COMMISSION OF INQUIRY

ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

APRIL 29, 2008

Appearances:

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

Rolf Pritchard/Megan Collins . . . . Her Majesty in Right of NL

Peter Browne/Jane Hennebury . . . . . . Doctors Kara Laing et al

Daniel Simmons/Sarah Learmonth . . . Eastern Regional Integrated
. . . . Health Authority

Darlene Russell. . . . . Members of the Breast Cancer
. . . . Testing Class Action

Mark Pike . . . . NL Medical Association

Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)
David Eaton . . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

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MS. LOUISE JONES - RESUMES THE STAND

Examination by Sandra Chaytor, Q.C. . . . . Pgs. 3 - 451

Certificate

1 THE COMMISSIONER:
2 Q. Good morning. Please be seated. Ms. Chaytor.
3 MS. LOUISE JONES, EXAMINATION-IN-CHIEF BY SANDRA CHAYTOR,
4 Q.C. (CONTINUED)
5 CHAYTOR, Q.C.:
6 Q. Good morning, Commissioner. Good morning, Ms.
7 Jones.
8 MS. JONES:
9 A. Good morning.
10 CHAYTOR, Q.C.:
11 Q. Commissioner, there's been a change to Exhibit
12 P-0488. There are some additional pages
13 added. So I just wanted to bring that to the
14 attention of counsel in case their page
15 numbers aren't the same as what they're saying
16 on the screen today.
17 THE COMMISSIONER:
18 Q. That number again was P-0488?
19 CHAYTOR, Q.C.:
20 Q. P-0488.
21 THE COMMISSIONER:
22 Q. So do I take it material that had been
23 redacted has been placed back in?
24 CHAYTOR, Q.C.:
25 Q. Has been put back in, that's right.

1 THE COMMISSIONER:
2 Q. Thank you.
3 CHAYTOR, Q.C.:
4 Q. It's from pages 96 onwards. I believe it now
5 goes from 96 to 128 or around there. So
6 anything after 96 the page numbers will have
7 changed.
8 THE COMMISSIONER:
9 Q. All right.
10 CHAYTOR, Q.C.:
11 Q. Changed by about four pages, I understand.
12 THE COMMISSIONER:
13 Q. Thank you.
14 CHAYTOR, Q.C.:
15 Q. And these aren't things that were redacted by
16 Mr. Simmons. I just want to assure him that
17 these are pages that we had chose not to use
18 but we realize that there are some questions
19 around those pages.
20 THE COMMISSIONER:
21 Q. All right. Thank you.
22 CHAYTOR, Q.C.:
23 Q. Ms. Jones.
24 MS. JONES:
25 A. Good morning.

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1 CHAYTOR, Q.C.:
2 Q. Good morning. I just want to go back, please,
3 for a moment, to P-0784. And, Ms. Jones, I'm
4 not sure if you can speak to this or not.
5 This is the letter that you found on the desk
6 of Mr. Tilley when you took over the office.
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. The letter of May 30th, 2007 intended for John
11 Abbott.
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. And have you learned who may have put the
16 words "Never sent" and crossed out the page?
17 MS. JONES:
18 A. No. I heard something this morning that it
19 may not have been George, but I don't know
20 anything about that.
21 CHAYTOR, Q.C.:
22 Q. Okay. What did you hear this morning about
23 that?
24 MS. JONES:
25 A. That it may have been the secretary and that

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1 we will have to confirm that.
2 CHAYTOR, Q.C.:
3 Q. So Joyce Penney?
4 MS. JONES:
5 A. Joyce Penney.
6 CHAYTOR, Q.C.:
7 Q. So you haven't had any discussions with Joyce
8 Penney around that?
9 MS. JONES:
10 A. No.
11 CHAYTOR, Q.C.:
12 Q. Do you know when this was marked on the
13 letter?
14 MS. JONES:
15 A. Absolutely not.
16 CHAYTOR, Q.C.:
17 Q. Okay. On this letter, when you found it on
18 the desk, was it in an envelope?
19 MS. JONES:
20 A. It was in one of those interdepartmental
21 envelopes, you know, the ones with the little
22 holes on it on the front of the desk.
23 CHAYTOR, Q.C.:
24 Q. So not an envelope for mailing?
25 MS. JONES:

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1 A. No.
2 CHAYTOR, Q.C.:
3 Q. Can you just describe that for me again?
4 MS. JONES:
5 A. One of those brown envelopes with the holes
6 through it that you have multiple people that
7 you can send through. So it would have
8 probably--I don't know. Mr. Tilley probably
9 would have put it in there and just left it on
10 the corner of his desk.
11 CHAYTOR, Q.C.:
12 Q. Okay.
13 MR. SIMMONS:
14 Q. One of those, perhaps?
15 MS. JONES:
16 A. That's exactly it.
17 CHAYTOR, Q.C.:
18 Q. There we go. Thank you, Mr. Simmons.
19 MS. JONES:
20 A. The thing on the back -
21 CHAYTOR, Q.C.:
22 Q. Is that the actual envelope?
23 MS. JONES:
24 A. Usually has a string on the back.
25 UNKNOWN SPEAKER:

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1 Q. (Inaudible).
2 CHAYTOR, Q.C.:
3 Q. Is that the actual envelope?
4 MR. SIMMONS:
5 Q. No, this one says the transmission date April
6 22nd to Louise Jones, so -
7 CHAYTOR, Q.C.:
8 Q. April 22nd, which year?
9 MR. SIMMONS:
10 Q. I don't know if we can determine -
11 CHAYTOR, Q.C.:
12 Q. '07.
13 MR. SIMMONS:
14 Q. - where it came from, but if you want to
15 (unintelligible) on the break, we can have a
16 look at that.
17 CHAYTOR, Q.C.:
18 Q. We will have a look, thank you.
19 MS. JONES:
20 A. That was the kind of an envelope that it was
21 in.
22 CHAYTOR, Q.C.:
23 Q. That's the kind of envelope, though. That's
24 not necessarily the envelope.
25 MS. JONES:

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1 A. No, that's not necessarily the envelope.
2 CHAYTOR, Q.C.:
3 Q. Thank you. I think when we left off last day,
4 we were looking at P-0774. And I had
5 basically finished with the excerpts from the
6 minutes that I was referring to on this. If
7 we just look back over the--most of this
8 meeting, obviously, was taken up with the
9 ER/PR issue, presentation on ER/PR.
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. Dr. Denic and Dr. Laing both presented that
14 day?
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. And there were a number of other guests in
19 attendance. I understood from your evidence
20 yesterday that this was in preparation for the
21 upcoming media technical briefing?
22 MS. JONES:
23 A. That was what we would have understood that we
24 would have been getting information that would
25 have been used.

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1 CHAYTOR, Q.C.:
2 Q. Was there any discussion with the executive as
3 to what information would be disclosed to the
4 media at the briefing?
5 MS. JONES:
6 A. I don't have any recall of that. It was
7 really for a briefing for the executive.
8 CHAYTOR, Q.C.:
9 Q. So, for example, the bullet that we spent some
10 time on yesterday about the concern about
11 certain information being protected under the
12 Evidence Act, was there any discussion around
13 that in terms of what could be relayed then to
14 the greater public?
15 MS. JONES:
16 A. There wouldn't have been any discussion.
17 CHAYTOR, Q.C.:
18 Q. Was there any discussion around what would be
19 relayed in terms of the overall numbers of
20 patients who had had changes in their results?
21 MS. JONES:
22 A. There was never any discussion about that at
23 executive.
24 CHAYTOR, Q.C.:
25 Q. Never?

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1 MS. JONES:
2 A. Never.
3 CHAYTOR, Q.C.:
4 Q. At executive, okay. So then if we look at
5 0775, please, Registrar? And this, I believe,
6 is your next executive management meeting,
7 which is December 6th, 2006?
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. And again, Mr. Tilley is chairing and we have
12 yourself, Oscar Howell?
13 MS. JONES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. You're there twice again.
17 MS. JONES:
18 A. Twice a couple of times now.
19 CHAYTOR, Q.C.:
20 Q. It's pretty remarkable. Pat Pilgrim. Susan
21 Bonnell is not at this one?
22 MS. JONES:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. And if we look at where the ER/PR issue is

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1 discussed, ER/PR on page 5. ER/PR, estrogen
2 and progesterone testing, review media
3 briefing. And it looks like Dr. Howell spoke
4 to the issue?
5 MS. JONES:
6 A. um.
7 CHAYTOR, Q.C.:
8 Q. "Dr. Howell advised that next week there will
9 be a briefing to the media on ER/PR. Susan
10 Bonnell is involved in preparing the media
11 briefing."
12 MS. JONES:
13 A. Yeah.
14 CHAYTOR, Q.C.:
15 Q. Executive discussed the pros and cons of going
16 back to the media on this issue, including the
17 limitations in light of the fact that the
18 findings in the review are protected under the
19 Evidence Act.
20 MS. JONES:
21 A. Okay.
22 CHAYTOR, Q.C.:
23 Q. So it looks to me like--it goes on to say,
24 "However, executive was supportive of moving
25 forward with the media briefing, including the

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1 technical briefing to cover areas such as
2 chronology of events, understanding of the
3 principles and practices of disclosure,
4 understanding the ER/PR test."
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. So it looks to me like it would have been
9 discussed on this occasion, which would have
10 been about five days before the briefing?
11 MS. JONES:
12 A. In terms of the previous minutes talked about
13 that taking it outside between Dan Boone and
14 Oscar Howell having a discussion. And this
15 would have been at exactly the pros and cons
16 and not moving forward with the peer review
17 information, the Evidence Act, yeah.
18 CHAYTOR, Q.C.:
19 Q. Yes. My question was in terms of whether it
20 came up at executive as to what will be
21 disclosed to the public in light of any
22 restrictions -
23 MS. JONES:
24 A. Not the content, only the -
25 CHAYTOR, Q.C.:

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1 Q. - felt to be placed by the Evidence Act?
2 MS. JONES:
3 A. Yeah. Only the pros and cons, right.
4 CHAYTOR, Q.C.:
5 Q. So what do you recall having been discussed on
6 this date?
7 MS. JONES:
8 A. Probably only protection under the Evidence
9 Act, but not the content of the reports
10 because they were not--we really were not
11 aware of the contents of the report, only in
12 their generalities. So it was, this here was
13 where--what you see that comes out of here is
14 that we go with the chronology of events, the
15 principles and those kinds of things. So that
16 was the decision.
17 CHAYTOR, Q.C.:
18 Q. So the decision of executive was to go with
19 chronology of events?
20 MS. JONES:
21 A. Um.
22 CHAYTOR, Q.C.:
23 Q. Disclose any information regarding the
24 chronology of events, understanding the
25 principles and practices of disclosure?

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1 MS. JONES:
2 A. That's right.
3 CHAYTOR, Q.C.:
4 Q. And understanding the ER/PR test itself?
5 MS. JONES:
6 A. ER/PR test, yes.
7 CHAYTOR, Q.C.:
8 Q. And what was the decision of executive in
9 terms of releasing the results of the test?
10 MS. JONES:
11 A. We weren't--there was no decision by
12 executive, there were many ways in terms of
13 looking at numbers, but there was no--there
14 was no input from the executive as to what
15 numbers would be discussed or disclosed. Many
16 different kinds of numbers could be out there,
17 but that was talked about outside of that
18 meeting.
19 CHAYTOR, Q.C.:
20 Q. Okay. So did executive discuss the issue of
21 here are the numbers that we have, here's--we
22 can look at the people who were impacted or
23 received a change in treatment, we can look at
24 the people who had the change in results, was
25 that kind of detail discussed at executive?

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1 MS. JONES:
2 A. Numbers weren't talked about, but those were
3 maybe the kinds of things, but I don't know if
4 it was in this meeting or not. But there was
5 always the issue of the false negative rate
6 and those kinds of things and what was a
7 complete, you know, like, what would not so
8 much make sense, but what were the numbers,
9 what did they actually mean. And it always
10 came back to we were having this discussion
11 and we had gone down this road around
12 treatment change and in terms of identifying
13 patients who could benefit from treatment. So
14 that would have been one of the things that
15 would have been said.
16 CHAYTOR, Q.C.:
17 Q. Okay.
18 MS. JONES:
19 A. Now, whether it was inside this meeting or
20 not, but that, it was always, the ER/PR issue
21 was always around identifying individuals who
22 could benefit from treatment.
23 CHAYTOR, Q.C.:
24 Q. Yes, and I understand that and that was the
25 rationale put forward for using that number in

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1 the media briefing.
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. So my question to you is whether or not that
6 discussion took place at executive and whether
7 it was the decision of executive management -
8 MS. JONES:
9 A. Was not the decision.
10 CHAYTOR, Q.C.:
11 Q. - to present in that manner?
12 MS. JONES:
13 A. No, it was not the decision of executive.
14 CHAYTOR, Q.C.:
15 Q. So executive was aware, though, that those
16 were the issues?
17 MS. JONES:
18 A. That there would be an issue of trying to
19 calculate an error rate and -
20 CHAYTOR, Q.C.:
21 Q. By who, who would be coming up with the issue
22 of trying to calculate an error rate?
23 MS. JONES:
24 A. Well, there was always the issue of what
25 percentage of change was there, what was the

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1 false negative issue, what was the lab and
2 what were the rates, but there was no
3 consensus as to what that was all about.
4 CHAYTOR, Q.C.:
5 Q. So it was discussed, though, at executive
6 management level?
7 MS. JONES:
8 A. That there was different ways of looking at
9 error rates.
10 CHAYTOR, Q.C.:
11 Q. Yes. And was executive management aware that
12 in going forward with the technical briefing
13 that the overall numbers would not be
14 disclosed?
15 MS. JONES:
16 A. No, there was no discussion made at executive.
17 They were made outside of the executive as to
18 what numbers were going to be used in the
19 briefing.
20 CHAYTOR, Q.C.:
21 Q. So the decision was made outside of executive?
22 MS. JONES:
23 A. That's right.
24 CHAYTOR, Q.C.:
25 Q. But was the executive aware that that was the

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1 approach that would be taken by those who were
2 doing the presentation?
3 MS. JONES:
4 A. The discussion was wide ranging and there was
5 no decisions made inside of this meeting.
6 CHAYTOR, Q.C.:
7 Q. Okay. I realize there was no decision made.
8 What my question is is whether or not the
9 executive was aware that that was the approach
10 that was to be taken -
11 MS. JONES:
12 A. No, it wasn't.
13 CHAYTOR, Q.C.:
14 Q. - that they would not--okay. When did you
15 become aware of that?
16 MS. JONES:
17 A. Well, it was only with the technical briefing
18 itself.
19 CHAYTOR, Q.C.:
20 Q. Okay. So in terms of other discussions around
21 this, outside of the executive management
22 committee, what other discussions did you have
23 around that issue?
24 MS. JONES:
25 A. I didn't have any.

