
18 be handled internally or if she--if we need to
19 go outside and what have you. So in that
20 case, while we were having that discussion -
21 COFFEY, Q.C.:
22 Q. So this new policy, just so we don't omit to
23 deal with it, this more recent policy, the one
24 you've described, the current one -
25 MR. SINGLETON:

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1 A. The in-house service, yes, so at this time
2 when this case was -
3 COFFEY, Q.C.:
4 Q. No, when did that begin?
5 MR. SINGLETON:
6 A. Oh, probably within, certainly within the last
7 year or so, yes. So at that time we didn't
8 have in-house legal service and I was having a
9 discussion with Heather about her involvement
10 and so on and she said that Dan Boone, the
11 lawyer had been involved with the case and
12 knew the ins and outs of it and that's why he
13 became part of it because he was the lawyer
14 available or willing to be available if we
15 could get the right time and that in fact was
16 a bit of the issue on it, but to me, it seemed
17 not only reasonable, but good that a lawyer
18 who is already informed about the history of
19 the case and the complexities of it, would
20 come to the discussion, rather than having to
21 have someone pick it up from scratch and, you
22 know, review it right from the beginning, as
23 complicated as it was.
24 COFFEY, Q.C.:
25 Q. Now, Mr. Singleton, whose idea was it to get a

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1 lawyer involved?
2 MR. SINGLETON:
3 A. That would have been mine at that point.
4 COFFEY, Q.C.:
5 Q. And in the course of discussing it with Ms.
6 Predham, she told you about Mr. Boone's
7 involvement -
8 MR. SINGLETON:
9 A. That's right, well she was giving me the
10 information about the history of the case and
11 those kinds of things, she, you know, told me
12 that Dan Boone was involved with it and those
13 kinds of things.
14 COFFEY, Q.C.:
15 Q. Did she tell you the nature of his
16 involvement?
17 MR. SINGLETON:
18 A. No, well I would know from having worked in
19 the organization that he represented many of
20 the HIROC cases and the like.
21 COFFEY, Q.C.:
22 Q. Meaning that his role would be to do what?
23 MR. SINGLETON:
24 A. Well HIROC is the insurance agency, total
25 liability factor is a large piece of it, but

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1 in the meantime, he had been part of
2 discussions that we had in other ethics cases
3 that he participated in, you know, he was
4 there because of the connection through is
5 role with HIROC that he was certainly a great
6 resource in the discussions on some of the
7 other cases.
8 COFFEY, Q.C.:
9 Q. Now, in his role with HIROC, you understood
10 his role with HIROC to be what?
11 MR. SINGLETON:
12 A. Well to be legal counsel on the matter in that
13 he would be helping with the--helping others
14 to understand the laws related to the,
15 whatever discussions would be coming about and
16 to help the rest of us with the interpretation
17 of the laws and to give advice on how to move
18 forward with the interpretation of that law.
19 COFFEY, Q.C.:
20 Q. So you understood that the lawyer for Eastern
21 Health's insurance company, who was defending
22 them I take it by that point in time, were you
23 aware that that were being sued?
24 MR. SINGLETON:
25 A. No.

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1 COFFEY, Q.C.:
2 Q. You weren't aware of that?
3 MR. SINGLETON:
4 A. No, I didn't--that was not an issue to our
5 ethics discussion, not an issue to me, it
6 wasn't part of the discussion at all.
7 COFFEY, Q.C.:
8 Q. So first nor last, leading up to the ethics
9 consult, during the ethics consult, the report
10 went out or the opinion went out, the
11 consultation opinion went out, and you didn't
12 realize that Mr. Boone was actually defending
13 Eastern Health on behalf of HIROC or acting
14 for HIROC and defending Eastern Health in a
15 lawsuit, you didn't realize that?
16 MR. SINGLETON:
17 A. No, no, I certainly wasn't part of and it
18 certainly wasn't relevant to any
19 considerations that I had.
20 COFFEY, Q.C.:
21 Q. So if you--did you understand that, look, if
22 Eastern Health is being sued over this ER/PR
23 matter that Mr. Boone is actually defending
24 Eastern Health? Did you understand that at
25 the time?

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1 MR. SINGLETON:
2 A. Pardon me?
3 COFFEY, Q.C.:
4 Q. Did you understand--you didn't understand that
5 at the time, in May and June of '06, you did
6 not realize that Mr. Boone was actually the
7 lawyer defending Eastern Health in claims by
8 families, living or dead for that matter?
9 MR. SINGLETON:
10 A. No, I don't -
11 COFFEY, Q.C.:
12 Q. You weren't aware.
13 MR. SINGLETON:
14 A. That's right, it was not an issue to me, I
15 wasn't thinking about it or asking about it,
16 nor do I ever remember being told about it.
17 COFFEY, Q.C.:
18 Q. Would it be relevant, do you think?
19 MR. SINGLETON:
20 A. I'm not sure if it would have been, like just
21 to kind of pitch it back to my thinking at the
22 time, one of the concerns I had was that we
23 have a lawyer available in the ethics consult
24 who would be able to, to the extent that we
25 needed it, give legal opinion on laws that

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1 might be relevant to the disclosure matters
2 that we'll be discussing or to the health
3 records or whatever the case might be, and,
4 you know, I certainly didn't think about the
5 issue of who represents whom in liability case
6 at that time and whether or not it would have
7 made a difference, you know, then or now.
8 COFFEY, Q.C.:
9 Q. Do you think now, if you came across a
10 situation like this again, do you think now
11 you would have asked a question about whether,
12 you know, what if any of the lawyer's
13 involvement, the nature of it is?
14 MR. SINGLETON:
15 A. Well now we have an in-house legal service.
16 COFFEY, Q.C.:
17 Q. Well if they referred you to an outside
18 lawyer, if your in-house lawyer referred you
19 to an outside lawyer, would you want to know
20 whether the lawyer who shows up or is going to
21 show up, has any involvement in the actual
22 matter and the nature of that involvement?
23 MR. SINGLETON:
24 A. Well probably as a result of all of this, I'd
25 probably inquire, I'm not sure what the result

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1 of that would be, but I'd probably inquire,
2 yeah.
3 COFFEY, Q.C.:
4 Q. So what did you understand about the nature
5 then of Mr. Boone's involvement in this?
6 MR. SINGLETON:
7 A. In the ethics consult?
8 COFFEY, Q.C.:
9 Q. No, in his prior involvement in this very
10 matter?
11 MR. SINGLETON:
12 A. Well, I guess -
13 COFFEY, Q.C.:
14 Q. And how was he involved? Involved how? He
15 knew about the background, so how was he
16 involved?
17 MR. SINGLETON:
18 A. How was he involved?
19 COFFEY, Q.C.:
20 Q. Yes, what was your understanding about how Mr.
21 Boone was involved in this?
22 MR. SINGLETON:
23 A. Well at the time when I had the discussions
24 with Heather Predham and she would have
25 described to me that he was giving the legal

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1 advice, I'm not sure what terminology she
2 used, but basically he was the lawyer who was,
3 you know, handling the case or something to
4 that effect, that was about as much--as far as
5 I went with any analysis of what that meant,
6 that basically he was informed with it and you
7 know, that there would have been
8 complications, obviously by the fact that this
9 is, you know, all these issues are unfolding,
10 so that's kind of as far as I went with it, I
11 didn't think much about what the impact of,
12 you know, what he would be pursing or what his
13 goals would have been.
14 COFFEY, Q.C.:
15 Q. In organizing the people to participate in an
16 ethics consult, do any considerations of
17 potential conflicts of interest factor into
18 that as to who participates and whether they
19 have a conflict of interest in it?
20 MR. SINGLETON:
21 A. Yeah, quite often you'll presume that there's
22 a certain amount of conflict of interest
23 because there are people there, sometimes
24 there are family members there who have an
25 interest, sometimes there are, you know,

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1 that's exactly why there is an ethics consult
2 because there is a dispute that people are
3 representing their interests of one sort of
4 another and that's quite often, you know, what
5 the heart of the matter is, is that people's
6 interests are different from each other.
7 COFFEY, Q.C.:
8 Q. How about the potentiality for a conflict of
9 interest on the part of the professionals that
10 are involved? Does that weigh into who is
11 asked into the room and what consideration, if
12 any, is given to their views?
13 MR. SINGLETON:
14 A. To some extent I think, yeah, but it isn't
15 something that we have really had much need to
16 do a screening on, but I suppose to some
17 extent, you know, it's part of it, I suppose
18 by the selection of people normally and
19 typically.
20 COFFEY, Q.C.:
21 Q. And so here, if we could just -
22 MR. SINGLETON:
23 A. Let me just say like some situations that
24 we've had where conflict of interests have
25 been quite relevant is where people have, you

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1 know, some personal connection or relationship
2 and so on with the case at hand and so they
3 obviously wouldn't be part of it for that
4 reason.
5 COFFEY, Q.C.:
6 Q. Now here, sir, did it cross your mind that
7 potentially some of the professionals in the
8 room had a conflict of interest--or at least
9 had an interest in this matter, did it cross
10 your--did you know that at the time?
11 MR. SINGLETON:
12 A. No, it really never crossed my mind, I can say
13 quite definitively because the mindset that I
14 had on it was that we would want a need to
15 have someone there with a background as a
16 lawyer training and then this individual, Dan
17 Boone, had--was familiar with the case and
18 kind of presumption that, you know, he would
19 be giving us legal advice out of the scope of
20 his own code of ethics, the professional code
21 of ethics and so on and so that presumption
22 was kind of there in the professional domain.
23 COFFEY, Q.C.:
24 Q. So from your perspective and I want to be fair
25 here, so from your perspective as the

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1 organizer, you're relying upon Mr. Boone's own
2 views of his role as a lawyer, his ethics as a
3 lawyer and the professional physicians in the
4 same way, if they shouldn't be there, you were
5 relying upon them to excuse themselves, is
6 that -
7 MR. SINGLETON:
8 A. Yeah, you could put it that way.
9 COFFEY, Q.C.:
10 Q. Is that a -
11 MR. SINGLETON:
12 A. Yeah, but in the meantime now, I had not
13 highlighted for them, nor amongst others that
14 we've had involved in ethics consults, you
15 know, we haven't had them to declare a
16 conflict of interest prior to participation,
17 so that might be implicit to them by the
18 invitation there that -
19 COFFEY, Q.C.:
20 Q. Now in relation to the people who would
21 actually be in the room, I take it other than-
22 -well Mr. Pullman, he didn't end up there,
23 but--and I'm sorry, Ms. Bandrauk?
24 MR. SINGLETON:
25 A. Bandrauk, Dr. Bandrauk.

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1 COFFEY, Q.C.:
2 Q. Bandrauk who did end up actually there, I take
3 it?
4 MR. SINGLETON:
5 A. Yeah, that's right.
6 COFFEY, Q.C.:
7 Q. Other than you and her, ultimately, the two
8 least informed people in the room were
9 yourselves, the two of you, because all the
10 others had some prior involvement in this.
11 MR. SINGLETON:
12 A. Yeah.
13 COFFEY, Q.C.:
14 Q. In terms of who actually was there, there was
15 doctors, pathologists, oncologists, Ms.
16 Predham, Dan Boone.
17 MR. SINGLETON:
18 A. Yeah, that's right and that's pretty typical
19 to an ethics consult that that in fact, I
20 suppose in some ways is what an ethics consult
21 does, it brings together parties who have
22 experience in the case and in the matter at
23 hand and then part of the challenge in
24 facilitating an ethics case and the discussion
25 that is, you know, led to a great extent by

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1 the ethicist is the kind of what we might say
2 put an ethics lens on the matters that others
3 have already been engaged in.
4 COFFEY, Q.C.:
5 Q. So it would be--and I take it, the ethicist
6 and you as a facilitator, the ethicist would
7 be relying upon those in the know, as it were,
8 to -
9 MR. SINGLETON:
10 A. Fill in the -
11 COFFEY, Q.C.:
12 Q. Let you know anything that you should know.
13 MR. SINGLETON:
14 A. That's right, yes, that's kind of what it was,
15 yes.
16 COFFEY, Q.C.:
17 Q. Is there any actual materials, written
18 materials that you have before such a meeting
19 that you, you know, the brief, as it were, the
20 summary.
21 MR. SINGLETON:
22 A. Well, you know, in these cases I'd probably
23 collect some, a bit of background to it, you
24 know, just -
25 COFFEY, Q.C.:

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1 Q. Well this particular one, did you have
2 anything, kind of a summary before you went
3 in, like a written summary that you could
4 review to get some -
5 MR. SINGLETON:
6 A. No, no, that's part of what we do on the front
7 end of an ethics consult is to have a, you
8 know, an outline of the facts, we ask the
9 people who are involved in the case to and to
10 fill it in and to make sure that what we are
11 getting here in the discussion are, in fact,
12 the facts of the case.
13 COFFEY, Q.C.:
14 Q. That's during the actual meeting itself.
15 MR. SINGLETON:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. Okay, but there's not kind of a written thing
19 that you have before -
20 MR. SINGLETON:
21 A. No.
22 COFFEY, Q.C.:
23 Q. That you could read before.
24 MR. SINGLETON:
25 A. No, no.