Page 20

1 CHAYTOR, Q.C.:
2 Q. Okay.
3 MS. JONES:
4 A. Because I wasn't involved in this particular
5 issue.
6 CHAYTOR, Q.C.:
7 Q. Okay. So a few minutes ago when you said you
8 may have heard it from, through other
9 discussions, who would those discussions--what
10 discussions were you referring to?
11 MS. JONES:
12 A. Just the generic discussions that would happen
13 maybe in, I can't even say telephone calls or
14 whatever, we were together in different
15 meetings or whatever, but not inside of
16 executive.
17 CHAYTOR, Q.C.:
18 Q. So you would be at St. Clare's during this
19 time period?
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. Who else at executive is with you at St.
24 Clare's?
25 MS. JONES:

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1 A. Nobody.
2 CHAYTOR, Q.C.:
3 Q. Nobody. So if you had other discussions
4 around it, it would have to be in the context
5 of a meeting?
6 MS. JONES:
7 A. Or -
8 CHAYTOR, Q.C.:
9 Q. Or telephone discussion?
10 MS. JONES:
11 A. Or telephone conversations or when, you know,
12 when people came together in various forms.
13 CHAYTOR, Q.C.:
14 Q. So at the end of this meeting on December 6th,
15 2006 the executive management were not aware
16 that -
17 MS. JONES:
18 A. What the decision was going to be with respect
19 to what was inside the technical briefing.
20 CHAYTOR, Q.C.:
21 Q. Did the executive--so executive was aware,
22 though, that this was an issue being
23 discussed, about what the numbers could mean
24 or how the numbers could be interpreted, the
25 executive was aware of that?

Page 22

1 MS. JONES:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. And that was discussed. So who did executive
5 leave the decision to?
6 MS. JONES:
7 A. It was a group that was managing that
8 particular issue. We had communications, we
9 had Dr. Howell at this particular time, as
10 well as Mr. Tilley. They were the ones that
11 were involved in the decisions. And I'm not
12 sure who others may have been involved in
13 discussions as they were leading up to that
14 technical briefing.
15 CHAYTOR, Q.C.:
16 Q. So it would have been Mr. Tilley, Dr. Howell
17 and whoever else they may have engaged in the
18 decision?
19 MS. JONES:
20 A. That's right, that's right.
21 CHAYTOR, Q.C.:
22 Q. Okay. And the actual what would be disclosed,
23 we know there was a fairly elaborate briefing
24 put together?
25 MS. JONES:

Page 23

1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. With power point slides. Did you receive that
4 prior to the briefing?
5 MS. JONES:
6 A. I have no recall of receiving it prior to the
7 briefing.
8 CHAYTOR, Q.C.:
9 Q. And you yourself did not learn of the content
10 and the fact that full numbers were not
11 disclosed until after the briefing?
12 MS. JONES:
13 A. That's right.
14 CHAYTOR, Q.C.:
15 Q. And how did you learn of that?
16 MS. JONES:
17 A. I have no recall as to how I learned about
18 that. And probably it was after the briefing,
19 it was a discussion around what--how the
20 briefing went, probably more so that than
21 anything else.
22 CHAYTOR, Q.C.:
23 Q. And who would you have had that discussion
24 with?
25 MS. JONES:

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1 A. That probably would have been inside of
2 executive as well, because I would not have
3 had discussions with individuals about that,
4 you know, unless we were inside of a meeting
5 or happen to be in contact with individuals.
6 CHAYTOR, Q.C.:
7 Q. And what about the issue of what may have
8 caused the problems with the testing? What's
9 indicated here in the minutes is that the
10 chronology would be covered.
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. Understanding the principles and practices of
15 disclosure and understanding the test. What
16 was to be disclosed, if anything, in terms of
17 what may have caused the problem?
18 MS. JONES:
19 A. I have no idea whether we had that kind of
20 discussion. I don't recall.
21 CHAYTOR, Q.C.:
22 Q. And whether or not there was a decision to not
23 disclose certain things such as we see
24 reference -
25 MS. JONES:

Page 25

1 A. The Evidence Act.
2 CHAYTOR, Q.C.:
3 Q. - to the findings and the reports.
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. Was that discussed at the executive?
8 MS. JONES:
9 A. Not that I can recall. What you actually see
10 here is what was the technical briefing all
11 about. There had been discussions in the fall
12 that we would go out with the technical
13 briefing to brief the media and bring them up
14 to scratch. And I know that there was a group
15 working on that through the fall. And at a
16 point in time when they were ready to go,
17 remembering that Dr. Howell was new to this,
18 Dr. Williams had exited the organization by
19 this time, so really it was a matter of making
20 Dr. Howell comfortable with what it is that
21 this particular issue was about and then
22 moving forward with that. We had committed,
23 you know, that we would do that through the
24 fall.
25 CHAYTOR, Q.C.:

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1 Q. And what does it mean when it says,
2 "Understanding the principles and practices of
3 disclosure."?
4 MS. JONES:
5 A. I can't tell you what actually was discussed
6 inside that meeting, but we always started
7 from the disclosure piece of individual
8 patient disclosure. And that would have been
9 our first priority in terms of discussing that
10 we would have wanted to have all of the
11 information and make that available to
12 individual clients.
13 CHAYTOR, Q.C.:
14 Q. And who would be speaking to the principles
15 and practices of disclosure at the technical
16 briefing?
17 MS. JONES:
18 A. I have no idea.
19 CHAYTOR, Q.C.:
20 Q. The minutes go on to say on, "The organization
21 plans to resume testing in our laboratory in
22 early 2007."
23 MS. JONES:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. Which we know did happen in February for the
2 St. John's or Eastern Health region.
3 MS. JONES:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. "On a related note, Dr. Howell advised that
7 Dr. K. Laing has agreed to stay on as clinical
8 chief."
9 MS. JONES:
10 A. Um.
11 CHAYTOR, Q.C.:
12 Q. "Campaign by oncologists to resign effect
13 January 1, 2007 is ongoing."
14 MS. JONES:
15 A. Um.
16 CHAYTOR, Q.C.:
17 Q. Okay. So what's that all about?
18 MS. JONES:
19 A. I think you really might need to talk to Dr.
20 Howell about how that all evolved, but I do
21 believe some of it was around workload and
22 their inability to be able to do their work in
23 a particular period of time. And I do know
24 that they have had--they carry higher case
25 loads than would be expected for oncologists.

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1 So I think this was all around that issue.
2 CHAYTOR, Q.C.:
3 Q. Okay. So this all comes under the 3.7 ER/PR
4 testing review.
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. And it's noted -
9 MS. JONES:
10 A. "On a related note."
11 CHAYTOR, Q.C.:
12 Q. So it's in that heading, "On a related note."
13 MS. JONES:
14 A. Um.
15 CHAYTOR, Q.C.:
16 Q. So was that issue related to the ER/PR issue?
17 MS. JONES:
18 A. I just think that the workload issue, ER/PR
19 would have compounded their workload issue,
20 but they were carrying high workloads compared
21 to national benchmarks. And -
22 CHAYTOR, Q.C.:
23 Q. And how did -
24 MS. JONES:
25 A. - not necessarily, it could have probably

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1 ended up with a different heading, but it
2 didn't end up with a different heading.
3 CHAYTOR, Q.C.:
4 Q. And how did the ER/PR issue compound the
5 oncologists' workload?
6 MS. JONES:
7 A. Because they were working after hours in terms
8 of doing chart reviews as well as doing
9 panelling, as well as dealing with patients on
10 not necessarily a daily basis around this
11 issue. So it was over and above the new
12 patients that they were seeing on a, you know,
13 as part of their routine work as well as then
14 dealing with all of the clients related to and
15 seeing people back in clinic who were panelled
16 for treatment changes and those kinds of
17 things.
18 CHAYTOR, Q.C.:
19 Q. And were all the oncologists involved in that?
20 For example, the panelling, that would have
21 been a select few of the oncologists?
22 MS. JONES:
23 A. A select few of the oncologists.
24 CHAYTOR, Q.C.:
25 Q. And were all the oncologists otherwise

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1 involved in chart reviews and seeing patients?
2 MS. JONES:
3 A. I can't speak to the exact detail. Kara Laing
4 and them will be able to tell you more about
5 that.
6 CHAYTOR, Q.C.:
7 Q. Okay. And Kara Laing agreeing to stay on as
8 clinical chief, how was that related to the
9 ER/PR issue?
10 MS. JONES:
11 A. I'm essentially thinking it was a workload and
12 a pay issue and that at the end of a point in
13 time Kara was clinical chief at the period of
14 time and that with the discussion with Dr.
15 Howell we were able to continue to have her
16 services in that role.
17 CHAYTOR, Q.C.:
18 Q. Okay. So in terms of it being related, if at
19 all, to the ER/PR issue and I appreciate what
20 you're saying as to where it's sitting here
21 within the minutes.
22 MS. JONES:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. It may be workload?

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1 MS. JONES:
2 A. It definitely is workload, it has been
3 workload in the oncology program for a long
4 time.
5 CHAYTOR, Q.C.:
6 Q. Okay. And that preceded the issue of ER/PR?
7 MS. JONES:
8 A. There have been vacancies within the oncology
9 position and number of oncologists that have
10 changed over the years and I'm sure others
11 will speak to you about that. And so there
12 has always been an issue of being able to
13 recruit and retain the number of oncologists
14 in the program.
15 CHAYTOR, Q.C.:
16 Q. And as I said, that preceded the ER/PR issue?
17 MS. JONES:
18 A. Preceded the ER/PR issue.
19 THE COMMISSIONER:
20 Q. I'm assuming you are still not up to scratch
21 on the number of oncologists?
22 MS. JONES:
23 A. We have seven oncologists right now.
24 THE COMMISSIONER:
25 Q. And what is the -

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1 MS. JONES:
2 A. We have one vacancy.
3 THE COMMISSIONER:
4 Q. - anticipated -
5 MS. JONES:
6 A. We have one vacancy, we have a person who's
7 left recently. And I think if you look at the
8 medical manpower plan, it's a need for maybe
9 nine or ten oncologists, but we have had
10 seven, down to six and in the last couple of
11 years we've grown that from three, four, five,
12 six. It's grown incrementally.
13 THE COMMISSIONER:
14 Q. So you have seven at the moment?
15 MS. JONES:
16 A. No, we have six at the moment.
17 THE COMMISSIONER:
18 Q. Sorry.
19 MS. JONES:
20 A. We had seven, we just lost one oncologist very
21 recently.
22 THE COMMISSIONER:
23 Q. You have six at the moment?
24 MS. JONES:
25 A. Yes.

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1 THE COMMISSIONER:
2 Q. Did you not say something about eight being
3 the number that you have positions for?
4 MS. JONES:
5 A. From a work--no, no. From a workload
6 perspective you need to understand how
7 physician manpower plan is developed in the
8 province. From a workload perspective there's
9 an anticipation that they need nine or ten to
10 do the workload that they are doing. And
11 right now they're on an alternate payment plan
12 because, in fact, those seven and just
13 recently the six individuals are carrying the
14 workload for nine or ten oncologists. So
15 there is an alternate payment plan to allow
16 them to be compensated for that workload.
17 THE COMMISSIONER:
18 Q. Okay. So that I do understand. When you're
19 saying that there's a workload plan, is that
20 Eastern Health's workload plan or is that some
21 kind of a provincial-wide plan for the number
22 of oncologists required given circumstances?
23 MS. JONES:
24 A. There is a process that you move through where
25 there is discussions with the government and

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1 there is a provincial medical manpower plan
2 that it's approved and funded. There is
3 always positions going forward based upon
4 workload to look to be funded. And the
5 shortfall between the seven that are currently
6 funded inside the plan and the nine or ten,
7 and I'm not quite sure, Dr. Kara Laing will be
8 able to speak to that or Dr. Howell more
9 eloquently than I can, but based upon the
10 workload and the benchmarks across this
11 country, in any other area we would have nine
12 or ten oncologists. And then what happens is
13 that they worked in the last period of time
14 probably, probably in the last 18 months to
15 develop what we call an alternate payment plan
16 to allow them to be compensated for workload
17 over and above what would be expected by a
18 single person to be able to provide in this
19 area.
20 THE COMMISSIONER:
21 Q. Okay. So when you talk about the nine or ten,
22 that is not the current number that the
23 province -
24 MS. JONES:
25 A. Funds.