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1 COFFEY, Q.C.:
2 Q. Okay. Now if I could, I'm just going to take
3 you through a couple of e-mails, P-1688
4 please? Now this is an e-mail from yourself,
5 May 30th, 2006, 3:43 p.m. to Denise Dunn, who
6 I gather was the administrative assistant for
7 Dr. Williams. Do I have that right, I think
8 Denise Dunn worked for Dr. Williams?
9 MR. SINGLETON:
10 A. Yes, yeah.
11 COFFEY, Q.C.:
12 Q. "Hi Denise, the dates tentative set for the
13 ethics discussion is June 13th, but now
14 Heather Predham tells me the lawyer may not be
15 able to attend, so it will probably be delayed
16 a bit, but I'm not sure how soon this matter
17 needs to be resolved. Louise advised me that
18 she did not see the need for her and Bob to be
19 involved unless the ethics discussion does not
20 adequately resolve the matter." So in this
21 context, adequately resolve the matter meant
22 what?
23 MR. SINGLETON:
24 A. That if we had our discussion and we didn't
25 have, couldn't come up with recommendations

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1 that would give some direction on it, well
2 then we'd report that back to them and I guess
3 they would have to, as an administration,
4 suggest the next step. It may involve ethics
5 and it may not, I'm not sure where it would
6 go.
7 COFFEY, Q.C.:
8 Q. Okay, now P-1689 please? These are two e-
9 mails, one of June 6th, 2006 at 4:32 p.m. from
10 yourself to Heather Predham and Lorraine
11 Woolgar. Who is Ms. Woolgar?
12 MR. SINGLETON:
13 A. Heather Predham's secretary and the subject is
14 "Ethics Case". "Hi, I was discussing the
15 progress on the ethics, re: disclosure with
16 Dr. Cook. We need to get this moved along
17 within the next couple of weeks. After that it
18 becomes almost impossible to get the people
19 together. Would an evening meeting be a
20 possibility? I know Dan Boone is hard to get
21 due to his court schedule, perhaps evening
22 would work. In the evening of June 19, 20 or
23 21 would work for Dr. Cook and I. We will
24 conscript from there. At a minimum we need
25 lawyer, ethicists and pathologists." And then

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1 the next day at 9:36 p.m., Ms. Predham
2 responds to yourself saying, "I finally got
3 Dan on the phone, he wants to participate, so
4 I forwarded the dates on to him, he'll confirm
5 his availability and get back to us later
6 today or in the a.m. As soon as I hear, I'll
7 let you know." So I'm going to ask you now,
8 was there any consideration given to using a
9 lawyer other than Mr. Boone?
10 MR. SINGLETON:
11 A. Well I can't remember exactly, but just having
12 re-read that, you know, I guess by that time I
13 was concerned about getting the, you know,
14 responding to the request that was made and
15 that is that we have an ethics consult and so
16 on my conversations with Heather, we had
17 decided to, that Dan Boone would be the lawyer
18 involved because he was involved, but by now I
19 was probably thinking, you know, if he can't
20 be available, we need to move forward with it
21 and so, you might see there that I mentioned
22 that we need a lawyer, ethicists and
23 pathologists, so I was thinking about having
24 someone from the profession -
25 COFFEY, Q.C.:

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1 Q. The legal profession.
2 MR. SINGLETON:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. So I take it on the 6th, late that afternoon
6 when you pushed the matter, you were advised
7 early the next morning that Mr. Boone would
8 make himself available in the evening?
9 MR. SINGLETON:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. If we could please, exhibit P-0780? Now this
13 is an e-mail from yourself, June 9th, 2006,
14 9:47 a.m. to a number of individuals, of
15 course you've sent it to yourself, I take it
16 you sent it to yourself just to keep a record?
17 MR. SINGLETON:
18 A. Well actually because when you hit reply all
19 if you're -
20 COFFEY, Q.C.:
21 Q. You'd end up being -
22 MR. SINGLETON:
23 A. Yeah, that's right.
24 COFFEY, Q.C.:
25 Q. By Dr. Williams, Louise Jones, Ms. Predham,

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1 Dr. Laing, Dr. Denic, Mr. Pullman, Dr. Denic
2 again, Ms. Bandrauk and Dr. McCarthy. And you
3 write, "Hi, we'll again have to reschedule our
4 meeting to discuss the disclosure of
5 information regarding deceased patients.
6 We've had difficulty getting a time with the
7 lawyer who has been handling the case. He is
8 in court almost every day of this month, but
9 we have now rescheduled to Monday, June 19th
10 at 5 p.m. Mr. Dan Boone, the lawyer, will
11 join us a bit late. The new time is Monday,
12 June 19th at 5 p.m. in a particular room, the
13 pastoral care and ethics office. We have
14 cancelled the meeting previously scheduled for
15 June 19th." So must have been one at another
16 time of the day, I take it. Sir, what do you
17 recall about the meeting? Did it go ahead
18 first of all?
19 MR. SINGLETON:
20 A. Yeah, it went ahead at 5 on June 19th.
21 COFFEY, Q.C.:
22 Q. And how did it go?
23 MR. SINGLETON:
24 A. Well it was, it went as most of the ethics
25 consults do, people arrived and we, everyone

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1 was there on time and that was good because it
2 is important when you are having those types
3 of discussions that you have everyone
4 available right from the beginning and that
5 they stay with it until it's over, it really
6 interferes with the discussions if people are
7 in and out and leaving and so on. And as you
8 can imagine, it's always a challenge in those
9 types of sessions because many people are on
10 call and they have, you know, things come up.
11 But anyway, in that particular case, people
12 were there on time and we got down to business
13 right away and we began with kind of drawing
14 out the facts of the case at least, you know,
15 in descriptions that -
16 COFFEY, Q.C.:
17 Q. Who provided those?
18 MR. SINGLETON:
19 A. Well a lot of, on the front end of it, was
20 provided by Dr. Denic and Dr. Cook in terms
21 of, you know, the history to where this began
22 to the extent that people had an understanding
23 of that and -
24 COFFEY, Q.C.:
25 Q. What were you told about that?

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1 MR. SINGLETON:
2 A. Now I wouldn't remember all of the details,
3 but I did have a few handwritten notes that
4 you probably have, but what was happening
5 there is there was some description of the
6 history when it, you know, the time range from
7 '97 to 2005 and then some numbers on the
8 number of cases involved and those kinds of
9 things were all kind of part of the discussion
10 on the front end, to get the lay of the land
11 kind of that we needed to move into the
12 discussion about what is the--what are the
13 ethical issues here and what are the, you
14 know, what's the scope of discussion that we
15 need to have on it.
16 COFFEY, Q.C.:
17 Q. So if I could, please, Drs. Denic and Cook,
18 the two pathologists, after everybody I take
19 it sits down and kind of says hello and gets
20 seated and get comfortable.
21 MR. SINGLETON:
22 A. Okay, if you want all these details, people
23 do, you know, we do the introductions and
24 where you're from and in terms of what
25 discipline you represent and what your role is

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1 within the organization or wherever.
2 COFFEY, Q.C.:
3 Q. Now what do you recall about what Dr. Cook or
4 Dr. Denic said about this matter? I
5 appreciate it was '97 to '05 and there were a
6 lot of people involved, they'd have the
7 numbers or Ms. Predham would have the numbers,
8 but what, if anything, did they say about what
9 actually happened?
10 MR. SINGLETON:
11 A. Well, actually, that kind of was part of the
12 listening that I was doing because one of the
13 roles that I knew I would have, as the
14 facilitator, is to try and bring this to some
15 kind of a summary as we moved through the
16 discussion, and you know, see what kind of
17 consensus we have and where we go and that, I
18 would be putting together the, you know,
19 whatever summary report would be on.
20 So I had been fairly involved, I suppose,
21 with the development of the policies around
22 disclosure that were already, you know,
23 developed and so on, throughout the life of
24 the Health Care Corporation, and they, as you
25 know, I'm sure, were about individual cases

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1 and so on.
2 COFFEY, Q.C.:
3 Q. That would be adverse event disclosure?
4 MR. SINGLETON:
5 A. Yeah, sorry, yeah, that type of stuff. So
6 that's kind of what I was, you know, listening
7 for in terms of, you know, what the history of
8 this is, or at least that's part of what I was
9 listening for in the history of it, was to the
10 whole business of, you know, is there somebody
11 who, you know, was making the same mistake
12 over and over and you know, or was there a
13 piece of equipment that, you know, was
14 malfunctioning over and over, those kinds of
15 concrete things that would be kind of typical
16 to -
17 COFFEY, Q.C.:
18 Q. That's what you're listening for, did you -
19 MR. SINGLETON:
20 A. Yeah, you know, to some of the individual type
21 of situations that we would have, you know,
22 had consideration of when we were developing
23 or working on policy with regard to disclosure
24 of adverse events. This, when we were into--
25 you know, and I don't remember the specifics

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1 of what Dr. Denic or Dr. Cook or anyone else
2 kind of said that filled in the kind of
3 history of it. But my sense of it, in the--
4 you know, in our discussion and especially in
5 putting together, you know, what is the reason
6 behind all this, that this was--you know, it
7 was big and it was systemic in that, you know,
8 it was clear to me, and I don't have--I'm not
9 a physician, I don't have a medical
10 background, I'm not a scientist, and so all of
11 the things that they were saying were factors
12 and so on was really, you know, stuff that was
13 not familiar to me, except to be able to
14 surmise from it that this is a systemic
15 problem and one problem was triggering another
16 or bouncing off another and, you know, it was,
17 as we all know by now, very complex.
18 COFFEY, Q.C.:
19 Q. Now sir, let me ask you, because I'm going to
20 come to the report, but in the report, you say
21 the following, quote: "there were no mistakes
22 or technical errors at the root of this
23 problem."
24 MR. SINGLETON:
25 A. Yeah.

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1 COFFEY, Q.C.:
2 Q. End quote, okay?
3 MR. SINGLETON:
4 A. Yeah.
5 COFFEY, Q.C.:
6 Q. Did you, during that meeting, or did anyone
7 else ask the physicians involved whether there
8 were any mistakes or technical errors at the
9 root of the problem?
10 MR. SINGLETON:
11 A. I wouldn't remember the precision of that, but
12 what I -
13 COFFEY, Q.C.:
14 Q. Did you ask whether there were any mistakes at
15 the root of the problem?
16 MR. SINGLETON:
17 A. Not--I can't say I did or I didn't.
18 COFFEY, Q.C.:
19 Q. Did you ask whether there were any technical
20 errors at the root of the problem?
21 MR. SINGLETON:
22 A. I can't say if I asked, but my conclusion, as
23 the facilitator, for what I--you know, what I
24 gleaned from what was said is that, you know,
25 it wasn't a matter--but, I have to say that

1 what I was thinking of when I was writing that
2 and what I was listening for was is there
3 someone or something that it could be traced
4 back to.
5 COFFEY, Q.C.:
6 Q. How about ones or things?
7 MR. SINGLETON:
8 A. Pardon me?
9 COFFEY, Q.C.:
10 Q. How about ones or things, more than one?
11 MR. SINGLETON:
12 A. Yeah, I mean -
13 COFFEY, Q.C.:
14 Q. In your world, what's magic about it being one
15 person as opposed to three or four or five
16 that you could actually point to? What
17 difference did it make whether it is one?
18 MR. SINGLETON:
19 A. I have hearing problems. I can't -
20 COFFEY, Q.C.:
21 Q. Okay, I'm asking, what difference does it make
22 that it is one? Why would you be concerned
23 about whether there's one individual you could
24 point to?
25 MR. SINGLETON:

1 A. Yes, it wouldn't be so relevant that it was
2 one, but at least if it was clearly
3 identifiable, you know, as being one or one
4 group, as far as that goes. But my sense of
5 it, at that time, is that this was broader
6 based, systemic. That it wasn't, you know,
7 that identifiable.
8 COFFEY, Q.C.:
9 Q. Did anyone ask those present, those in the
10 know present, so did either--and yourself and
11 Ms. Bandrauk would not--the ones not in the
12 know, as it were, did you ask those in the
13 know whether there were any investigations
14 into what had happened and why it had
15 happened?
16 MR. SINGLETON:
17 A. No, you know, I didn't--I was hearing Dr.
18 Denic and Dr. Cook give descriptions of what
19 was happening and then others, especially
20 Heather, was able to give information on
21 numbers and, you know, what efforts had been
22 made to contact patients and those kinds of
23 things, and so I didn't cross-examine them
24 about where they came up with that
25 information.