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1 THE COMMISSIONER:
2 Q. - is permitted to--is funding?
3 MS. JONES:
4 A. Yes.
5 THE COMMISSIONER:
6 Q. The nine or ten is the number that the
7 oncologists would argue given on workloads
8 over the country should be?
9 MS. JONES:
10 A. Should be.
11 THE COMMISSIONER:
12 Q. The province currently funds seven?
13 MS. JONES:
14 A. Seven.
15 THE COMMISSIONER:
16 Q. You currently have six?
17 MS. JONES:
18 A. We currently have six.
19 THE COMMISSIONER:
20 Q. All right. Thank you.
21 CHAYTOR, Q.C.:
22 Q. Ms. Jones, just continuing on then with the
23 minutes from the December 6th, 2006 executive
24 meeting. On page 7 there's 4.21, the heading
25 is "Board." "The December board meeting will

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1 include," and there's a number of items
2 redacted because obviously they're not
3 relevant to us. And then it says, "Executive
4 agreed that a brief executive report to the
5 board should be included in the board package
6 and will highlight the following points."
7 MS. JONES:
8 A. Um.
9 CHAYTOR, Q.C.:
10 Q. And the fifth bullet is "ER/PR", and Dr.
11 Howell, I presume, is the person going to do
12 the report on that?
13 MS. JONES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. Okay. And do you recall was there, in fact, a
17 briefing to the board in December on the ER/PR
18 issue?
19 MS. JONES:
20 A. When we talk about a brief executive report to
21 the board, every month executive brings
22 together issues that are going on to update
23 the board in between board meetings. So you
24 would have to check the actual executive
25 reports to the board to see. And I would very

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1 much expect that Dr. Howell has provided an
2 update.
3 CHAYTOR, Q.C.:
4 Q. Did you attend that board meeting in December?
5 MS. JONES:
6 A. You'll have to show me the minutes. There's
7 not many board meetings that I didn't attend.
8 CHAYTOR, Q.C.:
9 Q. Okay. I'm just wondering then in terms of
10 what you may have recalled about any
11 discussion around the media technical
12 briefing, what discussion there was and what
13 information was provided to the board on the
14 issues that we've just discussed?
15 MS. JONES:
16 A. Have no recall of that.
17 CHAYTOR, Q.C.:
18 Q. So whatever would be reflected in the minutes?
19 MS. JONES:
20 A. Yes. And whatever would have been in the
21 executive report at the time. May not have
22 been highlighted if the board didn't ask any
23 issues and were comfortable with the executive
24 report. Many times what is in the executive
25 report, unless it's a particular issue that we

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1 want specifically the board to be aware of, of
2 updates, there would be a verbal, as well.
3 CHAYTOR, Q.C.:
4 Q. To your knowledge did the--was the board made
5 aware prior to the media technical briefing as
6 to what information would be disclosed?
7 MS. JONES:
8 A. I have no idea. That would have come out of
9 Mr. Tilley's office to the board itself.
10 CHAYTOR, Q.C.:
11 Q. Page 9 of the same minutes, 5.4 is
12 "Information Management Committee." And
13 minutes from the November 3th, 2006
14 information management meeting were
15 circulated?
16 MS. JONES:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. And the next meeting is indicated to be
20 December 13th, 2006.
21 MS. JONES:
22 A. Um.
23 CHAYTOR, Q.C.:
24 Q. Is--this appears to be a regular reporting
25 item to executive management, the information

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1 management committee?
2 MS. JONES:
3 A. There is a number of subcommittees that report
4 in on a regular basis and this would be one of
5 them.
6 CHAYTOR, Q.C.:
7 Q. Okay. And SD, meaning Steve Dodge?
8 MS. JONES:
9 A. Steve Dodge.
10 CHAYTOR, Q.C.:
11 Q. So he would be the chair of that committee?
12 MS. JONES:
13 A. He's the chair of that committee.
14 CHAYTOR, Q.C.:
15 Q. Okay. And did this, up to this point in time,
16 in December, 2006--first I guess I should ask
17 you, what is the mandate of that committee?
18 MS. JONES:
19 A. It looks at all of the issues around
20 information management. It has health records
21 as part of it, it has clinical efficiency as
22 part of it, it has information management and
23 technology, it looks at our systems and our
24 processes and it has developed, maybe not by
25 November of 2006, an information management

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1 plan that we have brought forward in the
2 organization and does address issues that
3 cross multiple portfolios as we move forward.
4 CHAYTOR, Q.C.:
5 Q. Do you know whether or not the information
6 management committee was engaged in the ER/PR
7 issue?
8 MS. JONES:
9 A. I have no idea, but I would not think that it
10 was.
11 CHAYTOR, Q.C.:
12 Q. Why not?
13 MS. JONES:
14 A. Because the ER/PR is a clinical issue, okay.
15 You probably are asking the question around
16 database management.
17 CHAYTOR, Q.C.:
18 Q. Yes, and in terms of disclosure to patients.
19 MS. JONES:
20 A. And the database management would have been a
21 question I asked of the information technology
22 people early on in the game, in the summer of
23 2005 into 2006. So -
24 CHAYTOR, Q.C.:
25 Q. So who would those people be, it wouldn't be

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1 this committee?
2 MS. JONES:
3 A. No, it would have been the director--it would
4 have been people who work in information
5 management in terms of our computer, who run
6 our computer systems.
7 CHAYTOR, Q.C.:
8 Q. And who would they be?
9 MS. JONES:
10 A. The director is Terry Molden (phonetic), that
11 would be the director of information
12 management and technology. And there would be
13 consultants who work or managers who work in
14 there that may have been asked early along in
15 the game whether there was a way of developing
16 a database based upon what was asked for ER/PR
17 negatives.
18 CHAYTOR, Q.C.:
19 Q. And do you know if Terry Molden or the team
20 was actually approached on the ER/PR issue?
21 MS. JONES:
22 A. I do know just from conversation that they
23 were asked whether, in fact, the could get at
24 this particular information inside of the
25 Meditec databases and the answer was "We have

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1 no absolute way and what you've done is as
2 good as we can do."
3 CHAYTOR, Q.C.:
4 Q. The information management committee, is part
5 of the mandate of that committee to identify
6 issues with information management?
7 MS. JONES:
8 A. It is, part of the mandate is to move the
9 whole issue of information management forward
10 as well as develop an information management
11 plan for the organization that we would look
12 to resource over time.
13 CHAYTOR, Q.C.:
14 Q. And I'm going to ask you later on because you
15 go forward in November of 2007 to government
16 with a proposal on information management.
17 MS. JONES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. And was that issue brought forward to you
21 through the information management committee?
22 MS. JONES:
23 A. We have in--if you look at all of the budget
24 submissions, there have been submissions
25 around information management, our technology

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1 piece as well as decision support for a number
2 of years. And every year through the budget
3 process we would be putting forward what our
4 needs are in that particular area. What the
5 November of 2007 was, was pulling together the
6 pieces that were already inside of the budget
7 and had been inside of the budget for years.
8 So it was a--after the November 2nd press
9 conference that the minister had with
10 releasing some of the database numbers the
11 premier very clearly said "Whatever they need
12 with respect to data management, we will give
13 them." So what I did at that particular time
14 was brought together a group of individuals,
15 says "You have sixteen and a half million
16 dollars inside of this budget request for this
17 year. Which parts are the critical pieces
18 that we need to move forward on a priority
19 basis?" And that's where that came from.
20 CHAYTOR, Q.C.:
21 Q. Yes, okay. And I'll get to that with you in
22 November of '07.
23 MS. JONES:
24 A. Yeah.
25 CHAYTOR, Q.C.:

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1 Q. But I'm just wondering what role, if any, this
2 information management committee may have
3 played in that -
4 MS. JONES:
5 A. They would have, the individual pieces would
6 have been identified and been priorized (sic.)
7 through the information management committee.
8 CHAYTOR, Q.C.:
9 Q. So was it the information management committee
10 over the years that you're referring to, was
11 it that committee that was bringing forward
12 issues of information management to then look
13 for funding in the budget?
14 MS. JONES:
15 A. They would have been the ones that would have
16 been tasked for identifying the priority of
17 the issues and which way we should line them
18 up.
19 CHAYTOR, Q.C.:
20 Q. And from that information then the budget
21 submission on those items would go forward?
22 MS. JONES:
23 A. Absolutely.
24 CHAYTOR, Q.C.:
25 Q. When was this committee put in place?

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1 MS. JONES:
2 A. Probably early in the life of Eastern Health.
3 I can't tell you. I would definitely say
4 before the end of the year into 2006, right.
5 So here we have December, 2006, we came
6 together in April of 2005, so I would be
7 thinking by the time January, 2006 or so came
8 we would have had enough structures in place
9 to be able to start to pull together.
10 CHAYTOR, Q.C.:
11 Q. So this committee wasn't even in existence at
12 the time that the ER/PR issue first arose?
13 MS. JONES:
14 A. No. Really the information management
15 committee, there would have been previous
16 committees in the old Health Care Corporation,
17 I'm not sure about the other legacy boards,
18 where there would have been an overarching
19 committee. But inside of Eastern Health this
20 particular committee has been part of the
21 structure relatively early on.
22 CHAYTOR, Q.C.:
23 Q. So was the creation of this committee in any
24 way related to the issues that were
25 encountered in the ER/PR issue?

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1 MS. JONES:
2 A. No, this is part of the ongoing operation of
3 an organization where you would have a group
4 that brings together multiple stakeholders.
5 In this instance it would have been health
6 records, it would have been information
7 management and technology and other senior
8 executives in--or program directors in our
9 neck of the woods that actually have some play
10 in information management. So clinical
11 efficiency would have been there as well as
12 some of the chief operating officers as we
13 look to evolve our information management
14 systems.
15 CHAYTOR, Q.C.:
16 Q. Okay. I'm going to leave that now and I'd
17 like to come back to an issue that I started
18 to address yesterday, and that's the issue of
19 accountability.
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And I'm wondering how does Eastern Health
24 define and measure accountability?
25 MS. JONES:

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1 A. I think you have to start from the board. And
2 what we have at the board is a number of way
3 that the board operates inside a policy
4 governance, so it has what it calls executive
5 limitations. And what we have is a group of
6 executive limitations for the executive which
7 is really the CEO, which are usually negative
8 statements, you know, to insure that whatever.
9 And so over the evolving of Eastern Health
10 there has been a monitoring process and a
11 reporting process on executive limitations
12 through to the board. And so then below that
13 what happens is is that depending on what the
14 actual limitation is that we're asked to
15 report to the board, there would be a
16 monitoring report completed and that would
17 involve many areas, depending on what is it
18 that would create a monitoring report. And we
19 are attempting to get much more defined with
20 trying to not just deliver a didactic in terms
21 of a verbal report of this is the number of
22 things that we've done or this is how we've
23 done it, that we're trying to move more and
24 more just like the rest of the country is to
25 outcome measures to show that, in fact, what

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1 they are asking, there is an improvement in
2 health or those kinds of things. So regularly
3 now the board receives a number of monitoring
4 reports, so there's always the financial
5 reports, so every time that we meet there is
6 the board of directors there's a statement
7 there that talks about all of the things we've
8 done there. And then inside of each one of
9 the committees, whether it's the planning
10 committee, the safety and improvement
11 committee oral reports go straight to the
12 board on executive limitations. So that's
13 kind of how the Board has been working its way
14 through. It's been evolving its executive
15 limitations and refining them to the point
16 where it is comfortable with the information
17 that it's getting, that it believes that
18 assures them of what's going on inside the
19 organization. Then as an executive and as
20 individuals who work in various parts of the
21 organization, we pull that together. Apart
22 from that, we have -
23 CHAYTOR, Q.C.:
24 Q. Can I just stop you for a minute?
25 MS. JONES:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. When did the process of providing the
4 monitoring reports to the Board, when did that
5 come into being?
6 MS. JONES:
7 A. The Board started probably in its first year
8 of operation to look at what kind of
9 governance style it had. We brought down a
10 lady by the name of Carol Gabana and then they
11 worked through their board governance
12 policies, and then following the board
13 governance policies, then the executive was
14 tasked with providing reports to assure the
15 Board, interpreting what that limitation was
16 and providing reports to the Board on those.
17 Apart from that though, there's also Board
18 objectives that come from either--with the
19 government and with the board with respect to
20 what actual objectives it wants to achieve in
21 the run of a year, and at the end of the year,
22 there is an annual report that goes to the
23 board that, to my knowledge, also performs
24 part of the--becomes part of the performance
25 appraisal for the chief executive officer and

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1 inside of that, there are objectives that are
2 set by the CEO for everyone of the chief
3 executive officers and the vice-presidents.
4 So there are objectives that are set and then
5 there are yearly reports on that.
6 Inside of the portfolio in which you
7 operate, then you meet with your program
8 directors and managers and set objectives for
9 them as to what you want to achieve. They're
10 all lined up, for all intents and purposes,
11 inside the strategic plan that the government
12 and then the Board has operated on and then
13 Eastern Health has an operating plan as well.
14 So we report on the operating plan, where we
15 are, how far along we've met, where are the
16 objectives. They come up the line and then
17 they eventually feed the Board, based upon
18 what the Board needs to hear.
19 CHAYTOR, Q.C.:
20 Q. So when were the monitoring reports first
21 initiated? When did the Board first receive
22 its first monitoring report?
23 MS. JONES:
24 A. They would have probably--you really need to
25 go back to the Board minutes.

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1 CHAYTOR, Q.C.:
2 Q. Would it be '06? Would it be 2007?
3 MS. JONES:
4 A. It would have been in '06. There would have
5 definitely been the financial ones. They had
6 always--once we got on the ground and into the
7 fall and we had people, those ones went fairly
8 regularly, meaning every two months there
9 would have been a report that had gone, and
10 they've tweaked how they want to see those
11 reports over time.
12 The safety and improvement committee has
13 only been in place since about February last
14 year and we've almost been through all of the
15 ELs that they have done in that particular
16 area. So we're almost on the second cycle of
17 everyone and some monitoring reports go more
18 often than the other, but at least they're
19 annually, and we're on the second cycle of
20 most of them.
21 CHAYTOR, Q.C.:
22 Q. So that's the process from really 2006 up to
23 the current?
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. That's the process that's in place now?
3 MS. JONES:
4 A. Absolutely.
5 CHAYTOR, Q.C.:
6 Q. And are you able to speak to what was the
7 process in the time period leading up to 2005?
8 MS. JONES:
9 A. Before -
10 CHAYTOR, Q.C.:
11 Q. From 1997 right up through 2005.
12 MS. JONES:
13 A. Right, okay. At that point in time, are we
14 talking about Health Care Corporation?
15 Because that's the only one I can speak to.
16 CHAYTOR, Q.C.:
17 Q. That's the only one you can speak to.
18 MS. JONES:
19 A. Okay, at that point in time, what we did have,
20 it wasn't a policy governance model, but there
21 would have been reports from the chief
22 executive officer through to the Board,
23 similar in some ways to the executive reports
24 that would have been sent out, and there would
25 have been--there were more committees of the

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1 board in the old Health Care Corporation of
2 St. John's, so that a lot of the work that was
3 done by the Board was done through committee
4 work and there were reports that went in. If
5 we're talking about the quality committee,
6 there would have been yearly--there would have
7 been a cadre of program directors and that on
8 a regular basis that would have met with the
9 subcommittees of the board and provided
10 quality reports to the Board that would have
11 eventually went to the Board table for
12 information or for action.
13 CHAYTOR, Q.C.:
14 Q. Okay, and can you, in a nutshell then, just
15 tell what essentially is the difference
16 between that and how it now works?
17 MS. JONES:
18 A. Essentially, the difference is that the Board
19 has been very directive in what it sets out in
20 terms of what it wants to see and what it will
21 not allow the organization to do. So it's a
22 reversal and it is very clearly identifying
23 what is acceptable to the Board and what is
24 not acceptable to the Board. Then allowing
25 the organization, through its executive, to

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1 bring forward evidence to the board of work in
2 this particular area. So it's more outcome
3 based versus more provide a report on what we
4 have done, like how many surgeries have we
5 done, what's our occupancy like, what's our
6 wait list like. It is more driving us to the
7 other side of really what value are we getting
8 for our money and where is it that as an
9 organization we want to go and from a planning
10 perspective, making sure that the things that
11 the Board, as well as the government, have
12 clearly outlined that they want to move the
13 organization forward on, that those become
14 part of the reporting process.
15 CHAYTOR, Q.C.:
16 Q. And how does the government give input into
17 that?
18 MS. JONES:
19 A. The government gives input to that in that it
20 has a strategy plan for the Department of
21 Health and through--in 2005, they had sent
22 those out to the health authorities and
23 identified these are the strategic areas that
24 we want to move inside in terms of health.
25 How can you contribute to that? And so

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1 therefore, whether you put it in your
2 operational plan, which is very local, or
3 whether you put it in the strategic plan,
4 which is a board plan for the organization,
5 you had to indicate what plans you actually
6 had it on and we report back to the government
7 on a yearly basis on what we've been able to
8 achieve in the plan. So inside of the new
9 transparency and accountability, we're one of
10 the organizations that has to provide yearly
11 reports, strategic plan approved by the
12 government, and then reporting through to the
13 public and the government on that plan.
14 CHAYTOR, Q.C.:
15 Q. And we heard from Minister Wiseman, that
16 annual report is the same annual report that
17 goes forward at your annual general meeting?
18 MS. JONES:
19 A. At the annual general meeting.
20 CHAYTOR, Q.C.:
21 Q. Which is distributed to the public, so that -
22 MS. JONES:
23 A. Distributed to the public and put in the House
24 as well.
25 CHAYTOR, Q.C.:

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1 Q. You indicated in answering my question on
2 accountability that you brought in an external
3 person -
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. - to advise the Board, Carol -
8 MS. JONES:
9 A. Carol Gabana.
10 CHAYTOR, Q.C.:
11 Q. Yes, and you said the Board, to reassure the
12 Board in terms of the information that it was
13 receiving and the types of information, that
14 it's getting the right information.
15 MS. JONES:
16 A. Well -
17 CHAYTOR, Q.C.:
18 Q. Was there any loss of confidence in the Board
19 in terms of the information flow?
20 MS. JONES:
21 A. I think that you need to understand what Carol
22 Gabana does. She's a consultant with policy
23 governance. The Board brought her in to
24 educate them on a policy governance model and
25 what ends mean and what executive limitations

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1 mean and board policies and those kinds of
2 things. So once they had the education, then
3 they worked to define how their own ends would
4 look like and we worked the ends, what the
5 ultimate organization would ultimately want.
6 We did that in a strategic planning process
7 with the Board, and then the Board
8 individually worked on what executive
9 limitations it wanted, and they then passed
10 those over to the executive to move forward
11 with.
12 In December of this year, we brought her
13 back again to have a education session with
14 the Board, as well was with the executive,
15 around, okay, this is where we are at this
16 point in time. These are some of the
17 monitoring reports. What other advice would
18 you have for us as we continue to move
19 forward?
20 CHAYTOR, Q.C.:
21 Q. My question was not so much as to what the
22 external person had done. It was whether or
23 not there was an indication that the Board had
24 lost confidence in the information flow to the
25 Board.

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1 MS. JONES:
2 A. No, this was the way that the Board wanted to
3 operate as a board.
4 CHAYTOR, Q.C.:
5 Q. So in terms of reassuring the Board in terms
6 of information, you're not aware of any loss
7 of confidence by the Board in terms of the
8 information that it had been receiving or the
9 manner in which it had been receiving
10 information?
11 MS. JONES:
12 A. There was always a discussion in the
13 beginning. Eastern Health is a very large
14 organization. What is it that the Board needs
15 to take to be out of operations and into
16 governance, and this was the model that they
17 elected to move forward with. So it was
18 really their way of organizing their work and
19 for us to provide them with information to
20 move their--or to address their issues and
21 move them forward.
22 CHAYTOR, Q.C.:
23 Q. Okay, and so you're not -
24 THE COMMISSIONER:
25 Q. I'm sorry, while we're on the topic, did you

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1 say that this lady, Carol Cabana -
2 MS. JONES:
3 A. Gabana.
4 THE COMMISSIONER:
5 Q. Gabana.
6 MS. JONES:
7 A. G-A-B -
8 THE COMMISSIONER:
9 Q. G?
10 MS. JONES:
11 A. Yes.
12 THE COMMISSIONER:
13 Q. Was a consultant with policy governance?
14 MS. JONES:
15 A. Yeah. She's a -
16 THE COMMISSIONER:
17 Q. Is that an organization?
18 MS. JONES:
19 A. She works with an organization, but there are
20 a number of people, if--you might know the
21 Carver model of policy governance. That's the
22 one that would be in the--most written about,
23 but this particular lady doesn't work for
24 Carver herself. This particular lady works
25 with a lot of public bodies and health care

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1 bodies, talking about policy governance and
2 using the principles of policy governance in
3 working boards through how they want to set
4 their own organization up and their own
5 structure.
6 THE COMMISSIONER:
7 Q. So she's an independent contractor?
8 MS. JONES:
9 A. She's an independent contractor.
10 THE COMMISSIONER:
11 Q. You weren't suggesting she belonged to some
12 group that was -
13 MS. JONES:
14 A. No.
15 THE COMMISSIONER:
16 Q. Okay. Sorry, I misunderstood her role. All
17 right, thank you.
18 MS. JONES:
19 A. No, she's a consultant.
20 CHAYTOR, Q.C.:
21 Q. And this wouldn't be a pure Carver model in
22 any event. It's modified?
23 MS. JONES:
24 A. Yes. It's modified only to the extent that
25 Carver has no--it's a committee of the board

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1 and there generally are no subcommittees of
2 the board, but Carver really doesn't say that
3 you cannot have subcommittees. So everything
4 that happens in the subcommittees, the
5 planning committee, the finance committee and
6 the safety and improvement committee, in terms
7 of the executive limitations and that, all
8 feed into the Board. So the Board sees all of
9 those monitoring reports and in fact adopts
10 them in that way.
11 CHAYTOR, Q.C.:
12 Q. So in terms of accountability and what it
13 means in Eastern Health, is it limited to
14 what's required by the legislation or is it
15 something over and above that?
16 MS. JONES:
17 A. It's over and above that, because the
18 legislation can't go in every direction. When
19 we talk about accountability, we talk about
20 staff accountability for the work that they
21 particularly perform and whether it's through
22 performance appraisals or meeting the
23 standards, okay, of care, either for a
24 profession or whatever. So the accountability
25 starts right at the front line. But in terms

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1 of how it works its way up and what actually
2 gets to the Board, the Board would determine,
3 and if you look at their executive limitation
4 policies, they're wide ranging. They're
5 everything from policy to staff to competence
6 to safety to infrastructure and the whole
7 gamut.
8 CHAYTOR, Q.C.:
9 Q. Some people in speaking of accountability will
10 use accountability as sort of an overarching
11 and will talk about things such as standards -
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. - transparency, oversight, and another key
16 word we often hear is answerability. How is
17 it that answerability fits into Eastern
18 Health's accountability scheme?
19 MS. JONES:
20 A. I'm not sure. Maybe you need to give me some
21 sense of what you -
22 CHAYTOR, Q.C.:
23 Q. Are you familiar with that term,
24 answerability?
25 MS. JONES:

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1 A. I'm not familiar with the term of
2 answerability.
3 CHAYTOR, Q.C.:
4 Q. So you described how it would work.
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. How people are--how the accountability
9 framework works within your organization, from
10 the Board on down through the frontline
11 workers.
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. So at the end of the day, if there has been an
16 issue in terms of accountability, how are
17 people--how do people answer to that?
18 MS. JONES:
19 A. It depends on what the issue is. Generally it
20 is an exploration of what has gone on and what
21 we have done to actually address the issue.
22 So therefore, depending on the nature of the
23 issue, then there would be different ways of
24 moving that forward on a very, very local--we
25 always start with the base of the organization

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1 to understand fully what is an what
2 encompasses an issue.
3 CHAYTOR, Q.C.:
4 Q. Well, for example, yesterday in dealing or
5 speaking specifically to this issue -
6 MS. JONES:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. - you indicated that there had been
10 accountability and Dr. Howell or Dr. Williams
11 would be able to speak to that.
12 MS. JONES:
13 A. Yeah.
14 CHAYTOR, Q.C.:
15 Q. In terms of the laboratory medicine program,
16 and what do you understand--what was the
17 accountability? How were the people held
18 answerable in that situation?
19 MS. JONES:
20 A. You really do have to absolutely ask those
21 individuals. Each one of us would work in a
22 different fashion. They would have obviously
23 investigated and discovered what went on. We
24 have, and we talk about in our quality
25 framework, looking at issues and resolving

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1 them and quality improving them all the time.
2 So that is part of the way that we do business
3 and part of the way of moving issues forward
4 so that they don't ever happen again. What
5 actually happened in that, I don't know.
6 CHAYTOR, Q.C.:
7 Q. And I will ask those individuals, but I'm
8 asking you as the acting interim CEO -
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. - do you know the answer to my question?
13 MS. JONES:
14 A. No, I don't know the answer to your question.
15 CHAYTOR, Q.C.:
16 Q. So you have not asked?
17 MS. JONES:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. And is there any reason why you would not have
21 asked?
22 MS. JONES:
23 A. The issues that we're dealing with at this
24 particular point in time arose from 1990--from
25 2005 and my assumption is that they would have

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1 been dealt with. They were investigated at
2 the time. We put significant initiatives in
3 place to ensure that we had a quality service,
4 at least on ER/PR, and therefore that whatever
5 happened in that period of time to get us to
6 the point of testing again was where we are
7 today.
8 CHAYTOR, Q.C.:
9 Q. So it happened prior to you taking over your
10 current position?
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. At the time that you assumed the position of
15 interim CEO, did you have any meetings with
16 the Department of Health and Community
17 Services?
18 MS. JONES:
19 A. When I--the first meeting that I had was with
20 Robert Thompson on the 19th of July.
21 CHAYTOR, Q.C.:
22 Q. And we'll talk a bit about that meeting. What
23 was your perception of the relationship
24 between Eastern Health and the Department at
25 that point in time?