1 COFFEY, Q.C.:
2 Q. No.
3 MR. SINGLETON:
4 A. These were the people--these had been the
5 former director and the current director of
6 the lab, and so I would take it for granted
7 they knew and understood what we were talking
8 about.
9 COFFEY, Q.C.:
10 Q. P-0045, please. It's P-0046 actually. I
11 apologize. And sir, this is a report of Dr.
12 Banerjee, of the B.C. Cancer Agency, October
13 17th 2005, actually addressed to Dr. Cook,
14 okay, one of the gentlemen who was in the room
15 with you that day, on June 19th, and if I
16 could, I'm just going to--went too far, go
17 back. Now here, this is in October of 2005.
18 Well, actually here, I'll just go back one
19 more. Dr. Banerjee, after reviewing what
20 he'd--you know, what he was asked to do, he
21 had advised Dr. Cook in October 2005, under
22 review of cases, "I reviewed a number of cases
23 from the retrospective testing set with Dr.
24 Donald Cook. All of the cases that had
25 converted from negative to positive by

1 switching platforms had one or more of the
2 following characteristics: 1. poor fixation;
3 2. negative internal controls; 3. absent
4 internal controls. It is apparent that too
5 much reliance is being placed on external
6 positive controls with no attention paid to
7 internal controls."
8 Later in the same report, under a heading
9 that it reads "conclusions about the reasons
10 for test failure: 1. is the DAKO system
11 faulty?" and he says "this is unlikely" and
12 goes on to say why. "2. Is the Ventana system
13 too sensitive?" He says there's no evidence
14 that that's so. "3. Is there a problem with
15 tissue fixation? There appears to be
16 inadequate attention paid by the grossing
17 pathologists to the thickness of tissue
18 slices, quality and adequacy of fixation, and
19 there's no standardized fixation protocol that
20 everyone adheres to." Now that day, did any
21 of the physicians present advise you that an
22 outside or that they had reason to believe,
23 without advising who told them, they had
24 reason to believe that tissue fixation was a
25 problem and it related to, potentially, their

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1 work and their colleagues' work? Did they
2 tell you that?
3 MR. SINGLETON:
4 A. If they did, I wasn't -
5 COFFEY, Q.C.:
6 Q. You didn't hear it?
7 MR. SINGLETON:
8 A. Didn't register with me.
9 COFFEY, Q.C.:
10 Q. Okay.
11 MR. SINGLETON:
12 A. No.
13 COFFEY, Q.C.:
14 Q. Do you think if a physician in that room had
15 said that "we have reason to believe that our
16 own work, and perhaps the work of our
17 colleagues, was deficient here, potentially
18 deficient here" would you remember that?
19 Because it would be relevant, I'm going to
20 suggest, to -
21 MR. SINGLETON:
22 A. I think I would, yeah. I mean, I made a few
23 scratch notes and some of the stuff that I had
24 there was, you know, stuff that probably
25 others wouldn't jot down. There might be

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1 stuff that--but yeah, I think I would remember
2 that, yeah.
3 COFFEY, Q.C.:
4 Q. And it goes on to say, "4. Inadequate or no
5 attention is being paid by the reporting
6 pathologist to the status of internal controls
7 with inappropriately exclusive reliance on
8 external positive controls." Do you recall
9 being told that day, by any of those present,
10 that at least there was perhaps reason to
11 believe that inadequate or no attention had
12 been paid by the pathologists to internal
13 controls related to this test?
14 MR. SINGLETON:
15 A. No, that wasn't--you know, I'm sure that
16 wasn't.
17 COFFEY, Q.C.:
18 Q. Don't remember that coming up?
19 MR. SINGLETON:
20 A. Yeah.
21 COFFEY, Q.C.:
22 Q. Okay.
23 MR. SINGLETON:
24 A. But in the meantime now, the scope of the
25 discussion, direction that our discussion was

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1 taking was about the fact that there is
2 information available and -
3 COFFEY, Q.C.:
4 Q. And I'll get to that in a moment. I just want
5 to be--because you do make the statement, it's
6 -
7 MR. SIMMONS:
8 Q. Madam Commissioner, I think Mr. Singleton
9 should be allowed to at least finish his
10 statement that he started to make there.
11 COFFEY, Q.C.:
12 Q. Okay.
13 MR. SIMMONS:
14 Q. (Inaudible) answer the questions.
15 COFFEY, Q.C.:
16 Q. Well, I'm going to--I will allow him to do it
17 and I have no -
18 MR. SIMMONS:
19 Q. Well, you interrupted.
20 THE COMMISSIONER:
21 Q. Mr. Singleton, you were trying to give us a
22 thought, so why don't you finish that thought.
23 MR. SINGLETON:
24 A. Yes, simply to say that the discussion, the
25 direction of our discussion that day was

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1 really about the issues of communicating with
2 families and what needs to be taken into
3 consideration in communicating with families,
4 that this information is available and may be
5 available, and so that was the direction. We
6 didn't, you know, spend much time on -
7 THE COMMISSIONER:
8 Q. Sorry, this information is available or may be
9 available?
10 MR. SINGLETON:
11 A. That the--you know, that the information about
12 the tests have been done and there's results
13 back and whether or not it would have--you
14 know, did your mother or your wife or whatever
15 the case might be who has died, we've had
16 samples retested. These were the kinds of
17 things that we were talking about that day,
18 you know, that type of information is there,
19 it's part of the person's health record and,
20 you know, who should be informed or at least
21 have the information offered to them. That's
22 what we were--most of our discussion was
23 about. It wasn't about the kind of history of
24 how it all came about.
25 COFFEY, Q.C.:

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1 Q. And I'll come to that, come back to that.
2 MR. SINGLETON:
3 A. Yeah, but I need to say though that because
4 our discussion came up in the--and this ethics
5 consult came about because as efforts were
6 made to contact patients, generally speaking,
7 following the, you know, guidelines around
8 disclosure of adverse events and so on, but
9 that it was because when efforts were made to
10 contact patients and discovered that some of
11 the people that testing had been done on had
12 already died, that that's where this issue
13 came from, and so we didn't--I suppose didn't
14 really need to get into the discussion of how
15 it all came about because already efforts were
16 being made to contact patients, but these
17 patients were dead. So that's kind of where,
18 you know, kind of in the history of where our
19 ethics consult kind of picked up, and that was
20 relevant to the discussion of, you know, what
21 this case is about.
22 THE COMMISSIONER:
23 Q. I'm sorry, are you saying that your ethics
24 consult arose because it was assumed that
25 everybody who had been retested was alive and

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1 when they started contacting people -
2 MR. SINGLETON:
3 A. That's right, that was part of the
4 information. That was part of kind of the
5 discussion that day, that it was only when
6 results started coming back from Mount Sinai
7 and, you know, a routine was set up to start
8 contacting some of the--start contacting
9 patients.
10 THE COMMISSIONER:
11 Q. Okay.
12 MR. SINGLETON:
13 A. That they discovered it, and I'm not sure if
14 they knew that some of the patients were dead
15 beforehand or not, but, you know, and we
16 didn't get into that discussion.
17 THE COMMISSIONER:
18 Q. So you're not sure whether they had known
19 before they started contacting patients -
20 MR. SINGLETON:
21 A. My sense of it was that -
22 THE COMMISSIONER:
23 Q. - that some of them had already died?
24 MR. SINGLETON:
25 A. - really, you know, I suppose, all this was

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1 happening and it was happening at a very busy
2 time and what have you, that really nobody had
3 anticipated some of the tests that we're
4 sending away may--when they come back and we
5 contact the patients that some of the--or we
6 make efforts to contact the patients, we may
7 discover that some of the patients are dead.
8 So that's kind of -
9 THE COMMISSIONER:
10 Q. Yes, but, I'm sorry, that's a couple of
11 different things. So I just want to make sure
12 I understand clearly what you understood.
13 MR. SINGLETON:
14 A. Yeah.
15 THE COMMISSIONER:
16 Q. Because in response to Mr. Coffey's question,
17 I understood you to be saying that the reason
18 that this consult was made was because when
19 those at Eastern Health who were starting to
20 contact patients with the results of tests
21 discovered that in fact some of these people
22 had already died in the process of consulting
23 or I'm sorry, in the process of contacting
24 people to give them the results of their tests
25 or retests, as opposed to a situation where

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1 they knew that some of their retests were on
2 patients who had already died and then they
3 were sort of saying "well, what do we do with
4 this information." Two different things.
5 MR. SINGLETON:
6 A. Yes. Okay, well the consult came because Dr.
7 Cook had, you know, some records in the lab
8 that they couldn't kind of complete, sign off,
9 as he called it, because the patients were
10 dead and this information was there and it
11 hadn't gone anywhere. But that situation came
12 about, to some extent, or at least related to
13 that is the fact that the batches of samples
14 that were sent for retesting, as I understood
15 it, were--included some people who, by the
16 time the results came back, at least, some
17 patients who were dead.
18 THE COMMISSIONER:
19 Q. Okay.
20 MR. SINGLETON:
21 A. And so then what do we--we have their records,
22 so what do we do with it?
23 THE COMMISSIONER:
24 Q. Okay. So was it your understanding they did
25 not intend to send the samples from those who

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1 had died, or did they not know any of them had
2 died?
3 MR. SINGLETON:
4 A. My understanding is that they didn't--you
5 know, that it hadn't been part of the culling
6 out.
7 THE COMMISSIONER:
8 Q. Okay.
9 MR. SINGLETON:
10 A. And I'm not sure if they had the means to even
11 be able to separate the samples (inaudible -
12 coughing)
13 THE COMMISSIONER:
14 Q. Mr. Coffey -
15 MR. SINGLETON:
16 A. But you know, I guess a piece that I can speak
17 to is that in the discussion that day, they
18 knew that by the time the results came back
19 and they started contacting people, and I
20 think there were incidents where they--when
21 they made the contact, they discovered at that
22 point or when they were about to make the
23 contact that the patient was dead.
24 THE COMMISSIONER:
25 Q. All right, thank you.

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1 MR. SINGLETON:
2 A. So that's kind of where the--and that was very
3 relevant in the discussion that day because,
4 you know, Heather from Quality Department was
5 describing some of the steps that they had put
6 in place to, you know, prepare the people who
7 were going to be making the calls to the
8 patients and that, and then some of them
9 discovered that the patients were dead.
10 THE COMMISSIONER:
11 Q. Mr. Coffey, it's about 3:30.
12 COFFEY, Q.C.:
13 Q. Could I just one more e-mail, please,
14 Commissioner?
15 THE COMMISSIONER:
16 Q. Sure, yes.
17 COFFEY, Q.C.:
18 Q. Exhibit P-0781, because I'm going to come back
19 to the actual meeting, okay, but right now
20 before we break.
21 THE COMMISSIONER:
22 Q. We usually have an afternoon break, Mr.
23 Singleton. That's what--we usually have an
24 afternoon break. I'm just telling Mr. Coffey
25 it's about time.

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1 COFFEY, Q.C.:
2 Q. And this is an e-mail from yourself, Tuesday,
3 June 20th, 2006, at 10:20 a.m. to Dr.
4 Williams. You say "Hi, Bob. Yesterday we had
5 the ethics consult on ER/PR. Very good
6 discussion and outcome. I will forward the
7 summary later. In the meantime, an issue
8 can"--I'm sorry, I presume it should be "came
9 up that I want to give you a heads up on. Dr.
10 Denic had a document or report from an
11 external reviewer of the lab processes,
12 etcetera, here. He read from it and mentioned
13 that he would use the report as part of
14 information he was sharing with others. It
15 seems the report or opinion had been done for
16 Dan Boone and he did not want the information
17 shared, as at this time, it is privileged.
18 Dr. Denic understood from you that he was not
19 to copy it, but Dan seemed to be a bit
20 concerned that it was being quoted the expert
21 being referred to. Dan's concern seems to be
22 about the privileged status of the report
23 which he may need in proceeding later on.
24 Anyway, just thought you might want to know
25 there was a bit of fuss about this." Signed

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1 Rick.
2 Now just in the context here, "he read
3 from it" which in the third line is Dr. Denic,
4 I presume. Third line, end of the line.
5 MR. SINGLETON:
6 A. Yes, yeah.
7 COFFEY, Q.C.:
8 Q. As Dr. Denic "read from it, and mentioned that
9 he" that is Dr. Denic, "would use the report
10 as part of information he was sharing with
11 others," and in the next sentence, "it was
12 done for Dan Boone and he did not want the
13 information shared." That is, I take it, Mr.
14 Boone didn't want it shared? That's who--I
15 got the players right, do I?
16 MR. SINGLETON:
17 A. Yeah, yeah.
18 COFFEY, Q.C.:
19 Q. Okay, and now sir, why was it that you would
20 send this e-mail to Dr. Williams?
21 MR. SINGLETON:
22 A. I hadn't remembered anything about that until
23 you showed it here, but now I remember, yeah,
24 there was a--I didn't know what was in the
25 report, but simply because it was--Bob

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1 Williams had asked me to--or you know, I did
2 the ethics consult, he had asked for an ethics
3 consult. This came up as part of the
4 discussion. There was an item talked about
5 that wasn't--there was--I don't recollect--I
6 don't know very much of the content of it. I
7 don't remember any of the content of what was
8 there, and I'm not sure if it's the report
9 that you talked about earlier, but I remember,
10 and it's only now that I remember it, that
11 there was some discussion and difference of
12 opinion between Dr. Denic and Dan Boone about
13 what should be done and the status of that
14 type of report, and that was the word, I
15 remember now, that was used, that it was
16 privileged, and that was--I never really--I
17 don't think I thought of it since I sent the
18 note to Bob Williams.
19 COFFEY, Q.C.:
20 Q. Why did you send a note to Bob Williams about
21 it?
22 MR. SINGLETON:
23 A. Because he was the one who asked for the
24 ethics consult. This came up in the
25 discussion. The people who were there didn't

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1 want it to be part of--they didn't participate
2 in the discussion of the content of it, but I
3 felt that as a medical director that this was
4 a matter that where a report had been--you
5 know, was there and it was--I didn't know the
6 content of it, but it was obviously content in
7 it that would be relevant to this matter at
8 hand, and so I felt Bob Williams should know
9 about it, that there was a difference of
10 opinion between two people who participated in
11 the ethics consult about whether or not the
12 content of this should be distributed or not.
13 COFFEY, Q.C.:
14 Q. Within the group at the meeting?
15 MR. SINGLETON:
16 A. Or anywhere, as far as that goes.
17 COFFEY, Q.C.:
18 Q. Yes, but within the group at the meeting?
19 "Dr. Denic," you said here, "had a document, a
20 report, from an external reviewer of the lab
21 process. He read from it." So I take it, at
22 the meeting, Dr. Denic started to read from
23 this report, whatever report it was.
24 MR. SINGLETON:
25 A. Yeah.