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1 MS. JONES:
2 A. I guess it was fair to say, particularly with
3 the Burin Radiology issue and ER/PR issue,
4 that it would have been tense.
5 CHAYTOR, Q.C.:
6 Q. And were there any concerns articulated to you
7 from the Department's perspective as to how--
8 why there was that tension and how to address
9 it on a go-forward basis?
10 MS. JONES:
11 A. No. When we first met, one of the very first
12 things that we talked about was rules of
13 engagement, in terms of--and those were the
14 term that the Board would have used and we
15 would have used in terms of communication and
16 communication to the Department, requesting
17 information, what were the channels, what were
18 the most appropriate channels, what you could
19 expect from us and what we expected from the
20 Department. So over a period of time, and I
21 think you heard that being said yesterday,
22 there seemed to be more information going
23 outside the organization at levels in the
24 organization that either the executive or the
25 senior team was not aware of, and we really

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1 needed to understand that. Do I absolutely
2 understand, because as we move forward, style
3 for different deputy ministers or style for
4 ministers sometimes reflects some of the ways
5 things happen, but the traditional way that
6 we'd always dealt with is the deputy minister
7 to the CEO, and at the ADM level, it would
8 have been the chief operating officers and
9 then unless it's on an individual specific
10 basis, you know, very, very concrete around
11 what was a budget figure on something, then
12 there may have been lower than that and that
13 the minister and the Board chair were the ones
14 that had that interaction. So that had been
15 the traditional hierarchy that had been used
16 in health care and we needed to understand
17 whether that in fact was the way that we were
18 moving forward.
19 CHAYTOR, Q.C.:
20 Q. So, if I understand your answer, that that had
21 not been necessarily the practice. That there
22 were other avenues of information flow
23 happening?
24 MS. JONES:
25 A. Other avenues, yes.

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1 CHAYTOR, Q.C.:
2 Q. That the executive and your senior team were
3 not aware of?
4 MS. JONES:
5 A. Yes, and a request for information that
6 sometimes we may not have felt would have
7 really--you know, it was very operational in
8 nature, and so therefore, the question was is
9 there a need for this to go. So it wasn't
10 questioning whether the department had a right
11 to have that information, but it was sort of
12 "okay, why are you asking that kind of a
13 question? Is there something we need to know
14 about it? What is it that you're really
15 looking for?" Those kinds of things.
16 CHAYTOR, Q.C.:
17 Q. So at what level was the concern? At what
18 level or who was the information flowing to
19 and from?
20 MS. JONES:
21 A. All parts of the organization and then we
22 would hear executives say, "oh, I didn't know
23 that that was at the Department or that they
24 were asking those questions." So that was
25 part of it.

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1 CHAYTOR, Q.C.:
2 Q. And specifically dealing with the issue we
3 have here, the ER/PR issue, what concerns were
4 identified as to the information flow going
5 from Eastern Health to the Department?
6 MS. JONES:
7 A. I can't speak to that because I wasn't sitting
8 in the CEO role and I really didn't have a
9 part to play in the ER role. So what
10 information was going back and forth around
11 ER/PR, I can't speak to that.
12 CHAYTOR, Q.C.:
13 Q. It's an issue that lands in your lap early in
14 July 2007.
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. And one of the concerns that's expressed to
19 you, giving rise to tension between the
20 Department and Eastern Health, I take it, is
21 the fact that there was information coming to
22 the Department at levels that perhaps it
23 shouldn't be, or the Department was requesting
24 information at levels that perhaps it
25 shouldn't have been. Is that what I'm

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1 understanding you to say?
2 MS. JONES:
3 A. I think that when I took over in July 9th of
4 2007, the biggest issue that was on our plate
5 at that time, the immediate issue, was Burin
6 Radiology.
7 CHAYTOR, Q.C.:
8 Q. Yes.
9 MS. JONES:
10 A. Okay, so not that I want to speak about Burin
11 radiology inside of this forum, but I think
12 that that gives you some sense because we were
13 already named with the Commission of Inquiry
14 and a lot of the mechanics of the Commission
15 of Inquiry were there. So there was not a lot
16 of requests for information, except for what
17 I'd alluded to, a list of documents that the
18 Department wanted to start to prepare itself
19 for. So really ER/PR was not part of my
20 discussion with the Department, except to the
21 tune of the information which came a little
22 bit later. What I can say is as we went in--
23 as I took on the job, there was very much, in
24 terms of the Burin radiology, a request for
25 Eastern Health to want to be out there

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1 immediately to talk about what the issue was
2 with Burin radiology. You know that we had an
3 issue as well with database on that particular
4 one. We were not convinced that we had a full
5 database. We knew we didn't have a full
6 database and there was--the Board chair was
7 dealing with the Minister, who wanted us to be
8 out early to talk to the public, and we
9 weren't prepared to be out early talking to
10 the public because we didn't know what the
11 issue was. All we could say is "we don't know
12 what the issue is. We do have"--and it was
13 two days. It was Wednesday by the time I had
14 gotten out. So there was discussions that
15 were going on between the Minister and the
16 Board chair, so that's fine, that's where the
17 issue needs to happen, and then there was
18 discussion with "when are you going out with--
19 Mr. Tilley has left. The media are picking it
20 up that it's on Burin radiology, and you need
21 to be out there," and in a new job, in a new
22 day, for me, I hadn't had a handle on that and
23 I wasn't prepared to be out in the media on
24 the Monday or even the Tuesday. We were out
25 on the Wednesday and we basically say "when

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1 we--you know that we have an issue here.
2 We're trying to reread all of the Burin
3 radiology. We have people working on it, and
4 soon as we have something absolute that we can
5 tell you and give you a good handle about
6 what's going on." So that's what I talk about
7 when I say what I was feeling in the first day
8 or so, but it was not on ER/PR because the
9 issue was the Burin radiology.
10 When we did talk on the 19th of the
11 month, it very much--the Burin radiology, we
12 had taken care of, but on the 19th of the
13 month, it was "where are we going with this
14 database?" and the issue of Eastern Health had
15 wanted to move forward with a database. It
16 was clear that the decision between the CEO
17 and Robert Thompson at the time was that NLCHI
18 would move forward on that. So how are we, as
19 an organization, going to work together so
20 that we can complement one another, that you
21 get what you need out of it and we get what we
22 need out of it.
23 CHAYTOR, Q.C.:
24 Q. And I'll get to that meeting in a moment.
25 Just a couple of things on what you've said to

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1 us there, in terms of the approach of Eastern
2 Health on the Burin radiology issue.
3 MS. JONES:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. And you indicated that you certainly had the
7 Minister saying that the Minister wanted you
8 to be out there in the public?
9 MS. JONES:
10 A. The Department wanted us to be out there in
11 the public.
12 CHAYTOR, Q.C.:
13 Q. And did I understand though that the issue had
14 already become a public issue at that point in
15 time?
16 MS. JONES:
17 A. There was--I do know that there was press
18 releases ready to probably go on the 6th,
19 which would have been a Friday. I wouldn't
20 have been aware of any of that and they had
21 wanted to move those out, which is--there was
22 -
23 CHAYTOR, Q.C.:
24 Q. You were saying in your answer though, you
25 said that it was indicated to you that the

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1 media were already aware of the issue.
2 MS. JONES:
3 A. Of the Burin radiology issue, yeah.
4 CHAYTOR, Q.C.:
5 Q. So I'm just wondering if there was a different
6 position taken -
7 MS. JONES:
8 A. They were trying to -
9 CHAYTOR, Q.C.:
10 Q. - by Eastern Health--different position taken
11 by Eastern Health in going forward on the
12 Burin radiology issue, going public, I should
13 say, as opposed to on the ER/PR? But what I'm
14 hearing you say is that, no, the media were
15 already aware as well of the Burin radiology
16 before Eastern Health went out?
17 MS. JONES:
18 A. That's right, and Burin radiology had started
19 in June. So, you know, there was--the
20 Minister had indicated that we would do the
21 work in two weeks, okay, and complete the work
22 and that, and we were working our way through
23 that. So as a Burin radiology issue, in terms
24 of the work and updating in terms of that,
25 that all happened prior to my day, but on the

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1 9th of July, with Mr. Tilley's resignation,
2 there was suspicion that it was around the
3 work on the Burin radiology.
4 CHAYTOR, Q.C.:
5 Q. So was the issue already in the media prior to
6 Eastern Health going forward with this press
7 release?
8 MS. JONES:
9 A. I do believe, but not to the extent or the
10 numbers that we were talking about.
11 CHAYTOR, Q.C.:
12 Q. And why is it that the Department then was
13 pushing you to get out there and -
14 MS. JONES:
15 A. You'll have to ask the Department on that. I
16 was a new CEO at the time. It was very clear
17 I wasn't prepared to be out there on the date
18 of a CEO that had resigned. I had just
19 started. I was not familiar with that
20 particular file.
21 CHAYTOR, Q.C.:
22 Q. And who did you have discussions with on that?
23 MS. JONES:
24 A. I had discussions with the Board chair on
25 that, as well as with the Department, and the

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1 Department would have been--it would have been
2 with the Deputy Minister at the time.
3 CHAYTOR, Q.C.:
4 Q. So if I could just come back to the
5 information flow on the ER/PR issue. Your
6 understanding on that, or any concerns
7 regarding the information flow, that comes out
8 of the July 19th meeting, is when you first
9 become aware that there were issues on
10 information flow on the ER/PR issue?
11 MS. JONES:
12 A. I'm not--that's not my--my issue on the 19th
13 was a database issue. So it was not on how
14 information was going in or out on ER/PR. It
15 was how information inside the entire
16 organization, regardless of what file, was
17 being requested at different levels in the
18 organization and that, in fact, if it was
19 being requested, please respect a process of
20 coming into the organization at a certain
21 level. If there's information, we will get it
22 for you, and we will pass it on. But that
23 kind of information.
24 CHAYTOR, Q.C.:
25 Q. So did I misunderstand when then--I understood

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1 that you did become aware that there were
2 concerns about the flow of information on the
3 ER/PR issue and the levels and that executive,
4 for instance, you said had not--and the senior
5 team had not been aware that there was
6 information flowing.
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. I understood that to be what had happened in
11 the past.
12 MS. JONES:
13 A. In the past.
14 CHAYTOR, Q.C.:
15 Q. So when did that come to your attention and
16 how?
17 MS. JONES:
18 A. I think all through the file, and particularly
19 as you go through the May and the Commission
20 of Inquiry and that. I wouldn't--like I say,
21 I didn't have the file. I had nothing to do
22 with it, but it was, oh, in through the
23 communication area, requesting things from the
24 Department through the communication people,
25 through communication people, that kind of

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1 issues we were experiencing.
2 CHAYTOR, Q.C.:
3 Q. Okay. So how did that come to your attention?
4 MS. JONES:
5 A. It was just generally people knew that, you
6 know, the communication director had gotten a
7 call on this and needed to respond on this in
8 a particular period of time, and I've
9 experienced that myself, even in the job that
10 I'm in, where a request comes in, maybe it's--
11 maybe it's a complaint or maybe it's something
12 that's coming up in the House, because the
13 House is open now, and they want information
14 so that they're able to brief the minister on
15 particular areas or issues.
16 CHAYTOR, Q.C.:
17 Q. Okay, so a specific example would have been
18 the concern that communications were happening
19 at the level of the communications people?
20 MS. JONES:
21 A. Yes, because there were being requests coming
22 in from communications to our communications
23 department to get information on A, B, C or D
24 and to get it to the Department.
25 CHAYTOR, Q.C.:

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1 Q. And so what should be happening is the
2 minister speaks to the Board chair, the deputy
3 minister speaks to the CEO, the ADMs may speak
4 to the -
5 MS. JONES:
6 A. Speak to the COOs.
7 CHAYTOR, Q.C.:
8 Q. - CEOs, and there should not be the
9 communication going on between the
10 communications people, unless somebody out of
11 those -
12 MS. JONES:
13 A. Already has alerted us to say "we're looking
14 for information on--can your communication
15 person and my communication person work
16 together" on whatever it is. So usually the
17 communication people don't have any of that
18 information. It has to come from people that
19 are working in the area, right. The
20 communication people are your communication
21 people, but we were getting lots of requests
22 in from communications to communications
23 around a particular issue.
24 CHAYTOR, Q.C.:
25 Q. And we certainly see in this ER/PR issue, we

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1 see a lot of correspondence along those lines
2 between the communications people.
3 MS. JONES:
4 A. Absolutely.
5 CHAYTOR, Q.C.:
6 Q. So that was determined not to be the
7 appropriate practice?
8 MS. JONES:
9 A. That's not the appropriate practice. The
10 information needs to come from the people
11 working in the area, not the people who were
12 going to help to communicate it.
13 CHAYTOR, Q.C.:
14 Q. And so was it determined, for example, the
15 communications--some communications from Susan
16 Bonnell, there was communications from Deborah
17 Pennell, was it determined that those had been
18 done without the prior approval or knowledge
19 of the appropriate executive or senior team
20 member?
21 MS. JONES:
22 A. I can't speak to the individual pieces of
23 communication, but it would have been that
24 they would not have had that knowledge, okay,
25 so they would have had to go some place to get

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1 that knowledge, because they do not know all
2 aspects of the organization.
3 CHAYTOR, Q.C.:
4 Q. Because I take it that the communication is
5 only, inappropriate or not, in keeping with
6 your practice or standard, if it has not been
7 approved by an executive person or a senior
8 management person.
9 MS. JONES:
10 A. And knowing what would be going back and
11 forth.
12 CHAYTOR, Q.C.:
13 Q. That there would be knowledge at the executive
14 level.
15 MS. JONES:
16 A. Yeah, and you know, at the end of the day,
17 what we would have been clearly saying to
18 people, it's inappropriate for--you know, like
19 if they're saying "I'm calling on behalf of,
20 because Moira Hennessey or Robert Thompson
21 can't get to you. They're inside of a
22 meeting," that's fine, but you know, it's
23 where are they calling inside the
24 organization.
25 CHAYTOR, Q.C.:

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1 Q. So was it more of a concern that the
2 department was approaching Eastern Health
3 looking for information at a level other than
4 what Eastern Health was comfortable with?
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. It was that concern?
9 MS. JONES:
10 A. It was that, and it was clearly, and the words
11 were used was rules of engagement. If the
12 Minister was going to be speaking to something
13 and wanted something specific, then maybe it
14 was the Board chair or if the Board chair
15 wasn't around then we would find somebody.
16 Lots of times, the staff of the department
17 actually worked with the executive to get
18 issues that may eventually--I would feed my
19 board chair to say "this is an issue. This is
20 what we've talked about with the department,
21 and I know the minister is going forward with
22 this," and you know, "you need to connect."
23 CHAYTOR, Q.C.:
24 Q. And rules of engagement, is that -
25 MS. JONES:

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1 A. That's just a word -
2 CHAYTOR, Q.C.:
3 Q. Whose term was that? Whose term, is that the
4 department?
5 MS. JONES:
6 A. That was Joan Dawe's.
7 CHAYTOR, Q.C.:
8 Q. That was Joan Dawe's?
9 MS. JONES:
10 A. That's Joan Dawe's word and it happened that
11 we used that word and we also brought it
12 inside the Newfoundland and Labrador Health
13 Board's Association when we had discussions
14 with the minister when the board chairs and
15 the CEOs, because he comes in on a regular
16 basis to have discussion.
17 CHAYTOR, Q.C.:
18 Q. And did Mrs. Dawe use that term specifically
19 in this case?
20 MS. JONES:
21 A. Yes, it's the term we've used.
22 CHAYTOR, Q.C.:
23 Q. So she took hold of this issue and felt
24 strongly that this had to happen?
25 MS. JONES:

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1 A. Yes, absolutely.
2 CHAYTOR, Q.C.:
3 Q. And okay, so in terms of now the
4 communications between Eastern Health and the
5 Department, are you satisfied that the
6 communications are taking place at the
7 appropriate levels?
8 MS. JONES:
9 A. There are times when we do get calls
10 inappropriately into, but we will follow up
11 when we know about that. They will--we have
12 some new people and that they always look to
13 us to get information, but if it's a call that
14 I felt that I should have gotten or a COO
15 should have gotten, we will make a call back
16 to the department and say "really, you should
17 have made that phone call into us. We'll get
18 you that information. That's not a problem."
19 But it becomes a courtesy piece.
20 CHAYTOR, Q.C.:
21 Q. Who's your current director of communications?
22 MS. JONES:
23 A. We have Dianne Hart.
24 CHAYTOR, Q.C.:
25 Q. And when did Ms. Hart take the position?

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1 MS. JONES:
2 A. She came in this position--we split
3 communications into an internal and external
4 communications and Dianne came on board in
5 February.
6 CHAYTOR, Q.C.:
7 Q. And which is she responsible for?
8 MS. JONES:
9 A. She's responsible for external communications.
10 CHAYTOR, Q.C.:
11 Q. And who's responsible for internal?
12 MS. JONES:
13 A. Susan Bonnell.
14 CHAYTOR, Q.C.:
15 Q. And that means within the organization?
16 MS. JONES:
17 A. Within the organization and the work that
18 needs to be done there.
19 CHAYTOR, Q.C.:
20 Q. Okay, and so you have two directors of
21 communications?
22 MS. JONES:
23 A. We have two directors of communications, one
24 for internal and one for external right now.
25 CHAYTOR, Q.C.:

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1 Q. And external would include communications with
2 the Department?
3 MS. JONES:
4 A. With the department and taking on the public
5 relations and the interface with the media.
6 CHAYTOR, Q.C.:
7 Q. And other stakeholders, I take it as well?
8 MS. JONES:
9 A. And other stakeholders.
10 CHAYTOR, Q.C.:
11 Q. And internal would be just within your
12 organization?
13 MS. JONES:
14 A. Yes, and we're currently going through a
15 process of what are the most appropriate
16 vehicles for communicating with our 12,000
17 staff.
18 CHAYTOR, Q.C.:
19 Q. And was that decision to make the change, in
20 terms of breaking that role down into two
21 pieces, was that at all related to the
22 handling of the ER/PR issue?
23 MS. JONES:
24 A. Not the handling of the ER/PR issue as and
25 under resourcing in our communications

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1 department and we had spent very little time
2 and energy on internal communications. We
3 have a staff of 12,000 people who we had heard
4 from them clearly that they were not knowing
5 what was going on inside of Eastern Health. So
6 in the fall of this year, when we did some
7 budget allocations to try to strengthen up a
8 number of areas in the organization, human
9 resources being one of it, communications was
10 another. That's when we made the decision to
11 make that split.
12 CHAYTOR, Q.C.:
13 Q. And internal communications, that would be
14 more of a human resources position I would
15 think.
16 MS. JONES:
17 A. Not necessarily. We have a lot of website
18 development. We have some focus groups going
19 on now to find out how staff want to be
20 communicated with. We have internal
21 publications, all of those kinds of things.
22 So yes, there would be a part of engaging our
23 workforce in it, but that wouldn't be the
24 whole focus of that particular role.
25 CHAYTOR, Q.C.:

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1 Q. And so your website for internal
2 communications, that would be your intranet I
3 take it?
4 MS. JONES:
5 A. Intranet, yes.
6 CHAYTOR, Q.C.:
7 Q. At the time that you assumed the position that
8 you're in now, who did you understand, at that
9 point in time, was managing the ER/PR issue
10 within Eastern Health?
11 MS. JONES:
12 A. On a lab side, it would have been Dr. Howell,
13 and then on a quality side, for things that
14 were anything left there, Pat Pilgrim had the
15 quality portfolio at that time.
16 CHAYTOR, Q.C.:
17 Q. And we've talked -
18 MS. JONES:
19 A. So there wasn't a single person managing the
20 ER/PR issue.
21 CHAYTOR, Q.C.:
22 Q. And we talked a lot about the situation that
23 you found, in terms of the relationship with
24 the department, was there one particular
25 person in the department who seemed to be

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1 managing the issue?
2 MS. JONES:
3 A. No, not that I'm aware of.
4 CHAYTOR, Q.C.:
5 Q. Were you finding, when you first took on the
6 role, that there was a lot of direction coming
7 from the department or a lot more--I don't
8 want to use the word "interference", but a lot
9 more frequency of contact with the department
10 than had been the case in the past?
11 MS. JONES:
12 A. I have no idea in terms of the CEO role, what
13 direction was coming. I do know very clearly
14 that right--the very first day when we were
15 having the discussion about wanting Eastern
16 Health to go out in the media on the Burin
17 radiology, I said it won't happen and I
18 remember Dr. Howell being in my office,
19 because at that point in time I was not fully
20 aware of the issue and we had executive down
21 in--I had executive pulled together for the
22 afternoon and I remember going down the
23 corridor and saying, "well, I guess my day as
24 CEO has just ended" because I said, I'm not in
25 a position, because I don't know the

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1 information to be able to get out there. So I
2 said, one day as a CEO. Okay, very good, I'll
3 go back to my old job. But we started off
4 with a very clear, that yes, the department
5 and ourselves, we could discuss it, but at the
6 end of the day, if it was operational issues
7 and that, that we move forward. There was
8 that issue of public disclosure and there's no
9 question about that, but at that point in time
10 I didn't know what this issue was about and
11 having your CEO out there, again like in ER/PR
12 where we had database issues, we had database
13 issues with Burin radiology. That was not
14 where I knew the board would want us to be at
15 that point in time. They would have wanted us
16 to be much more assured about what it is and
17 how we were moving forward.
18 CHAYTOR, Q.C.:
19 Q. Ms. Jones, so I take it from that answer that
20 if there were to be any crossing over the line
21 by the department, you set the ground rules
22 from day one and said here's--and pushed back
23 to the extent that you felt you needed to?
24 MS. JONES:
25 A. And remember, I was new in the role, I had not

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1 known what had gone on before and I was
2 dealing with a number of files that were on
3 the desk that I needed to have some sense of
4 what they were before I would even make a
5 decision about what I would do.
6 CHAYTOR, Q.C.:
7 Q. Was there any change from your perspective in
8 the relationship between Eastern Health and
9 the department when the new legislation was
10 proclaimed April 1st of this year? Did that
11 impact how things were carried out at all?
12 MS. JONES:
13 A. No, because we were operating under the
14 assumption that the Regional Health
15 Authorities Act was already in place, so
16 coming in place as of April 1, really, from an
17 operational perspective and dealing with the
18 department was not the issue. And there is
19 one piece in that legislation that says the
20 minister has a right to information that I was
21 aware of, as I read the Act, as I'm getting my
22 self in tune with being the CEO and going
23 through those legislations. So very early on,
24 there is a piece in that Act that says
25 information can flow through to the

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1 department.
2 CHAYTOR, Q.C.:
3 Q. So if the deputy minister or the minister were
4 to provide you with a direction -
5 MS. JONES:
6 A. Uh-hm.
7 CHAYTOR, Q.C.:
8 Q. For example, a direction in terms of public
9 disclosure on a health issue, would you feel
10 obligated to comply?
11 MS. JONES:
12 A. I would have discussion--depending on what the
13 issue was, if I agreed with it, and you know,
14 it would have been an area that we would have
15 been going in, then it wouldn't have been an
16 issue, we probably would have been out there
17 before we have that. If there was something
18 around that, then I would have talked to the
19 board chair.
20 CHAYTOR, Q.C.:
21 Q. So is it your understanding that there's room
22 to negotiate? If you're given a direction and
23 told -
24 MS. JONES:
25 A. You don't generally get direction. I have not

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1 experienced that, there was discussion around
2 -
3 CHAYTOR, Q.C.:
4 Q. No, not what has happened, just your
5 understanding of what the lines of authority
6 are right now and keeping in mind the
7 legislation.
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Can the deputy minister or minister give you
12 direction to do something?
13 MS. JONES:
14 A. The minister would not be giving me direction.
15 I would be having discussions with the deputy
16 minister, but the decision to move forward on
17 a particular issue would be a board issue. If
18 there was a difference, then it would be the
19 board chair who would be talking to the
20 minister.
21 CHAYTOR, Q.C.:
22 Q. So if there were a difference in how you
23 thought the matter should be handled, you
24 would go to your board chair?
25 MS. JONES:

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1 A. I would go to the board chair.
2 CHAYTOR, Q.C.:
3 Q. And you would take direction from your board
4 chair?
5 MS. JONES:
6 A. Absolutely.
7 CHAYTOR, Q.C.:
8 Q. If we could have P-0702 please? And this is
9 correspondence, Ms. Jones, it's written to Mr.
10 Tilley, June 29th, 2007.
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. And I think, however, that you are the person
15 who ends up replying to the correspondence on
16 July 23rd, 2007.
17 MS. JONES:
18 A. That's right.
19 CHAYTOR, Q.C.:
20 Q. That's on the second page of the exhibit.
21 MS. JONES:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. So if we just look at this letter, Mr.
25 Thompson is advising that he's recently been

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1 appointed to assume the role as secretary to
2 Cabinet for the management of health issues
3 and in this position, "I will assume
4 responsibility for preparing the provincial
5 government and health system for full and open
6 participation in the Commission of Inquiry."
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And he's also to chair a task force on the
11 management of adverse health events. And in
12 the third paragraph, "At this point, I am
13 asking you as well to collect and send to me
14 copies of all documents from your records in
15 the following categories related to ER/PR
16 testing between 1997 and 2005:
17 correspondence, e-mails, reports, briefing
18 notes, presentations, press releases and
19 backgrounders. Please forward these
20 documents"--then he goes on to say who to send
21 the documents to and that it's to be
22 comprehensive in respect of all employees who
23 had been involved.
24 MS. JONES:
25 A. Uh-hm.

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1 CHAYTOR, Q.C.:
2 Q. Why did you understand that Mr. Thompson was
3 asking Eastern Health to forward all its
4 documentation on the ER/PR issue to the
5 department?
6 MS. JONES:
7 A. It was, in Robert's words, it was to prepare
8 the department for open and full disclosure
9 with the Commission of Inquiry. So that was
10 the words that he would have used and this was
11 written to George, so I'm not sure at what
12 kind of conversation would have happened with
13 George, but when we met on the 19th, this is
14 very--George had already started to collect,
15 probably long before this, information to
16 house it in a single--in the corporate office.
17 So I don't know if there had been discussion
18 earlier with this, but it was to prepare the
19 department, was the words that Robert used,
20 for the Commission of Inquiry.
21 CHAYTOR, Q.C.:
22 Q. Why would the department need Eastern Health's
23 documentation to do that?
24 MS. JONES:
25 A. I have no idea and that would have been one of

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1 the questions that I would have asked and then
2 I went to the Regional Health Authorities Act
3 and found that in the new Regional Health
4 Authorities Act, albeit not proclaimed at the
5 time, it was any information. So a number of
6 this, pieces of presentations and that, you
7 also heard me reference because this is very
8 wide ranging. We were collecting some things
9 and then when Mr. Simmons came on, we said,
10 okay, let's--we are preparing ourselves for
11 the inquiry as well, so let's get a vehicle
12 and find a vehicle to work through so that
13 information can go through to the department,
14 as well as forwarding to yourselves.
15 CHAYTOR, Q.C.:
16 Q. So I take it that you did have some concerns,
17 you asked the question why.
18 MS. JONES:
19 A. Oh yes, yeah.
20 CHAYTOR, Q.C.:
21 Q. And to the point where you checked the
22 legislation to see if you had to in fact
23 comply with the request.
24 MS. JONES:
25 A. That's right. Because I was not aware that we

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1 were sending information to that extent to the
2 department, and when we looked at the list of
3 information that Mr. Thompson was wanting to
4 see, the list included some things such as
5 quality assurance programs for a period of
6 time and all of that kind of stuff, and that
7 would not normally be kinds of things that the
8 department would have been looking for. So no
9 problem with open disclosure, no problem with
10 preparing information, but we wanted to make
11 sure that that was what we should be doing.
12 CHAYTOR, Q.C.:
13 Q. And so you complied with the request, I take
14 it, and you sent -
15 MS. JONES:
16 A. Over time.
17 CHAYTOR, Q.C.:
18 Q. - all the documentation regarding this issue
19 to the department.
20 MS. JONES:
21 A. To the department, right, and we sent it
22 through our lawyers.
23 CHAYTOR, Q.C.:
24 Q. To us as well, of course.
25 MS. JONES:

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1 A. Yes, that's right.
2 CHAYTOR, Q.C.:
3 Q. You're under summons to do it here.
4 MS. JONES:
5 A. Uh-hm. Under the Regional Health Authorities
6 Act -
7 CHAYTOR, Q.C.:
8 Q. Legislative mandate you're interpreting to
9 having to do it for the department.
10 MS. JONES:
11 A. Yes, which was new. I checked the old
12 Regional Health Authorities Act and that
13 provision was in it.
14 CHAYTOR, Q.C.:
15 Q. The old Hospitals Act.
16 MS. JONES:
17 A. The old Hospitals Act. That provision wasn't
18 in the old Hospitals that I could clearly see,
19 but it was clearly listed in the new Regional
20 Health Authority Act.
21 CHAYTOR, Q.C.:
22 Q. And July 23rd, 2007, then we have your
23 response.
24 MS. JONES:
25 A. Uh-hm.