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1 COFFEY, Q.C.:
2 Q. He started to read from it and Dan Boone got
3 upset about it or objected?
4 MR. SINGLETON:
5 A. Must have been, yeah, yeah.
6 COFFEY, Q.C.:
7 Q. But you said there was quite a fuss about it,
8 so.
9 MR. SINGLETON:
10 A. Yeah, okay.
11 COFFEY, Q.C.:
12 Q. I take it he did get upset about it?
13 MR. SINGLETON:
14 A. Well, it had been a disagreement anyway, yeah.
15 COFFEY, Q.C.:
16 Q. Yes.
17 MR. SINGLETON:
18 A. Yeah, yeah.
19 COFFEY, Q.C.:
20 Q. And he didn't want, that is, Mr. Boone did not
21 want Dr. Denic to talk about this in front of
22 the group and read from that report in front
23 of the group?
24 MR. SINGLETON:
25 A. That must have been. I don't remember. It

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1 wasn't, the report certainly wasn't read
2 there.
3 COFFEY, Q.C.:
4 Q. I appreciate that. But he started to -
5 MR. SINGLETON:
6 A. Yeah, yeah, yeah.
7 COFFEY, Q.C.:
8 Q. - and that caused the reaction from Mr. Boone?
9 MR. SINGLETON:
10 A. That's right, yeah, yeah, yeah.
11 COFFEY, Q.C.:
12 Q. And therefore those at the meeting, I take it,
13 Dr. Denic didn't continue then, Dr. Denic -
14 MR. SINGLETON:
15 A. That's right.
16 COFFEY, Q.C.:
17 Q. - acceded to Mr. Boone's -
18 MR. SINGLETON:
19 A. Yeah, yeah.
20 COFFEY, Q.C.:
21 Q. - request that he not read from it?
22 MR. SINGLETON:
23 A. Yeah.
24 COFFEY, Q.C.:
25 Q. I'm correct on that?

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1 MR. SINGLETON:
2 A. Yeah.
3 COFFEY, Q.C.:
4 Q. And that having happened then those at the
5 meeting didn't ever get apprised, those who
6 didn't have the report did never get apprised
7 of what was in the report? Is that correct?
8 MR. SINGLETON:
9 A. That's right, oh, yeah, yeah, yeah.
10 COFFEY, Q.C.:
11 Q. Okay.
12 MR. SINGLETON:
13 A. That's right, yeah, yeah.
14 COFFEY, Q.C.:
15 Q. And why then would you bring that to Dr.
16 Williams' attention, what difference would it
17 make to Dr. Williams in this context?
18 MR. SINGLETON:
19 A. Yeah, well, I don't know, but it wouldn't
20 have--wouldn't be uncommon for me in a
21 situation like that to say, because this issue
22 is there and there's kind of a, you know, it's
23 a--there's a disagreement, it's obviously not
24 going to resolve anything now, so it wouldn't
25 be uncommon for me to say I'll need to pass

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1 this on to Dr. Williams or somebody.
2 Obviously he was, I think, well, he was
3 certainly the person that I was--you know,
4 that asked for the ethics consult and he
5 would, you know, he was overseeing the whole
6 service, obviously, had the authority to make
7 a decision whether or not, within Eastern
8 Health, at least, that type of information
9 would be shared among people who were
10 involved.
11 COFFEY, Q.C.:
12 Q. Did it ever, that subject matter ever come up
13 again, did Dr. Williams ever come back to you
14 or anybody else ever talk to you about that
15 again?
16 MR. SINGLETON:
17 A. No.
18 COFFEY, Q.C.:
19 Q. Okay. Thank you, Commissioner, we'll break.
20 COMMISSIONER:
21 Q. We'll take an afternoon break.
22 (RECESS)
23 COMMISSIONER:
24 Q. Mr. Coffey?
25 COFFEY, Q.C.:

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1 Q. Thank you, Commissioner. Just before I
2 continue, Could I ask that Exhibits P-1718 and
3 1719 be entered, please?
4 COMMISSIONER:
5 Q. Entered.
6 EXHIBIT P-1718 ENTERED INTO EVIDENCE.
7 EXHIBIT P-1719 ENTERED INTO EVIDENCE.
8 COFFEY, Q.C.:
9 Q. If we could just look at, please, P-1719?
10 This is what sort of a document? It's there
11 on the screen.
12 MR. SINGLETON:
13 A. That's the pamphlet that we had in Health Care
14 Corporation to describe the ethics
15 consultation service.
16 COFFEY, Q.C.:
17 Q. Is there an equivalent now in Eastern Health?
18 MR. SINGLETON:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. Okay. And, as well, if we could, please, P-
22 1718? And I take it that, sir, this is the
23 letter that you received from--1718 at page 1
24 is the letter you received from, well, Dr.
25 Cook via Dr. Williams?

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1 MR. SINGLETON:
2 A. Right, yeah.
3 COFFEY, Q.C.:
4 Q. And, in fact, it is the May 3rd, 2006 letter
5 from Donald Cook to Dr. Williams except that
6 Dr. Williams has endorsed a request of you on
7 it. Is that -
8 MR. SINGLETON:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. To do the ethics consult. And on that point,
12 here in the top right-hand side, I believe it
13 says May 18th, 2006. "Denise, as discussed,"
14 something "you arrange with ethics review.
15 Thanks, Bob Williams." or "BW"?
16 MR. SINGLETON:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. And here toward the bottom of the page, whose
20 handwriting is that?
21 MR. SINGLETON:
22 A. It's mine.
23 COFFEY, Q.C.:
24 Q. Okay. I take it this would be the--some notes
25 you made in speaking with Dr. Cook? Would

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1 that be -
2 MR. SINGLETON:
3 A. Yes, yeah, most likely, yeah, yeah, or--and,
4 you know, some stuff that I would have just
5 jotted down as I was preparing for and after,
6 yeah.
7 COFFEY, Q.C.:
8 Q. Yes, you have a phone number for Dr. Cook, I
9 believe, and overall and Nash Denic's number,
10 work number?
11 MR. SINGLETON:
12 A. Yeah.
13 COFFEY, Q.C.:
14 Q. And Kara Laing is referenced and Louise Jones,
15 Bob Williams and D. Pullman, so I take it it's
16 a kind of initial draft of who might be -
17 MR. SINGLETON:
18 A. That's right, yeah, yeah.
19 COFFEY, Q.C.:
20 Q. - involved?
21 MR. SINGLETON:
22 A. Yeah.
23 COFFEY, Q.C.:
24 Q. If we could, please, page 3 of this exhibit.
25 These, I take it, are your handwritten notes

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1 of the meeting of June 19th, 2006?
2 MR. SINGLETON:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. And sometimes, of course, sometimes
6 handwritten notes are legible and sometimes
7 they're not and sometimes you can misinterpret
8 what's there, so I'm just going to quickly run
9 down through them. You've got Joy McCarthy,
10 Don Cook, Heather Predham.
11 MR. SINGLETON:
12 A. Denic.
13 COFFEY, Q.C.:
14 Q. Denic, okay, I just wanted to be certain of
15 that. Denic.
16 MR. SINGLETON:
17 A. Just a scribble, "RS", my -
18 COFFEY, Q.C.:
19 Q. Yourself, yes. Dan Boone and Ms. Bandrauk?
20 MR. SINGLETON:
21 A. That's right.
22 COFFEY, Q.C.:
23 Q. And "ER/PR, new system of" something, "April,
24 2004"?
25 MR. SINGLETON:

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1 A. That's right, "diagnosed", yeah.
2 COFFEY, Q.C.:
3 Q. Oh, "New diagnostic system, April, 2004."
4 MR. SINGLETON:
5 A. Um.
6 COFFEY, Q.C.:
7 Q. "May, '97-August, 2005. 950 samples. 24
8 percent conversion. 73 percent."?
9 MR. SINGLETON:
10 A. Yeah.
11 COFFEY, Q.C.:
12 Q. What was--who gave the 24 percent conversion,
13 do you know where that came from?
14 MR. SINGLETON:
15 A. No, I don't know who. It was obviously
16 someone gave, you know, in the information
17 that we were--that was being brought forward,
18 you know, these are some of the numbers.
19 COFFEY, Q.C.:
20 Q. And there's a reference here to "Initial
21 testing, retesting of deceased, 174."? See
22 that?
23 MR. SINGLETON:
24 A. Yeah.
25 COFFEY, Q.C.:

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1 Q. I have that correct, do I?
2 MR. SINGLETON:
3 A. Yeah, yeah, you have what's written there
4 correct, yeah.
5 COFFEY, Q.C.:
6 Q. And what is this here out to the right-hand
7 side?
8 MR. SINGLETON:
9 A. In the bracket kind of thing?
10 COFFEY, Q.C.:
11 Q. Yes.
12 MR. SINGLETON:
13 A. Okay. These were kind of notes that I was
14 making for myself as, you know, we started to
15 get into the discussion of the issue of
16 contacting families and, you know, the duty to
17 inform or the right to know, the right to
18 access information, just a couple of notes
19 that I made for myself that from listening to
20 the discussion as we got into it, points that
21 I wanted to make sure that we captured and
22 that we had adequate discussion on were three,
23 up to that point, at least. One was the
24 concept of negative right, the second was a
25 question of who has access.

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1 COFFEY, Q.C.:
2 Q. Um-hm.
3 MR. SINGLETON:
4 A. And the third I put there is
5 "avoidable/unavoidable".
6 COFFEY, Q.C.:
7 Q. Yes. And I'll be coming to that in the
8 context of the report. I just want to try and
9 make sure that I got the -
10 MR. SINGLETON:
11 A. The words.
12 COFFEY, Q.C.:
13 Q. - interpretation of what's written here
14 correct.
15 MR. SINGLETON:
16 A. Yeah.
17 COFFEY, Q.C.:
18 Q. And then I take it there's reference to
19 "Medical and" -
20 MR. SINGLETON:
21 A. "Radiological".
22 COFFEY, Q.C.:
23 Q. "Radiological."
24 MR. SINGLETON:
25 A. Yeah.

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1 COFFEY, Q.C.:
2 Q. And -
3 MR. SINGLETON:
4 A. And that was, it's just comments that had been
5 made by the oncologists about, you know,
6 treatment and what have you.
7 COFFEY, Q.C.:
8 Q. And there's a reference "Post-menopausal, 47
9 percent reduction in death rate."
10 MR. SINGLETON:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. "Treatment plan."
14 MR. SINGLETON:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. That's there?
18 MR. SINGLETON:
19 A. Um-hm.
20 COFFEY, Q.C.:
21 Q. And then there's "Info, data based on
22 probability"?
23 MR. SINGLETON:
24 A. "Probability", yeah.
25 COFFEY, Q.C.:

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1 Q. And then out here to the right-hand side, "174
2 patient deceased, 101 tested, 17 tested
3 positive."?
4 MR. SINGLETON:
5 A. Right.
6 COFFEY, Q.C.:
7 Q. And then there's, below there's--what is that?
8 MR. SINGLETON:
9 A. "Recommendation", "rec:" but intended to be
10 "recommendation."
11 COFFEY, Q.C.:
12 Q. Okay, "recommendation." And "Negative right.
13 Who discloses?"
14 MR. SINGLETON:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. And what is this?
18 MR. SINGLETON:
19 A. "Pecking order of advance health care
20 directive."
21 COFFEY, Q.C.:
22 Q. Okay.
23 MR. SINGLETON:
24 A. Do you want an explanation of that now?
25 COFFEY, Q.C.:

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1 Q. If you would, please?
2 MR. SINGLETON:
3 A. Basically what we were coming to is that, you
4 know, who has a right to information and could
5 it be just anyone come forward and request
6 information from, on a deceased or from their
7 health record or would there be some sensible
8 and established process to use. And my
9 suggestion on it would be that we basically
10 follow the pecking order, to call it that, in
11 the Advanced Health Care Directive Act, that
12 begins with the spouse and children and, you
13 know.
14 COFFEY, Q.C.:
15 Q. Okay.
16 MR. SINGLETON:
17 A. Yeah, Section 10 of the Advanced Health Care
18 Directive.
19 COFFEY, Q.C.:
20 Q. In terms of determining who's, in effect, the
21 next of kin for those purposes?
22 MR. SINGLETON:
23 A. Yes, yeah, that's right.
24 COFFEY, Q.C.:
25 Q. Okay. And then there's below that "Written

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1 request" I take it?
2 MR. SINGLETON:
3 A. That's right, that the people wanted
4 information, that it would have be written and
5 that's basically to establish that they, in
6 fact, wanted the information and that they
7 would, you know, that we'd be following the
8 process or the pecking order, we might say.
9 COFFEY, Q.C.:
10 Q. Okay. If we could, please, the next page,
11 because you did have--you went onto the second
12 page. Could you tell us what this says?
13 There's an arrow and then it says -
14 MR. SINGLETON:
15 A. Okay. "No clinical advantage to testing".
16 COFFEY, Q.C.:
17 Q. Yes, sir.
18 MR. SINGLETON:
19 A. Yeah, okay.
20 COFFEY, Q.C.:
21 Q. Okay.
22 MR. SINGLETON:
23 A. Part of the discussion there was about the,
24 whether or not there would be a need to pursue
25 testing of all samples that were available if

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1 people were deceased or not. And so one of
2 the points was that, you know, there's no
3 clinical advantage to testing on people who
4 are dead, but there is a--there are other
5 issues and reasons to do it and so on. But
6 that was part of the consideration.
7 COFFEY, Q.C.:
8 Q. And the second entry, I take it, is
9 "Information is available."
10 MR. SINGLETON:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Which is the information concerning result, I
14 take it -
15 MR. SINGLETON:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. - whether the result was a changed result or
19 not, that was the information that was
20 available?
21 MR. SINGLETON:
22 A. Yes, yeah.
23 COFFEY, Q.C.:
24 Q. At that point did you understand there was any
25 other information available other than the

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1 actual result from Mount Sinai?
2 MR. SINGLETON:
3 A. No, no. And I need say, you know, like,
4 basically I think our discuss there is that it
5 was basically, or my kind of thinking on it
6 was that there's relevant information
7 available, regardless of what it is, you know.
8 COFFEY, Q.C.:
9 Q. And in this context, now, I want to ask you
10 about is, had you understood that there was a
11 kind of a review panel that had been involved
12 for the living's result, the results of the
13 living, results of the changes, that there had
14 been a group of physicians involved in getting
15 recommendations for treatment, did you realize
16 that that had gone on for the living patients?
17 MR. SINGLETON:
18 A. Like, I wouldn't have known it outside of that
19 discussion. And it was just so much, you
20 know, that evening -
21 COFFEY, Q.C.:
22 Q. And -
23 MR. SINGLETON:
24 A. - I'm not sure if the issue of panelling, if

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1 that's when I heard it or if I heard it later
2 than that, you know.
3 COFFEY, Q.C.:
4 Q. Okay. And so the idea, for example, having
5 such a panelling group review the results for
6 the deceased, that didn't come up, I take it,
7 at this meeting?
8 MR. SINGLETON:
9 A. No.
10 COFFEY, Q.C.:
11 Q. Okay. If we could, then, the next entry, the
12 third entry is "Negative right" -
13 MR. SINGLETON:
14 A. Yes. Actually, I suppose, it kind of did in a
15 way implicitly in that we had some discussions
16 about whether or not you would able to be--in
17 fact, I think I probably writed (sic.) there
18 something to the effect that, you know, that
19 there's a limit to the information of whether
20 or not something could make a difference,
21 whether or not something would have made a
22 difference.
23 COFFEY, Q.C.:
24 Q. Okay. Yeah, and that's -
25 MR. SINGLETON:

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1 A. Because -
2 COFFEY, Q.C.:
3 Q. That's the entry out here to the right, just
4 so the Commissioner can follow it. So this
5 says, "Limit to info re what difference it"--
6 could you just?
7 MR. SINGLETON:
8 A. Yeah. I think part of a word is cut off
9 there.
10 COFFEY, Q.C.:
11 Q. Yes. Do you have the original there?
12 MR. SINGLETON:
13 A. It would have--okay, yeah. "Limit to the
14 information re," maybe I can read it there
15 from the paper copy.
16 COFFEY, Q.C.:
17 Q. Sure.
18 MR. SINGLETON:
19 A. Myself. "Re what difference it" perhaps
20 "would", I not sure, part of the word is cut
21 off on the photocopy, "have made on"
22 something. I'm not sure what the last word
23 is.
24 COFFEY, Q.C.:
25 Q. Okay. And that, in that context then, the

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1 idea of whether or not the different result,
2 if known earlier, could have made the
3 difference to the outcome for the patient?
4 MR. SINGLETON:
5 A. Yeah, that's right. And, you know, that was
6 part of our discussion, as you know, could you
7 answer with certainty to anyone whether or not
8 somebody would still be alive if things had
9 been done differently.
10 COFFEY, Q.C.:
11 Q. And then the next entry here, what does that
12 say?
13 MR. SINGLETON:
14 A. "Negative right."
15 COFFEY, Q.C.:
16 Q. Oh, yes, the third entry. But no, right here.
17 MR. SINGLETON:
18 A. Okay. "Respect next of kin. Advanced Health
19 Care Directive, writing" basically kind of by
20 there I was kind of templating out what I
21 would be saying in the--you know, because, I
22 guess, I was jotting these things as we were
23 discussing and as then I was getting to the
24 point of bringing together the consensus of
25 what we would be, you know, what would be

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1 going into the report and most especially the
2 recommendations. And that's typically what we
3 do in an ethics consult is that towards the
4 end of it the facilitator will try to draw it
5 together so that, you know, we're clear on
6 what we would be recommending to whomever it
7 is who's made the request.
8 COFFEY, Q.C.:
9 Q. Here is, what's this entry here?
10 MR. SINGLETON:
11 A. The sentence you're underlining there?
12 COFFEY, Q.C.:
13 Q. Yes.
14 MR. SINGLETON:
15 A. "Appropriate person to disclose is case
16 contingent."
17 COFFEY, Q.C.:
18 Q. Okay. And what -
19 MR. SINGLETON:
20 A. And that meaning not to disclose to but who
21 should disclose. Part of the discussion
22 there, as well, though we didn't go into a
23 long ways, is, in fact, for families who
24 request information about a person who is
25 dead, then who should give the information.

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1 And the, you know, within the kind of spirit
2 of what we had established in the policy that
3 we had put in place about--that I'd done a
4 fair bit of work on, on the Advance Health
5 Care--or on the adverse events stuff, that we-
6 -it's important that the person who discloses
7 the information be able to answer questions
8 and so on, so that was part of what we were
9 talking about there. One of the issues that
10 came up in the discussion was whether or not
11 it should be the oncologists or others or a
12 nurse or what have you. And part of the
13 discussion there, I remember, as well, is that
14 there was some concern expressed by Dr.
15 McCarthy and I think she expressed it on
16 behalf of the oncology group that, you know,
17 they didn't see themselves as being the kind
18 of root of this problem and with the case
19 loads and so on that they didn't see
20 themselves as having that role. And I
21 remember distinctly in the discussion saying,
22 well, that's a matter that Dr. Williams will
23 sort out of who will follow up to make sure
24 that whoever is going to give information to
25 families when they request it is the

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1 appropriate ones to do so.
2 COFFEY, Q.C.:
3 Q. So you understood from Dr. McCarthy's comment
4 you've just referred to, and I take it you
5 understood she was speaking on behalf of the
6 oncologists?
7 MR. SINGLETON:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. As it were?
11 MR. SINGLETON:
12 A. Yes, yeah.
13 COFFEY, Q.C.:
14 Q. That, I'm sorry, we were not?
15 MR. SINGLETON:
16 A. You know, she had concern, I suppose, that
17 there be a presumption that the oncologists
18 would, you know, be handed this as another
19 piece of work to do. And part of the
20 discussion -
21 COFFEY, Q.C.:
22 Q. Did she have a reservation about that?
23 MR. SINGLETON:
24 A. Well, I think she had--because part of the
25 discussion that day and I think I would say a

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1 substantial piece of it is that we were
2 framing out, and I guess because of my own,
3 you know, work in the area of grief and grief
4 counselling, some of the considerations that
5 we brought into the discussion and that I
6 introduced into the discussion was that what
7 we're talking about here is people who have
8 most likely fairly recently lost a loved one,
9 they've lost a, you know, parent or a spouse
10 or a sibling or a close friend or whatever,
11 you know, it would be, and so it's not just a
12 matter of giving people information, this is
13 about disclosing very important information to
14 people who need to get it when they are ready
15 to receive it and in a way that facilitates,
16 you know, their processing of something that's
17 very crucial to them.
18 COFFEY, Q.C.:
19 Q. So you understood what Dr. McCarthy's view as
20 expressed was what?
21 MR. SINGLETON:
22 A. Well, Dr. McCarthy's comments in that related
23 to what we were talking about, that this is
24 not something you can do in five minutes, this
25 is something that's going to involve

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1 conversations and in some cases, you know,
2 several or many meetings and by the nature of
3 it. And I've mentioned a--I had words on my
4 scribbles, to call them that, or notes,
5 earlier on "avoidable/unavoidable" and that
6 really relates to that point, that from my
7 own, you know, perspective, I suppose, and, I
8 suppose the framework of grief counselling,
9 one of the things that we know is very
10 significant in how people deal with problems
11 or crisis or losses or whatever the trauma
12 might be in their life is whether or not they
13 perceive it as something that was avoidable or
14 unavoidable.
15 COFFEY, Q.C.:
16 Q. Um-hm.
17 MR. SINGLETON:
18 A. And, you know, I brought that point into the
19 discussion because from my own experience in
20 grief counselling it is very relevant to how
21 people will deal with matters. And knowing
22 that people who have recently had a loss, you
23 know, that this would be significant to them,
24 part of the discussion is that we need to
25 allow people to take this information when it

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1 will work for themselves and that they will
2 let it be known that the information is
3 available and they can come and request it
4 when it would work for them rather than kind
5 of doing it when it works for us, kind of
6 thing. So that was kind of part of the
7 discussion. But part of it, if I might
8 continue, is that we knew that this would
9 likely be, you know, significant for some
10 family, well, for all families, but
11 complicated to process for some and they'd
12 probably come back once, twice, three times
13 and more to get more information, so a simple
14 concern, or not a simple concern, but a
15 genuine concern from Dr. McCarthy is that
16 whoever is going to do it needs to be able to
17 do it right. And so, you know, she addressed
18 the issue or the concern from--and I
19 understood it to be not only her own, but from
20 the oncologists and that, you know, I remember
21 making the comment there that, you know,
22 that's a matter that Dr. Williams will have to
23 sort out, because I didn't want the ethics
24 consult to be, you know, about discussing and
25 any type of dispute about something that we

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1 had no control over.
2 COFFEY, Q.C.:
3 Q. Okay. Now, you had been involved--you
4 mentioned it a couple of times--involved in
5 drafting the disclosure policy involving
6 adverse events. At the time during this
7 ethics consult meeting, was there any
8 discussion of that policy?
9 MR. SINGLETON:
10 A. No, other than--I don't remember anything
11 explicit on it. I -
12 COFFEY, Q.C.:
13 Q. Was it referred to?
14 MR. SINGLETON:
15 A. I would have certainly been conscious of what
16 was kind of laid out as framework in the types
17 of cases that we mentioned before, individual
18 type cases and so on. But it wasn't taken out
19 and, kind of, referred to because I think, you
20 know, it was kind of a sense that it didn't
21 really fit that context.
22 COFFEY, Q.C.:
23 Q. Okay. Now, with respect to an ethics consult,
24 in this context, was any consideration given
25 to having a representative family members of

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1 the deceased involved in this?
2 MR. SINGLETON:
3 A. No, and that was--two comments on it. But the
4 first one is that the ethics consult was, kind
5 of, where it was in the chain of activities,
6 it was about deciding what would be done with
7 the information in terms of, you know, we have
8 started out with the issue that we have these
9 health records that haven't been signed off or
10 whatever way Dr. Cook wrote the concern. Dr.
11 Williams sent it on for an ethics consult. My
12 interpretation of it is that we need to look
13 at what would be the options and the ways of
14 approached it. So, it would, typically, if it
15 was in the kind of planning the approach to a
16 matter and see what would be the appropriate
17 options and so on, we wouldn't involve the
18 client or client representatives. But I think
19 the second consideration related to that is
20 that inviting the representative of one family
21 would be representative of one family and that
22 would, you know, work in when you're dealing
23 with one case. There's certainly no guarantee
24 that when you have, you know, something that
25 is fairly broad based, that inviting

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1 representative of one family or several even
2 is going to represent the way that any or all
3 would respond to the same type of situation.
4 But in the meantime, making that comment, the
5 reason why there wouldn't have been a family
6 at that time is because it was planning how
7 these health records, we might say, would be
8 handled or what type of disclosure would be
9 offered and so, other than -
10 COFFEY, Q.C.:
11 Q. Disclosure would be offered to the families?
12 MR. SINGLETON:
13 A. Pardon me?
14 COFFEY, Q.C.:
15 Q. Disclosure would, was being contemplated to be
16 offered to families, correct?
17 MR. SINGLETON:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. I'm correct on that.
21 MR. SINGLETON:
22 A. Well, that was, at least, what we recommended
23 from the ethics consult.
24 COFFEY, Q.C.:
25 Q. So, the group, disclosure in relation to which

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1 is being discussed here between all those
2 people you've listed, no thought was given or
3 voice within your hearing anyway to having one
4 or more people from that group or potentially
5 from that group consulted about this.
6 MR. SINGLETON:
7 A. No, that's right.
8 COFFEY, Q.C.:
9 Q. Okay.
10 MR. SINGLETON:
11 A. Yes, yes, yes.
12 COFFEY, Q.C.:
13 Q. So, it didn't come up and no one raised it?
14 MR. SINGLETON:
15 A. No, and that was because of--there was a
16 reason why it wouldn't have come up. I mean,
17 somebody may have brought it up in the
18 discussion, if they had wanted to, no one did.
19 MR. SINGLETON:
20 A. Okay, did anyone -
21 MR. SINGLETON:
22 A. But because, if I may continue -
23 COFFEY, Q.C.:
24 Q. Sure.