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1 CHAYTOR, Q.C.:
2 Q. And it's clearly a follow up to the letter of
3 June 29th, 2007 and your conversation of July
4 19th and I'll speak to you about more detail
5 on the meeting that you had on that date. "As
6 per our discussion of July 19th, 2007, your
7 request was not actioned until late last week
8 and the organization is now in the process of
9 collecting all documentation inside of Eastern
10 Health with respect to ER/PR. Our solicitor
11 for the judicial inquiry, Mr. Dan Simmons, has
12 indicated that prior to these documents being
13 transferred to the department, he wishes to
14 have a discussion with the department
15 solicitor to address a number of issues
16 associated with the transfer of documents."
17 MS. JONES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. So basically at this point in time, I take it
21 you're telling Mr. Thompson that we're going
22 to leave it in the hands of the solicitors?
23 MS. JONES:
24 A. Yes, you know, we will gather all the
25 information, you know, just like you didacted

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1 kinds of things, is there things that need to
2 come out of it, solicitor/client privilege,
3 some of these documents may very well have
4 been in that area as well. So we were leaving
5 that to Mr. Simmons and to Pat Pilgrim who was
6 coordinating and sending most of the
7 information to Mr. Simmons.
8 CHAYTOR, Q.C.:
9 Q. You didn't send Mr. Thompson the letter of May
10 30, 2007 that had been intended for Mr.
11 Abbott?
12 MS. JONES:
13 A. No.
14 CHAYTOR, Q.C.:
15 Q. Why did you not send that letter?
16 MS. JONES:
17 A. Because it was never sent and -
18 CHAYTOR, Q.C.:
19 Q. But now he's asking for anything relevant.
20 MS. JONES:
21 A. But what was and I think I clearly said it
22 yesterday, they were peer review reports.
23 CHAYTOR, Q.C.:
24 Q. Yes, but the letter itself.
25 CHAYTOR, Q.C.:

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1 Q. I never even thought of that particular letter
2 as going because the attachment--there was
3 obviously some discussion between John Abbott
4 and that and the attachments were peer review
5 and that was not to go forward, in my
6 estimation.
7 CHAYTOR, Q.C.:
8 Q. What answer did Mr. Thompson give you other
9 than, well, the legislation requires you to -
10 MS. JONES:
11 A. He didn't use -
12 CHAYTOR, Q.C.:
13 Q. He didn't say that?
14 MS. JONES:
15 A. He did not say that.
16 CHAYTOR, Q.C.:
17 Q. But you satisfied yourself -
18 MS. JONES:
19 A. I satisfied myself.
20 CHAYTOR, Q.C.:
21 Q. Okay. What reason did Mr. Thompson give you
22 in terms of being open and transparent in the
23 process, why would he need Eastern Health's
24 documentation?
25 MS. JONES:

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1 A. I have no idea. You need to ask Robert. I'm
2 sure that he was probably asking other regions
3 as well what was -
4 CHAYTOR, Q.C.:
5 Q. To do the same thing?
6 MS. JONES:
7 A. To do the same thing, but that will be a
8 discussion that you will have to have with
9 Robert. In my instance, -
10 CHAYTOR, Q.C.:
11 Q. So, he didn't explain that to you.
12 MS. JONES:
13 A. No, it was really just to prepare the
14 government for open disclosure inside the
15 Commission of Inquiry. And you also know at
16 that particular point in time, he was taking
17 on the responsibility through the Centre for
18 Health Information to develop the database.
19 CHAYTOR, Q.C.:
20 Q. But of course, all the e-mails from your
21 employees and that documentation wouldn't
22 necessarily be necessary for the database?
23 MS. JONES:
24 A. No, that's right.
25 CHAYTOR, Q.C.:

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1 Q. It's much broader than that.
2 MS. JONES:
3 A. And we didn't have--if you--the original
4 letter also referenced a task force on adverse
5 events. We didn't have any terms of reference
6 for that task force. And we didn't know at
7 that point in time and not until well into,
8 just recently, what the mandate was and if it
9 had any power behind it, legislative power, to
10 be able to get documentation from the various
11 regional health authorities.
12 CHAYTOR, Q.C.:
13 Q. Okay. If we could have P-0488, please, page
14 65. And if we scroll down here, Ms. Jones.
15 MS. JONES:
16 A. This is in September.
17 CHAYTOR, Q.C.:
18 Q. I'm sorry, yes, the date is September 19,
19 2007.
20 MS. JONES:
21 A. This fall, okay, that's fine.
22 CHAYTOR, Q.C.:
23 Q. And you are, of course, the interim president
24 and you're present. Ms. Pilgrim who's been
25 charged with the ER/PR issue and dealing with

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1 the Inquiry, I understand.
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And Dr. Howell.
6 MS. JONES:
7 A. Uh-hm.
8 CHAYTOR, Q.C.:
9 Q. So, normal people are in attendance.
10 MS. JONES:
11 A. Okay.
12 CHAYTOR, Q.C.:
13 Q. So, under 2.2 we have the judicial inquiry,
14 ER/PR and PP, I take it, stands for Pat
15 Pilgrim. The organization, the third bullet,
16 I guess the second one, "data collection is
17 ongoing as requested from the Commissioner".
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. The third bullet then is "the organization is
22 seeking clarification on the right of the
23 Department of Health and Community Services to
24 the detailed information being requested to
25 prepare the department for the COI".

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1 Commission of Inquiry, I take it.
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And then it says, "the terms of reference for
6 the task force on management of adverse health
7 events have not yet been released. There is
8 no legislative power at this time that gives
9 the task force or the department the right to
10 receive the information collected specifically
11 for the COI".
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. So, I take it this was an issue as late as
16 September, 2007 being discussed at executive
17 management.
18 MS. JONES:
19 A. Being discussed, we had already had some
20 discussion with Dan, Mr. Pritchard and Dan had
21 some discussion and I was still looking for
22 because we were waiting all fall for what was
23 the task force on adverse events. Even though
24 we were talking about this being ER/PR
25 related, was there any other legislative

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1 mandate that would allow it to go forward.
2 So, there was an agreement between Mr. Simmons
3 and the department that as we forwarded
4 through to the Commission, that they would get
5 it at the same time.
6 CHAYTOR, Q.C.:
7 Q. Okay. So, they would get it the same time the
8 Commission got it and it would be the same
9 documentation.
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. The meeting then that you had July 19, 2007
14 with Mr. Thompson, was there anything else
15 discussed in that meeting?
16 MS. JONES:
17 A. Well, rules of engagement was definitely one
18 of them and the task force on adverse events
19 and the ER/PR database would have been
20 discussed there and as well as Burin radiology
21 and where we were with the current Burin
22 radiology issue. Those definitely would have
23 been four things and there may have been an
24 operational issue, but I can't recall that.
25 But those would have been definitely on the

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1 radar screen and there's probably something in
2 later minutes that said, when I was talking to
3 Robert, these were the things that we talked
4 about.
5 CHAYTOR, Q.C.:
6 Q. Okay. And so in terms of the ER/PR issue, the
7 main focus was the database
8 MS. JONES:
9 A. And the information -
10 CHAYTOR, Q.C.:
11 Q. - and the department's request for this
12 information.
13 MS. JONES:
14 A. Absolutely.
15 CHAYTOR, Q.C.:
16 Q. Okay. Did anyone else attend that meeting?
17 MS. JONES:
18 A. No, that was Robert and myself.
19 CHAYTOR, Q.C.:
20 Q. And if we can have, please, P-0288. Okay,
21 this -
22 MS. JONES:
23 A. First day.
24 CHAYTOR, Q.C.:
25 Q. - your first day, yes. Executive management

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1 meeting July 9, 2007.
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. Was that a pre-scheduled meeting or -
6 MS. JONES:
7 A. No, there had been -
8 CHAYTOR, Q.C.:
9 Q. You gathered the troops together?
10 MS. JONES:
11 A. Well, the board chair and the vice chair met
12 with the executive at 8:30 in the morning and
13 told us about the resignation of Mr. Tilley
14 and we had a fairly frank discussion with the
15 board at that time and then I called the
16 executive management people together for 2:00
17 in the afternoon after I had gotten my head
18 around some things that had to happen that
19 day.
20 CHAYTOR, Q.C.:
21 Q. Fair enough, so this is your first day on the
22 job.
23 MS. JONES:
24 A. Uh-hm.
25 CHAYTOR, Q.C.:

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1 Q. And, of course, it indicates that Louise Jones
2 in her capacity as interim president and CEO
3 chaired the meeting. And under business,
4 board chair discussion with minister of Health
5 and Community Services. "Louise Jones advised
6 that"--Joan Dawe, I'm going to skip the
7 grammatical errors, "Joan Dawe, board chair,
8 contacted the minister requesting a meeting.
9 She provided him with a brief overview of
10 executives' concerns regarding the
11 organization's relationship and lack of
12 partnership with government." What was that
13 referencing?
14 MS. JONES:
15 A. That was referencing the conversation that the
16 board chair and the vice-chair heard in the
17 morning about executive and the rules of
18 engagement and the department requesting
19 information, a lot on an operational nature
20 and feeling that there was direction coming.
21 There was too much going on inside the
22 organization and personally in the COO
23 portfolio that I carried at the time, I didn't
24 have a lot of that, but there was a lot in
25 other portfolios that were getting calls and

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1 feeling as if there was direction being
2 provided and at the end of the day,
3 particularly there was a lot of discussion
4 around the Burin radiology review and the two-
5 week timeframe that was, you know, we did
6 accept it and clearly the organization did
7 accept it, but there was discussion that we
8 knew that it couldn't be done in two weeks,
9 but, you know, we would do our best to deliver
10 on it. So there was those kinds of
11 discussions, so the board very clearly heard,
12 at least the board chair and the vice-chair
13 how we were feeling and how much was going on
14 between the department and various parts of
15 the organization. And then it was, is the
16 government supporting Eastern Health in its
17 efforts to move things forward? Is it a
18 partnership or is it an adversarial role?
19 CHAYTOR, Q.C.:
20 Q. Okay. And if we could have P-0289 please?
21 And two days later another executive
22 management meeting. Was this your regularly
23 scheduled meeting?
24 MS. JONES:
25 A. This is a regularly scheduled meeting, on a

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1 Wednesday.
2 CHAYTOR, Q.C.:
3 Q. And again, of course, you're the interim
4 president and CEO and we have Oscar Howell
5 present and Pat Pilgrim present. And under
6 3.2.1 "Executive meeting with the Board of
7 Trustees. And the board chair offered the
8 executive to meet with the board to voice
9 their concerns directly to the board.
10 Executive declined the offer. Direction for
11 Louise Jones from executive collectively is to
12 continue its past practice and CEO will be the
13 conduit for the board. Louise Jones will
14 express these concerns to the board chair on
15 behalf of executive. On a related note,
16 Louise Jones advised that she will be meeting
17 with the deputy minister, Robert Thompson, so
18 that's your upcoming meeting at July 19th,
19 2007."
20 MS. JONES:
21 A. Uh-hm.
22 CHAYTOR, Q.C.:
23 Q. "Executive is requested to forward to Louise
24 Jones issue for discussion among the issues
25 that will be raised are lack of partnership

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1 with government, judicial inquiry, PR/ER."
2 MS. JONES:
3 A. Uh-hm.
4 CHAYTOR, Q.C.:
5 Q. So I take it those are the same concerns in
6 terms of lack of partnership with government
7 that you've just articulated?
8 MS. JONES:
9 A. Yes, absolutely.
10 CHAYTOR, Q.C.:
11 Q. And what was the issue in terms of the board
12 chair offering the executive to meet with the
13 board, directly.
14 MS. JONES:
15 A. When she met with us on the 9th of July in the
16 morning and had heard those concerns about,
17 you know, how the executive felt, she had not
18 personally heard those in as detailed and she
19 offered the executive the ability to talk to
20 the entire board if they felt the need to, and
21 the executive said, no, the board chair and
22 the vice chair heard our concerns, they're
23 aware of it and if there is the conduit, being
24 that the CEO is the only employee of the
25 board, if there was any other discussion, then