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1 MR. SINGLETON:
2 A. - because of the point at which the consult
3 was made was prior to making contacts with the
4 families and it seemed to me that what we were
5 discussing is what would be within reasonable
6 range of ways to approach this or what would
7 be the recommendation and so on?
8 COFFEY, Q.C.:
9 Q. Now -
10 THE COMMISSIONER:
11 Q. Hang on, hold onto that, just once again, a
12 point of clarification, and in your consult,
13 did you understand that the full range was on
14 the table, as it were, that is from not giving
15 any information through to making contact with
16 whatever you knew about the relatives of
17 anybody who is now deceased, without any of
18 these intermediate steps. Was the full range
19 of possibilities -
20 MR. SINGLETON:
21 A. Yes.
22 THE COMMISSIONER:
23 Q. - on the table?
24 MR. SINGLETON:
25 A. Yes, that's right, we didn't go in there with

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1 any, you know, with anything -
2 THE COMMISSIONER:
3 Q. So, included in the possibilities might be
4 that you might recommend that no action be
5 taken at all?
6 MR. SINGLETON:
7 A. That's right, it might have been, you know--
8 yeah.
9 THE COMMISSIONER:
10 Q. Thank you.
11 COFFEY, Q.C.:
12 Q. Okay. And was any thought given by you or
13 anybody voiced within your hearing any thought
14 to asking perhaps, consulting with, for
15 example, Mr. Dawe who is a spokesperson for
16 the Canadian Cancer Society, Newfoundland
17 branch?
18 MR. SINGLETON:
19 A. No, again, for the same reason, we were
20 looking at what we might need to do that.
21 COFFEY, Q.C.:
22 Q. Okay. So, it's entirely possible then, based
23 upon that scenario, that a decision could be
24 made that nothing should be done and the
25 people potentially affected or most affected

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1 by it would never be consulted.
2 MR. SINGLETON:
3 A. Yeah, well, that's right, I mean, hopefully
4 that wouldn't happen from an ethics consult,
5 but yeah.
6 COFFEY, Q.C.:
7 Q. And now sir, what did Mr. Boone, if anything,
8 say or contribute to the meeting, do you
9 recall?
10 MR. SINGLETON:
11 A. Well, we had some discussion on the front end
12 of it about the legal, not right in the
13 beginning, but what are the legal requirements
14 in a situation like this, what is the
15 obligation to inform or what is the right to,
16 of access to the health record of deceased
17 people and those kinds of things. And his -
18 COFFEY, Q.C.:
19 Q. Just before we get to that now, I should ask,
20 was he actually providing you with legal
21 advice?
22 MR. SINGLETON:
23 A. Well, he was the lawyer who was there to--
24 yeah, well, he was the lawyer who was there
25 and one of the issues we were looking at, what

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1 is--and I'm not sure if I asked it that way,
2 but one way or another, I would have been
3 inquiring from him, you know, what are we
4 legally obligated, obliged to do or what are
5 we legally obliged not to do. I probably
6 didn't say it in those specific words, but
7 that essentially would be the what we would be
8 -
9 COFFEY, Q.C.:
10 Q. Okay, before answering the question then, is
11 there -
12 THE COMMISSIONER:
13 Q. Yes, we should resolve this is.
14 COFFEY, Q.C.:
15 Q. Yes, I was going to say if Mr. -
16 THE COMMISSIONER:
17 Q. Is your client taking the position that any
18 advice given in this context is covered by
19 solicitor/client privileged or are you taking
20 the position that Mr. Boone was there as a
21 citizen who happens to be a lawyer?
22 MR. SIMMONS:
23 Q. It's not a controversial point and I won't
24 have any concern with the description of, as
25 Mr. Singleton is giving some description of

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1 what the view that was given there, as long as
2 it's understood that it's not in any way any
3 kind of waiver of privilege -
4 THE COMMISSIONER:
5 Q. Any kind of general privilege.
6 MR. SIMMONS:
7 Q. - otherwise in other circumstances.
8 COFFEY, Q.C.:
9 Q. Thank you.
10 THE COMMISSIONER:
11 Q. Thank you, Mr. Simmons.
12 COFFEY, Q.C.:
13 Q. Go ahead, sir.
14 MR. SINGLETON:
15 A. Oh yes, that's right, that's why I think twice
16 about having lawyers at ethic consults, some
17 time you need them. They contribute.
18 COFFEY, Q.C.:
19 Q. Go ahead, sir, what do you remember about -
20 MR. SINGLETON:
21 A. Well, the issue was and I guess my
22 recollection is what I was listening for, you
23 know, and how that comes across two years
24 after and so on, other than writing or in word
25 (phonetic) is a bit different, but what I was

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1 listening for is, you know, what is the range
2 of what we, by law, are obliged to do and
3 what, by law, are we obliged not to do.
4 COFFEY, Q.C.:
5 Q. Um-hm.
6 MR. SINGLETON:
7 A. And my understanding from Dan's comments on it
8 was, Dan Boone's comments on it, was in the
9 range of that one is about access to the
10 health record, whether or not someone, you
11 know, first of all, is there an obligation to
12 bring forward this information to people and,
13 you might say, impose it on them.
14 COFFEY, Q.C.:
15 Q. Um-hm.
16 MR. SINGLETON:
17 A. And the other is, is there an obligation to
18 hold it back because people are not, in fact,
19 entitled to another person's health record.
20 And within the range of his comment, my
21 understanding was and I'm not sure if I
22 represented it well in what I wrote or not,
23 but that there--and I forget exactly how it--
24 but it was something to the effect of that
25 there is no legal obligation--can't remember

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1 exactly how I -
2 COFFEY, Q.C.:
3 Q. And that's reflected in the report and I'll
4 take you through that.
5 MR. SINGLETON:
6 A. Okay.
7 COFFEY, Q.C.:
8 Q. Okay. So, what he said, you thought or hoped
9 at the time you were reflecting it in the
10 actual report.
11 MR. SINGLETON:
12 A. Yeah, yes.
13 COFFEY, Q.C.:
14 Q. Okay. If we could please, I'm on it now, if
15 we could just look at the following exhibits,
16 please, Exhibit P-0481, thank you, page two.
17 This is a document entitled Pastoral Care and
18 Ethics department, Eastern Health, it's May
19 29, 2007 there and there's a six written over
20 it. And it's to Dr. Robert Williams from Rick
21 Singleton re: ethics consult, ER/PR. And this
22 is two pages long.
23 MR. SINGLETON:
24 A. Yeah. Actually I should mention the dates on
25 it that when I printed that for whoever asked

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1 me to print it, there's a default date that
2 imposes in the memo. The actual date of that
3 was early, it was around the 20th or 21st.
4 COFFEY, Q.C.:
5 Q. And there are two other ones, I'll take you to
6 those in a moment. And I thought perhaps
7 that--not being very familiar with computers,
8 but I thought that perhaps, -
9 MR. SINGLETON:
10 A. That that might have been -
11 COFFEY, Q.C.:
12 Q. - potential explanation, at the time then I
13 take it you printed this -
14 MR. SINGLETON:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. - for whoever asked you, you just simply
18 signified six.
19 MR. SINGLETON:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. And so the report in question was done in June
23 of 2006?
24 MR. SINGLETON:
25 A. That's right, yes.

1 COFFEY, Q.C.:
2 Q. Okay. So, if we could then go please to
3 exhibit P-0073. Do you recall who it was that
4 asked you to print that out in May of '07?
5 MR. SINGLETON:
6 A. Gee, I'm not sure who asked--it might have
7 been--I'm not sure if it was Pam Elliott or it
8 might have been --I'm not sure.
9 COFFEY, Q.C.:
10 Q. Okay. So, why did you change then the seven
11 to the six? I take it, just simply -
12 MR. SINGLETON:
13 A. I don't think I did that, that doesn't look
14 like my -
15 COFFEY, Q.C.:
16 Q. That handwritten--oh, that's not yours?
17 MR. SINGLETON:
18 A. No, no, I probably just actually I mightn't
19 have printed it; my secretary might have taken
20 it out of the file.
21 COFFEY, Q.C.:
22 Q. So, if we could, just looking at this, this
23 is--I apologize--P-0783, I apologize,
24 Registrar. It's an e-mail of June 22, 2006,
25 3:04 p.m. from yourself to Dr. Williams and

1 Louise Jones, subject is ethics consult, "Hi
2 Bob, attached is the report from the ethics
3 consult re: ER/PR. Thanks. Rick". And then
4 attached to that is a Pastoral Care and Ethics
5 Department Eastern Health heading, it's dated
6 June 23, 2006, to Dr. Robert Williams from
7 yourself, re: ethic consult ER/PR.
8 MR. SINGLETON:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. And this one has got a Dr. Natalie Bandau,
12 it's typed -
13 MR. SINGLETON:
14 A. Bandrauk, yeah, it was a typo in her name, in
15 the previous ones, yeah.
16 COFFEY, Q.C.:
17 Q. And if I could have you bring up, please
18 Registrar, Exhibit P-0782. Now, this is on
19 pastoral care and ethics and this is the
20 actual letterhead itself because it's got the
21 General Hospital address and phone numbers and
22 so on there. It's dated June 20, 2006, it's
23 to the same, Dr. Williams, from yourself, re:
24 ethics consult, ER/PR, June 19, 2006. And
25 here Natalie Bandrauk, whose name is spelled

1 out, typed out correctly.
2 MR. SINGLETON:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Can you tell the Commissioner which of these
6 was prepared first?
7 MR. SINGLETON:
8 A. Most likely the one with the typos and so on
9 corrected was the second one.
10 COFFEY, Q.C.:
11 Q. Because what I'm looking at, the one with the
12 typo and it's handwritten, okay, the name is
13 handwritten.
14 MR. SINGLETON:
15 A. Okay, yes.
16 COFFEY, Q.C.:
17 Q. Is dated June 23, 2006 which is a day after,
18 sorry, is three days after P-0782 which has
19 got, if i could bring up P-0782 please, that's
20 got Dr. Natalie Bandrauk's name there, spelled
21 properly.
22 MR. SINGLETON:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And it's dated three days before.

1 MR. SINGLETON:
2 A. Yes. I'm not sure about that. I know the
3 sequence of how I do those things is that I do
4 and I would make, usually on the evening of
5 the 19th, I probably roughed up a few notes so
6 that I wouldn't forget things and then went
7 back and revised them and so on. Sometimes,
8 as I mentioned earlier, on the memos when you
9 open them or letterheads they re-date,
10 sometimes I knock out that default and then
11 type in a date below that for the actual thing
12 and so on. And I'm not sure if you compare
13 the two memos, if in fact, the date lines
14 would be on the same line or not. I'm not
15 sure there. Sometimes I think of catching the
16 fact that there was a wrong date above on
17 something that I was making an editorial on,
18 you know.
19 COFFEY, Q.C.:
20 Q. Sir, when you prepared your report, was this
21 circulated in draft form to anybody?
22 MR. SINGLETON:
23 A. I would, in that case, we did a review that
24 evening, you know of what it would have said.
25 I would at least have sent it to the ethicist

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1 who is the intensivist, to Natalie and ask her
2 to have a look at it and if there was anything
3 that she felt that needed to be revised, to
4 send it back to me before I finalized it. So,
5 that would probably have been, you know, asked
6 her to let me know by the next day or that
7 evening or whatever. I'd usually give a
8 fairly short turnaround for someone to have a
9 look at it.
10 COFFEY, Q.C.:
11 Q. How about anybody else?
12 MR. SINGLETON:
13 A. I'm not sure if I distribute it--sometimes,
14 you know, I would send something to somebody
15 who, if I felt there was a need to kind of get
16 all the--if there was a lot of data included
17 in the summary, I might sent it to somebody
18 who would actually have that, that would
19 correct it, but in that case, I don't really
20 remember now if I sent it to anyone or not. I
21 don't think I did because if I had received
22 feedback from people, it would have been
23 noticeable in the revisions of drafts and I'd
24 probably have kept the comments back.
25 COFFEY, Q.C.:

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1 Q. And you don't have any, I take it?
2 MR. SINGLETON:
3 A. No.
4 COFFEY, Q.C.:
5 Q. That you could find. So, Dr. Bandrauk, would
6 you have distributed it to her, a draft?
7 MR. SINGLETON:
8 A. Oh yes, yes.
9 COFFEY, Q.C.:
10 Q. Her, you said, is the one I would send it,
11 because she's the ethicist.
12 MR. SINGLETON:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. I note that--so which, from your perspective
16 of these documents, would you perceive or did
17 you distribute as the final version?
18 MR. SINGLETON:
19 A. Gee, I don't know. Because of the, you know,
20 the way that those dates imbed in the
21 document, I'm not sure, but if you've got a
22 copy of it from Dr. Williams, then you'd know,
23 you know, from his -
24 COFFEY, Q.C.:
25 Q. Well, that's -

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1 MR. SINGLETON:
2 A. Did you have that?
3 COFFEY, Q.C.:
4 Q. Well, if we could bring up P-0783, please.
5 Now this -
6 MR. SINGLETON:
7 A. Okay.
8 COFFEY, Q.C.:
9 Q. - in our world, documents collected by the VP
10 medical signifies -
11 MR. SINGLETON:
12 A. Yes, okay.
13 COFFEY, Q.C.:
14 Q. - that office.
15 MR. SINGLETON:
16 A. That would have been the one I distributed.
17 COFFEY, Q.C.:
18 Q. Okay, but this particular one is apparently
19 appended, apparently I say, appended to this
20 June 22 e-mail and this is the one though
21 that's got the misspelling of Dr. Bandrauk's
22 name.
23 MR. SINGLETON:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Do you know whose handwriting that is?
2 MR. SINGLETON:
3 A. No.
4 COFFEY, Q.C.:
5 Q. It's not yours, I take it?
6 MR. SINGLETON:
7 A. No.
8 COFFEY, Q.C.:
9 Q. Okay. And I'll just take you down through
10 this. In terms of that, why would you sign it
11 as the facilitator?
12 MR. SINGLETON:
13 A. Because I facilitated the ethics consultation.
14 COFFEY, Q.C.:
15 Q. Okay. And it's possible that the only person
16 though who attended the meeting, who actually
17 saw a copy of it before it went out, other
18 than yourself, is Dr. Bandrauk?
19 MR. SINGLETON:
20 A. Yes. She would have been the person I would
21 have sent it to, yes.
22 COFFEY, Q.C.:
23 Q. And so Mr. Boone, Ms. Predham, Dr. McCarthy,
24 Dr. Cook, Dr. Denic, it's quite possible they
25 didn't see this first or last?

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1 MR. SINGLETON:
2 A. That's right, possible and, you know but--if I
3 sent it to them, I didn't have any feedback
4 from them.
5 COFFEY, Q.C.:
6 Q. Okay. Now, we look here at the issue, you
7 frame it as "in the summer of 2005, the
8 director of laboratory medicine for Eastern
9 Health became aware there may be some problems
10 with testing the samples from breast cancer
11 patients that were processed to determine
12 appropriate follow-up with patients. The
13 specific test is for the presence of hormone
14 receptors in the tumor which may impact follow
15 up treatment, ER/PR". You continue, "the
16 problem with the results was rooted in the
17 test procedures used in the time period from
18 1997 to 2005. In 2005, samples known to have
19 been processed for this batch of patients were
20 forwarded to Mount Sinai in Toronto to
21 retesting at their lab. In the batch
22 forwarded to Mount Sinai, there were 101
23 samples from deceased patients, 19 of the
24 retested samples produced results that may
25 have resulted in a different care plan and

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1 treatment follow-up from that implemented
2 based on the original test results". Now,
3 that is, as well, in your notes actually, your
4 actual hand written notes.
5 If we could look back, please, at Exhibit
6 P-1718, page three. Thank you, Registrar.
7 And we scroll down the page here, 174 patients
8 deceased, 101 tested and I think it says here,
9 17 tested positive.
10 MR. SINGLETON:
11 A. Right.
12 COFFEY, Q.C.:
13 Q. Is that -
14 MR. SINGLETON:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. Now, here though if we could back then to P-
18 0783, page two. Here you've phrased it as
19 there were "101 samples from deceased
20 patients, 19 of the retested samples produced
21 results that may have resulted in a different
22 care plan and treatment follow-up than that
23 implemented based on the original test
24 results". So, who told you or the group at
25 the June 19 meeting that? Who identified 19

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1 and said of those, 19 of the retested samples
2 produced results that may have resulted in a
3 different care plan and treatment follow-up?
4 MR. SINGLETON:
5 A. I don't remember that.
6 COFFEY, Q.C.:
7 Q. You don't recall who?
8 MR. SINGLETON:
9 A. I don't remember who said that.
10 COFFEY, Q.C.:
11 Q. Well, thinking about those who were at the
12 meeting, who--it certainly wasn't yourself or
13 Dr. Bandrauk. Do you remember amongst the
14 others who were there?
15 MR. SINGLETON:
16 A. No, I don't, no.
17 COFFEY, Q.C.:
18 Q. Okay. Now, it goes on to say--what did you
19 understand that it meant at the time?
20 MR. SINGLETON:
21 A. That there were people who had tests whose
22 samples were retested and produced results
23 that may have resulted in a different care
24 plan and treatment follow up, as it says
25 there, then that implemented, so that if the

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1 results had been different, then they would
2 have been treated differently or treated
3 different.
4 COFFEY, Q.C.:
5 Q. Here it goes on, you say, "Important facts to
6 the history and understanding," that should be
7 "understanding of this case include the
8 following: There were no mistakes or
9 technical errors at the root of this problem."
10 MR. SINGLETON:
11 A. Um.
12 COFFEY, Q.C.:
13 Q. And I canvassed that with you earlier. I take
14 it that that was a conclusion you reached?
15 MR. SINGLETON:
16 A. Yes, that's right, that was my, you know,
17 listening for, as I explained earlier, that's
18 right, yeah.
19 COFFEY, Q.C.:
20 Q. Now, you go on to say here, "It is impossible
21 to know in any specific case if the outcome
22 for any individual patient would have been
23 different." Now, where did that come from,
24 that information?
25 MR. SINGLETON:

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1 A. Well, that was the discussion in the session.
2 And I remember Dr. McCarthy having some
3 comments of that sort, I'm not sure if that's
4 exactly what she said, but she probably would
5 be the one well informed about, you know, how
6 specific you can be to say whether or not if
7 the tests were different, that it would be
8 different for an individual patient.
9 COFFEY, Q.C.:
10 Q. Did anyone, do you recall, ask at that meeting
11 whether or not any actual analysis had been
12 done of specific cases to determine if the
13 outcome for an individual patient would have
14 been different or could have been different,
15 was there any actual analysis, anybody
16 actually asked, well, has anybody done this?
17 MR. SINGLETON:
18 A. No, no, no.
19 COFFEY, Q.C.:
20 Q. Okay.
21 MR. SINGLETON:
22 A. One of the things that was part of the
23 discussion was, and I think I mentioned it
24 probably in my--okay, it's there, as well.
25 The third point says -

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1 COFFEY, Q.C.:
2 Q. It says here, "Intervention for post-
3 menopausal women have positive impact by
4 lengthening life in 47 percent of patients
5 treated."
6 MR. SINGLETON:
7 A. Right. And we did have a discussion on, you
8 know, what -
9 COFFEY, Q.C.:
10 Q. What did that mean?
11 MR. SINGLETON:
12 A. How, you know, is it a matter of days, weeks,
13 months or years, right. And again, you know,
14 it wouldn't be definitive to any particular
15 case how--what the impact would be, what the
16 benefit would be for an individual.
17 COFFEY, Q.C.:
18 Q. I take it where you've written this, you
19 understood from what you heard from the
20 physicians at the meeting that intervention,
21 which I take it would be actual treatment with
22 Tamoxifen or the equivalent?
23 MR. SINGLETON:
24 A. Yeah.
25 COFFEY, Q.C.:

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1 Q. For post-menopausal women has a positive
2 impact by lengthening life of 47 percent of
3 the patient who get so treated?
4 MR. SINGLETON:
5 A. Yeah.
6 COFFEY, Q.C.:
7 Q. That's what that -
8 MR. SINGLETON:
9 A. Yeah, that's right, yeah.
10 COFFEY, Q.C.:
11 Q. And you go on to say, you framed it, "The main
12 ethical issue in this case pertains to
13 disclosure. There are several considerations
14 regarding the duty to disclose, the right of
15 families to be informed of results from the
16 retesting at Mount Sinai and who would
17 manage"--I'm sorry, "who should manage the
18 disclosure processes." And just before I go
19 on to the last paragraph, sir, would--if you
20 had understood at the time that there were
21 mistakes or technical errors at the root of
22 the problem, if you had understood that at the
23 time, somebody had said that to you, somebody
24 who would be in a position to know, had said
25 that to you, would that have made any

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1 difference here to the analysis? If somebody
2 had walked in and told you, look, you know,
3 Mr. Singleton, or Rick, whatever they called
4 you -
5 MR. SINGLETON:
6 A. Yeah.
7 COFFEY, Q.C.:
8 Q. Look, you know, it's our view or we have
9 reason to believe there were mistakes and/or
10 technical errors here.
11 MR. SINGLETON:
12 A. Yeah, yeah.
13 COFFEY, Q.C.:
14 Q. Would that have made--what, if any, difference
15 would that have made?
16 MR. SINGLETON:
17 A. I think, like, by the time I was writing this,
18 like, we had had the discussion that came to
19 the point of, you know, making recommendation
20 that we ought to make it known to families
21 that this information is available and they
22 can pursue it on their own. And so -
23 COFFEY, Q.C.:
24 Q. No, I'm asking you to think back to before you
25 made that decision.

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1 MR. SINGLETON:
2 A. Yeah. I can't do that.
3 COFFEY, Q.C.:
4 Q. Like, in the course of determining it, do you
5 at the time why is that relevant, why was that
6 relevant? Because you said "Important facts
7 to the history" are the following -
8 MR. SINGLETON:
9 A. Yeah, part of it, I guess, was, you know, that
10 a way of looking at it or part of the
11 framework that I was thinking of it in was the
12 context that we had about individual cases
13 where it's clear that there's, you know, a
14 specific identifiable cause or person or
15 whatever the case might be and from my
16 understanding of it then that this was not
17 that straightforward.
18 COFFEY, Q.C.:
19 Q. If there -
20 MR. SINGLETON:
21 A. That was relevant. To speculate on what we
22 would have discussed, I mean, I can't do that.
23 COFFEY, Q.C.:
24 Q. Perhaps you could tell the Commissioner,
25 though, what is the approach if the patient is

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1 dead, a single patient is dead, there's an
2 ethics consult and during that you are told at
3 the meeting that there were mistakes made
4 related, that arguably related to the person's
5 death, that caused the person's death or
6 contributed to it?
7 MR. SINGLETON:
8 A. Yes. Well -
9 COFFEY, Q.C.:
10 Q. What effect does that have in that sort of
11 situation?
12 MR. SINGLETON:
13 A. Are you asking me -
14 COFFEY, Q.C.:
15 Q. Yes, I'm asking you.
16 MR. SINGLETON:
17 A. To describe what is the process if -
18 COFFEY, Q.C.:
19 Q. Yes.
20 MR. SINGLETON:
21 A. - the death is clearly the result of -
22 COFFEY, Q.C.:
23 Q. Clearly or arguably.
24 MR. SINGLETON:
25 A. Yeah. Of a--well, clear immediate disclosure

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1 of the facts by somebody who is competent and
2 responsible to answer the questions and those
3 things. I mean, there's a protocol list set
4 out in the guidelines on disclosure of adverse
5 events, you know, within our organization.
6 COFFEY, Q.C.:
7 Q. So if there is seen to be or understood to be
8 a nexus between what could be described as a
9 mistake or a technical error, okay, on the one
10 hand.
11 MR. SINGLETON:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. And the person's death on the other, then it's
15 your understanding of the adverse health
16 events policy of the organization you work for
17 that the organization is required then to tell
18 the relatives?
19 MR. SINGLETON:
20 A. Yes, and -
21 COFFEY, Q.C.:
22 Q. That that's so?
23 MR. SINGLETON:
24 A. - further to that -
25 COFFEY, Q.C.:

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1 Q. Is that -
2 MR. SINGLETON:
3 A. - my understanding is -
4 COFFEY, Q.C.:
5 Q. Is my understanding -
6 MR. SINGLETON:
7 A. I'm sorry.
8 COFFEY, Q.C.:
9 Q. Is my understanding of that correct, this is -
10 MR. SINGLETON:
11 A. Yes. And in fact, my understanding of it in
12 that discussion was that what you're
13 describing there is what was being done for
14 patients who had been identified. But for
15 patients where, patients who were living where
16 giving them this information was--would be
17 relevant to the, you know, to their treatment
18 and what have you or that it would be material
19 to any decisions they would have to make. And
20 it's a part of the discussion that we were
21 having in the ethics consult that evening.
22 COFFEY, Q.C.:
23 Q. So to come back then, if at the time you had
24 been told in the group that there--we have
25 reason to believe there were mistakes made

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1 here or there were--or technical errors were
2 made here and they may have contributed to, in
3 some cases, patients' deaths earlier than
4 otherwise or contributed to in deaths here,
5 would that have made, bearing in mind the
6 policy, any difference to the approach taken
7 here in the report, in the final report?
8 MR. SINGLETON:
9 A. I'm not sure how it would have been part of
10 it. I think it would be a substantial part of
11 the discussion. I'm not sure if the
12 recommendations would be very different, but
13 it would be relevant, for sure, yeah, yeah.
14 COFFEY, Q.C.:
15 Q. And certainly, in the case of a single patient
16 and a single patient's death, the policy would
17 be that -
18 MR. SINGLETON:
19 A. A clearly isolated case, yeah.
20 COFFEY, Q.C.:
21 Q. - yes, then you have to go and tell the
22 family?
23 MR. SINGLETON:
24 A. Yeah, yeah.
25 COFFEY, Q.C.:

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1 Q. And if we could then, just continue on. It
2 says here "the obligation to disclose the
3 information to families is based, from an
4 ethics perspective, on the negative right of
5 families to the information about the
6 deceased. A negative right respects the right
7 of individuals or families to access
8 information, but it does not oblige anyone to
9 make direct contact with individuals or
10 families to provide the information. The
11 obligation to inform is different in this
12 situation than in situations where a mistake
13 has been made, where the information would
14 make a difference or potential difference in
15 the care plan or interventions of a patient."
16 So here then, and I take it for the
17 living, this would be the care plan, the last
18 phrase refers to them.
19 MR. SINGLETON:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. "Information would make a difference or
23 potential difference in the care plan or
24 interventions of a patient."
25 MR. SINGLETON:

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1 A. Yeah.
2 COFFEY, Q.C.:
3 Q. But you also say here, "the obligation to
4 inform is different in this situation than if
5 situation"--it should be "than in situations
6 where a mistake has been made." So where -
7 MR. SINGLETON:
8 A. Thinking back to that conversation that I had
9 described earlier, you know.
10 COFFEY, Q.C.:
11 Q. Okay, and then, if we could, please, you go on
12 to say, and I take it this is where Mr.
13 Boone's advice probably surfaces, "while
14 legally, no one has the right to a deceased
15 person's health record or other health
16 information in the context of the core values
17 of Eastern Health, and in the spirit of
18 goodwill, it is appropriate that Eastern
19 Health take reasonable steps to inform the
20 community that this problem has occurred, and
21 that information is available. This can be
22 done through local media and is part of the
23 follow up from previous media coverage of the
24 issue."
25 Here, sir, I take it Mr. Boone would have

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1 had input into that first subclause, "while
2 legally no one has the right"?
3 MR. SINGLETON:
4 A. Yes, and that's my reflection of what he might
5 have said.
6 COFFEY, Q.C.:
7 Q. Okay, but the rest of it then, there was, I
8 gather, a consensus in the spirit of goodwill,
9 that we'd make this--we, Eastern Health, would
10 make this known publicly?
11 MR. SINGLETON:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. That this information would be available.
15 MR. SINGLETON:
16 A. Yeah.
17 COFFEY, Q.C.:
18 Q. And there's a reference to "access to the
19 information, a health record must be requested
20 in writing, and of course, must come from an
21 individual or individuals in line of priority"
22 and then you go on about the--I take it, in
23 accordance with the health care directives.
24 MR. SINGLETON:
25 A. Um.

1 COFFEY, Q.C.:
2 Q. And substitute decision makers. "The request
3 will be handled according to the policies and
4 practices pertaining to health records," and
5 then you conclude by saying "contact with
6 families ought to be managed mainly by the
7 risk manager with the assistance of competent
8 staff from the Corporate Communications
9 department. The ethics consultation had
10 several recommendations in this regard. 1. A
11 press release prepared as this matter is being
12 resolved ought to mention that information
13 pertaining to deceased patients may be
14 available by contacting the appropriately
15 designated officer number."
16 Okay, so it was the considered view of
17 the group that such a press release should go
18 or should be available?
19 MR. SINGLETON:
20 A. Yeah.
21 COFFEY, Q.C.:
22 Q. "Efforts too should be--2. Efforts should be
23 made to ensure information about the retested
24 samples be presented by an individual
25 competent to explain the matters to the family

1 member." I take it that's the reference to
2 the risk management?
3 MR. SINGLETON:
4 A. Yes, or whether or not risk management, but
5 you know, handle logistics of it and be a
6 physician, you know, that matter we talked
7 about a few moments ago, yeah.
8 COFFEY, Q.C.:
9 Q. And "3. If families of deceased patients whose
10 samples have not been retested request the
11 same information, then it should be explained
12 that the sample has not yet been retested and
13 it will be retested if that is the preference
14 of the family, and that the retesting would be
15 done at the site doing this testing procedure
16 for Eastern Health when the request is made."
17 And you thanked all who participated in the
18 consultation for their time and attention.
19 Was there ever any feedback on this at all to
20 you?
21 MR. SINGLETON:
22 A. No, not--no, just had some conversations about
23 it with who? With Louise Jones after--because
24 I sent her and Bob Williams a copy of it, and
25 one of the items that I--one of the

1 recommendations on it was that Corporate
2 Communications, you know, the preparation of a
3 press release and so on, and Louise suggested
4 to me that I be sure to send a copy to
5 Corporate Communications, to Susan Bonnell, to
6 make sure that she saw that recommendation,
7 and I remember specifically preparing that e-
8 mail and sending it to her saying that we had
9 an ethics consult on this matter and there was
10 a recommendation there about a press release
11 and so on, so forwarded that to her.
12 COFFEY, Q.C.:
13 Q. To the people who should be so advised,
14 because they'd eventually end up involved
15 potentially in it?
16 MR. SINGLETON:
17 A. Yeah, yeah.
18 COFFEY, Q.C.:
19 Q. Just on this point, if we could look back at,
20 please, 1718? Now, I apologize, page--I'll
21 just go back here to page one. There you go.
22 Thank you. It's--the actual report of the
23 group, I take it, you sent to Dr. Williams and
24 you understood Dr. Williams would distribute
25 it to Dr. Cook?

1 MR. SINGLETON:
2 A. Yeah, I'm not sure--well, I think by the
3 nature of the--I likely sent it to all the
4 people who participated.
5 COFFEY, Q.C.:
6 Q. Okay. Just on this point, because Dr. Cook
7 had originally asked "these patients have not
8 been signed out for release from the system.
9 I would appreciate direction in how to proceed
10 further with these cases." Does the report
11 address that at all?
12 MR. SINGLETON:
13 A. Well, it addressed what--he was there in the
14 discussion, so he participated in it, and it
15 seemed to address the issues and that would be
16 one of the things we do in the wrap up is go
17 around the room a last time to see if there's
18 any outstanding issues or concerns or so on,
19 because it is generally a consensus process.
20 So we'd want to be sure that if someone had
21 issues or reservations that they brought it
22 forward, and my understanding is, and I think
23 the discussion itself verified that that was
24 really the heart of the matter. They had
25 these records and that was the issue, that

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1 there was information they weren't sure if it
2 should be filed or forwarded to someone or how
3 it had to be handled.
4 COFFEY, Q.C.:
5 Q. Again, on this point, you understood what Dr.
6 Cook was saying when he said "direction in how
7 to proceed further with these cases," which is
8 sign out for release.
9 MR. SINGLETON:
10 A. I understood it that they had the results back
11 from some cases where for some it was follow
12 up with the patients, for some the patients
13 were dead and so what do we do with them now.
14 We have--do we send the information to the
15 family doctor? Do we send it to the family?
16 Do we send it in health records as signed off
17 and case closed, or whatever.
18 COFFEY, Q.C.:
19 Q. Okay, do we send it like internally, in
20 effect, not to the family, it just stays
21 internally, or do we consult--that's what you
22 understood he meant by that?
23 MR. SINGLETON:
24 A. Yeah, yeah, that's right, yeah.
25 COFFEY, Q.C.:

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1 Q. Okay. If I could, please, exhibit P-0704?
2 Now, sir, this is a series of e-mails of July
3 5th and 6th, 2007. The one at the bottom of
4 the page if 9:07 a.m. on July 5th from
5 yourself to Louise Jones and you say, "Hi
6 Louise, last Friday the steering committee on
7 confidentiality, Marion Crowley, happened to
8 mention that the privacy commissioner
9 recommended release of health records, names
10 blocked out of patients involved in ER/PR.
11 She then went on to mention that she consulted
12 Rick Newman of HIC re: the ethics of such a
13 release. He advised he saw no problem with it
14 and made the analogy to anonymous chart
15 reviews, et cetera, as part of research. A
16 few concerns came to my mind, why would she
17 consult on the ethics outside her own
18 structure? Why would she consult with someone
19 who was not an ethicist and the comparison of
20 CBC chart access and researchers is somewhat
21 deficient." Signed by yourself. And then
22 later that day, that morning, Ms. Jones
23 responds to you and says, "Thanks for this. I
24 will pass this along to Pam, cc Pat Pilgrim."
25 And she says, "Pam, I would agree with Rick's

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1 point" and she goes on from there. And then
2 finally at the top of the page, Ms. Crowley on
3 July 6th, 2007, sends an e-mail to a number of
4 individuals, including yourself and explains
5 the context in which this occurred, that is
6 her discussion with Mr. Newman. So why, I
7 raise this with you is this, why were you
8 concerned at all about this at the time on
9 July 5th, 2007?
10 MR. SINGLETON:
11 A. Well mainly because we have an ethics service
12 within the organization and typically that's
13 where we would expect our--the ethics consult
14 to go--or to come.
15 COFFEY, Q.C.:
16 Q. And well then sir, and then overall from your
17 perspective then, here, what if any difference
18 did the fact that there was more than one
19 deceased patient involved make in the approach
20 ethically, if any?
21 MR. SINGLETON:
22 A. I'm not sure if the fact that there were so
23 many patients involved made as much difference
24 as the fact that to me, it seemed like the
25 root of it was so systemic that it wasn't as

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1 if there was one cause, that that, I think,
2 was more relevant to it than the other piece.
3 In fact, you know, I think one of the pieces
4 that I brought to the discussion and I think
5 it comes out of my work in the area of grief
6 and bereavement counselling is that I would be
7 concerned, I think conscientious to make sure
8 that we shouldn't lose sight of the fact that
9 whether you're dealing with one or hundreds,
10 that they are all families, all individuals
11 and the, you know, the immensity of the grief
12 and the distress is not one bit likened by the
13 fact that there are many and I suppose you'd
14 make an argument that it's probably
15 intensified by it.
16 COFFEY, Q.C.:
17 Q. So what difference did it make that there was
18 more than once cause--potentially more than
19 one cause?
20 MR. SINGLETON:
21 A. Well I think part of it is that, you know,
22 it's not only that there was more than one
23 cause, but to my understanding of it at that
24 time that it wasn't clear what that--what
25 those multiplicity of causes was or who or

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1 what would be responsible, that it was more,
2 you know, as I said, a whole system problem
3 and to some extent my understanding was that
4 it wasn't unique to Eastern Health, that
5 issues of false positives and all that kind of
6 stuff.
7 COFFEY, Q.C.:
8 Q. Who gave you that understanding?
9 MR. SINGLETON:
10 A. Well in the generalities of the description of
11 what, you know, how the laboratory testing is
12 done generally and the issue of false
13 positives and for that particular type of
14 testing, so I can't say who exactly -
15 COFFEY, Q.C.:
16 Q. I take it you mean false negatives in this
17 context?
18 MR. SINGLETON:
19 A. Yes, I'm sorry, yes.
20 COFFEY, Q.C.:
21 Q. And so you can't recall exactly who would have
22 told you or spoken to you about that.
23 MR. SINGLETON:
24 A. No, but I think it was kind of the, I'm sure
25 it would have been somebody who was informed

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1 about laboratory medicine, you know.
2 COFFEY, Q.C.:
3 Q. Okay, and the physicians involved, that you
4 actually dealt with, just to be clear on this,
5 they never did tell you first nor last, even
6 to this day they haven't told you about the
7 contents, for example, of Dr. Banerjee's
8 report?
9 MR. SINGLETON:
10 A. No.
11 COFFEY, Q.C.:
12 Q. That I read to you or I pointed to you
13 earlier, that kind of -
14 MR. SINGLETON:
15 A. Yeah, that's right.
16 COFFEY, Q.C.:
17 Q. Thank you, Commissioner.
18 THE COMMISSIONER:
19 Q. All right, it's getting a little late in the
20 day, but let's do the rounds of the room? Mr.
21 Pritchard?
22 MR. PRITCHARD:
23 Q. I don't have any questions, Commissioner.
24 THE COMMISSIONER:
25 Q. Mr. Browne?

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1 MR. BROWNE:
2 Q. Commissioner, I don't have any questions.
3 THE COMMISSIONER:
4 Q. All right, Ms. O'Dea?
5 MS. O'DEA:
6 Q. No questions, Commissioner.
7 THE COMMISSIONER:
8 Q. Ms. Newbury?
9 MS. NEWBURY:
10 Q. Probably about ten minutes.
11 THE COMMISSIONER:
12 Q. Mr. Crosbie?
13 CROSBIE, Q.C.:
14 Q. I would think I would half hour of questions,
15 yes.
16 THE COMMISSIONER:
17 Q. All right. Mr. Pike?
18 MR. PIKE:
19 Q. No questions.
20 THE COMMISSIONER:
21 Q. Mr. Simmons.
22 MR. SIMMONS:
23 Q. The issue is going to be that Mr. Singleton
24 right now, as you may have noticed from the
25 material -

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1 THE COMMISSIONER:
2 Q. Yes.
3 MR. SIMMONS:
4 Q. - in his C.V. is chairing a national bioethics
5 conference today and tomorrow.
6 THE COMMISSIONER:
7 Q. I understand that he is not available and
8 that's really the reason for my question, that
9 means that we're going to have to fit you in
10 at a later date, if that's all right with you,
11 Mr. Singleton. We don't want to interfere
12 anymore than we already have -
13 MR. SINGLETON:
14 A. I appreciate That.
15 THE COMMISSIONER:
16 Q. - with your activities with your conference.
17 MR. SINGLETON:
18 A. Uh-hm.
19 THE COMMISSIONER:
20 Q. Mr. Simmons, do you want to tell me how much
21 time you think, so we'll know what we're
22 looking for?
23 MR. SIMMONS:
24 Q. I'm expecting no more than ten or fifteen
25 minutes, depending, of course, on what comes

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1 out of the examination from either counsel.
2 THE COMMISSIONER:
3 Q. Well I recognize that, all right. Next week,
4 I think we'll all be thoroughly occupied with
5 the witnesses who have been already scheduled,
6 so perhaps, Mr. Simmons, if you and Commission
7 counsel would put your heads together about an
8 appropriate day where we can fit Mr. Singleton
9 in, perhaps a day where we're getting
10 witnesses who are not going to take a
11 particular long period of time or something
12 like that. In accordance with your schedule,
13 we'll accommodate your schedule as best we
14 can, Mr. Singleton.
15 MR. SINGLETON:
16 A. I really appreciate that, thank you very much.
17 THE COMMISSIONER:
18 Q. All right then, well I suggest we adjourn
19 until the morning at 9:30.

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1 CERTIFICATE
2 I, Judy Moss, hereby certify that the foregoing is
3 a true and correct transcript in the matter of the
4 Commission of Inquiry on Hormone Receptor Testing,
5 heard on the 19th day of June, A.D., 2008 before
6 the Honourable Justice Margaret A. Cameron,
7 Commissioner, at the Commission of Inquiry, St.
8 John's, Newfoundland and Labrador and was
9 transcribed by me to the best of my ability by
10 means of a sound apparatus.
11 Dated at St. John's, Newfoundland and Labrador
12 this 19th day of June, A.D., 2008
13 Judy Moss

-'-

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