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1 it would happen through me and the board
2 chair.
3 CHAYTOR, Q.C.:
4 Q. And 0290 please? And this is the executive
5 management meeting, July 25th, '07.
6 MS. JONES:
7 A. Yes, uh-hm.
8 CHAYTOR, Q.C.:
9 Q. And this is the summary of your meeting of
10 July 19th.
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. With deputy minister. This says CEOs meeting
15 with deputy minister, "Louise Jones to provide
16 an update on her meeting with deputy minister,
17 Robert Thompson, as follows"--that was
18 discussion as you said of the rules of
19 engagement -
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. - and "an understanding of each other's roles
24 and the need to keep the minister informed."
25 MS. JONES:

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1 A. That's right.
2 CHAYTOR, Q.C.:
3 Q. And what was that about in terms of the need
4 to keep the minister informed?
5 MS. JONES:
6 A. The minister needs to react to things that are
7 happening and that in order to be able to
8 react appropriately, then the department and
9 the minister needs to be able to be in the
10 loop on issues that are going on.
11 CHAYTOR, Q.C.:
12 Q. And it goes on to say "However, there must be
13 processes established whereby information is
14 requested through the executive level within
15 the organization and directed back through the
16 department." And that's what you've just told
17 us about a few moments ago.
18 MS. JONES:
19 A. That's what we've been talking about, yes.
20 CHAYTOR, Q.C.:
21 Q. "Louise Jones went on to explain that the day-
22 to-day communication of the organization is
23 carried out between"--and the levels that
24 you've indicated -
25 MS. JONES:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. "CEO, deputy minister and board chair links
4 directly with the minister. The organization
5 must also strengthen its communication
6 processes by ensuring that a vice president or
7 chief operating officer signs off on document
8 that is forwarded to the department. A formal
9 policy will be developed in this regard and
10 will need to be reinforced at the director's
11 level."
12 MS. JONES:
13 A. Uh-hm.
14 CHAYTOR, Q.C.:
15 Q. So what was the concern in terms of any
16 documentation that was going from Eastern
17 Health to the department?
18 MS. JONES:
19 A. Same as what we've said over the last day, a
20 lot of it may have been operational issues
21 that were in the purview of Eastern Health,
22 some of this may very well have been
23 information that the minister may have wanted
24 to know or needed to know to be able to
25 respond in the public, but, so if there was

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1 any formal documentation and information going
2 out, then we would want to have a sign off on
3 it.
4 CHAYTOR, Q.C.:
5 Q. So in terms of, of course, just the ER/PR
6 issue, are you aware of documentation that
7 went to the department, that there was a
8 concern had not had the appropriate sign off?
9 MS. JONES:
10 A. Prior to me coming, I would not know whether
11 there was information and Mrs. Pilgrim has
12 been managing most of the interactions,
13 particularly with the deputy minister on ER/PR
14 and database and all of those kinds of things,
15 so she's well aware of what's going back and
16 forth.
17 CHAYTOR, Q.C.:
18 Q. Yes, now this was discussed between you and
19 Mr. Thompson, though, on July 19th?
20 MS. JONES:
21 A. Yes, that's right.
22 CHAYTOR, Q.C.:
23 Q. And it was raised, obviously, as a concern.
24 MS. JONES:
25 A. That's right.

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1 CHAYTOR, Q.C.:
2 Q. I'm wondering if any of the documentation that
3 was of concern pertained to the ER/PR issue?
4 MS. JONES:
5 A. It was a generic issue and it wasn't saying
6 ER/PR or Burin radiology or whatever, it was
7 just a generic issue.
8 CHAYTOR, Q.C.:
9 Q. So if there had been such documentation that
10 went forward on the ER/PR issue -
11 MS. JONES:
12 A. It wouldn't have been brought up in this
13 meeting because it was a general -
14 CHAYTOR, Q.C.:
15 Q. But if there had been, Ms. Pilgrim would know
16 and she has not told you of that?
17 MS. JONES:
18 A. That's right and this is only three weeks into
19 a mandate.
20 CHAYTOR, Q.C.:
21 Q. But to this day, you're not aware of whether
22 or not there was documentation that was of
23 concern with respect to the ER/PR issue that
24 went to the department without appropriate
25 sign off?

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1 MS. JONES:
2 A. Not since July and anything that we had that
3 was going from an ER/PR perspective, went
4 through Mr. Simmons.
5 CHAYTOR, Q.C.:
6 Q. And a formal policy is to be developed. Has
7 that happened?
8 MS. JONES:
9 A. I can't absolutely say whether that formal
10 policy, but we sure did have discussion with
11 the senior executive and that may very well be
12 still in process, I can check on that for you
13 though.
14 CHAYTOR, Q.C.:
15 Q. Okay. "There was a brief discussion it says
16 on the Transparency and Accountability Act and
17 the minister's accountability to the public
18 for the health system with a recognition that
19 sometimes there will be a crossover."
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. What was that about?
24 MS. JONES:
25 A. That would have been, again, keeping the

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1 minister informed. Okay, sometimes it may end
2 up being operational issues, but we would have
3 to make a judgment call at that point in time.
4 CHAYTOR, Q.C.:
5 Q. So I just want to, you know, understand was
6 what was being said that, well, yes, we
7 understand that there are roles for everybody
8 to play here, but Ms. Jones, at the end of the
9 day, the minister, under the legislation, is
10 accountable to the public for the health
11 system?
12 MS. JONES:
13 A. That's exactly what that says and that even
14 though we're accountable for the delivering of
15 the service and accountable for that service,
16 that there may be times when there is a
17 crossover that information that we would
18 believe are very operational in nature would
19 have to be at the department and we would deal
20 with those on an individual basis.
21 CHAYTOR, Q.C.:
22 Q. So what the department was saying is that yes,
23 while we may have well defined roles and more
24 so once the legislation is proclaimed, even
25 though you're acting under the legislation,

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1 the minister at the end of the day wants to be
2 kept informed, because we read this also in
3 the context of the -
4 MS. JONES:
5 A. Absolutely.
6 CHAYTOR, Q.C.:
7 Q. - of the note previously, saying about keeping
8 the minister informed.
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. So the message you were getting from Mr.
13 Thompson is that at the end of the day, the
14 buck stops with the minister -
15 MS. JONES:
16 A. The minister.
17 CHAYTOR, Q.C.:
18 Q. And the minister wants to be well informed.
19 MS. JONES:
20 A. And it's a style issue and the minister has
21 been very clear with talking to the CEOs that
22 he needs more information than probably other
23 ministers would need, so that is part of his
24 accountability, he needs to understand. So we
25 respect that and whenever we've been asked for

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1 information, we have moved forward, but we've
2 always asked the question around the
3 operational piece.
4 CHAYTOR, Q.C.:
5 Q. And so on a go-forward basis, that has been
6 the practice?
7 MS. JONES:
8 A. That has been the practice.
9 CHAYTOR, Q.C.:
10 Q. And that if there has been an error, you err
11 on the side of providing too much, as opposed
12 to too little?
13 MS. JONES:
14 A. What we do is that if in fact there is
15 information that the minister is looking for,
16 and I will bring the board chair into that
17 discussion or other board members if the board
18 chair is not available. So in that instance,
19 we always will make that connection between
20 chair or board, as well as on the operational
21 CEO/DM level.
22 CHAYTOR, Q.C.:
23 Q. And the next bullet says "there was a brief
24 discussion on the"--and I take it that should
25 be the "Regional Health Authorities Act" -

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1 MS. JONES:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. "And their request for feedback."
5 MS. JONES:
6 A. That one was particularly in relation to the
7 Act and the Regulations because in the
8 Regulations we had been having some discussion
9 around the schedules that were attached and in
10 the Regional Health Authorities Act, there it
11 talks about the Regional Health Authority
12 having responsibility for long-term care and
13 where we have a relationship, a contract
14 relationship with the nursing homes in St.
15 John's and in Clarke's Beach, there was some
16 question because it was in a schedule in a
17 certain way whether in fact, who was
18 accountable for the delivery of long-term care
19 services. So there was discussion with the
20 department around that aspect of the schedules
21 and the regulations in relationship to the Act
22 and what was said in the Act around who has
23 responsibility, overall accountability for
24 long-term care.
25 CHAYTOR, Q.C.:

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1 Q. Okay, so it was limited to long-term care, as
2 opposed to acute care?
3 MS. JONES:
4 A. Yes, that's right.
5 CHAYTOR, Q.C.:
6 Q. And you also had a brief discussion on the
7 task force and adverse health events and the
8 sharing of information through that process?
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. So other than that, anything else, any other
13 recollection as to what was discussed between
14 you and Mr. -
15 MS. JONES:
16 A. That's fairly contemporary, that's a week, so
17 you know, we might have missed a point in
18 terms of capturing it, but that was the main
19 thrust of what executive needed to know.
20 CHAYTOR, Q.C.:
21 Q. Okay, and I'll just keep them open because the
22 next thing I wanted to cover with you is the
23 ATIPP request.
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Perhaps then Commissioner, before we get into
3 that, this would be a convenient time to take
4 the morning break.
5 THE COMMISSIONER:
6 Q. All right then, we'll take fifteen minutes.
7 (RECESS)
8 THE COMMISSIONER:
9 Q. Please be seated. Ms. Chaytor?
10 CHAYTOR, Q.C.:
11 Q. Thank you, Commissioner. Ms. Jones, when we
12 left, I was going to turn to a request from
13 ATIPP that was received or I should say, an
14 ATIPP request that Mark Quinn made with
15 respect to the ER/PR issue in July of 2007.
16 MS. JONES:
17 A. Uh-hm.
18 CHAYTOR, Q.C.:
19 Q. Or at least the response to it goes out in
20 July of 2007. And first I'll refer to,
21 please, P-0709. Now, Ms. Jones, this is your
22 correspondence to Mr. Mark Quinn of Canadian
23 Broadcasting Corporation, July 13th, 2007.
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Signed by you.
3 MS. JONES:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. And it's copied to Mr. Philip Wall, the
7 information and privacy commissioner.
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Perhaps you could give us the background to
12 this issue, why was the privacy commissioner
13 involved?
14 MS. JONES:
15 A. This was a request that had come in, as you
16 can see in the 15th of February and Eastern
17 Health, at that point in time, had denied the
18 request based upon the fact that there were
19 individual patient results that they were
20 looking for and there had been an appeal to
21 the privacy commissioner and we had gotten a
22 ruling from the privacy commissioner and
23 actually the content of that is down here,
24 that says that we were to provide the
25 applicant with a copy of the identified

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1 information.
2 CHAYTOR, Q.C.:
3 Q. So Mr. Quinn was looking--you're confirming in
4 your letter to him that on February 15th,
5 2007, Eastern Health received the request. He
6 was looking for the results from the hormone
7 receptor tests -
8 MS. JONES:
9 A. That's right.
10 CHAYTOR, Q.C.:
11 Q. In the province, sent for retesting from 1997
12 to the present and he was requesting the
13 original result of the first tests, as well as
14 the result of each retest.
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. He was also looking for the percentage changes
19 that were found.
20 MS. JONES:
21 A. Uh-hm.
22 CHAYTOR, Q.C.:
23 Q. And in each case what percentage of hormone
24 receptor positivity did the original test show
25 and what results did the retests find. And,

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1 of course, he says he does not request the
2 names of patients or any information.
3 MS. JONES:
4 A. That's right.
5 CHAYTOR, Q.C.:
6 Q. So when that request first came in, in
7 February of 2007, Eastern Health denied the
8 request.
9 MS. JONES:
10 A. They did.
11 CHAYTOR, Q.C.:
12 Q. Okay, and what was the basis for that?
13 MS. JONES:
14 A. Because even though he says he's not looking
15 for patient names, there was a sense that it's
16 health information, it was personal
17 information and there was discussion that if
18 he had--I don't say conventional wisdom, but
19 if there are two pieces of information about a
20 person known, then generally if you can find a
21 third piece, then you would be able to
22 identify that person personally, and so that
23 was part of it. So it was health information
24 that he was requesting and there was lots of
25 discussion about health information and

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1 whether that was protected and should continue
2 to be protected because it was individual
3 patient information, as well as the potential,
4 especially in a province like Newfoundland,
5 with two pieces or two data points to be able
6 to connect to an individual patient.
7 CHAYTOR, Q.C.:
8 Q. So if he had the original ER/PR test -
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. And the Mount Sinai's retest result -
13 MS. JONES:
14 A. And you already had the fact that somebody was
15 known to be a breast cancer patient, then
16 there's lots of discussion around how that
17 eventually may be able to link to an
18 individual patient result.
19 CHAYTOR, Q.C.:
20 Q. Yes, that's what I'm wondering, how if I know
21 someone's original ER/PR test result, then
22 their retest result, how that could ever lead
23 to the person's identification, it's two
24 numbers.
25 MS. JONES:

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1 A. Well you will need to talk to researchers and
2 that but they all--there was a conventional -
3 CHAYTOR, Q.C.:
4 Q. So who was giving Eastern Health that advice?
5 MS. JONES:
6 A. I don't know because I wasn't involved in this
7 at the time, but that was the information that
8 I was dealing with when I ended up having to
9 reply to this in the first week of being on my
10 desk, right.
11 CHAYTOR, Q.C.:
12 Q. So you don't know, well you're saying
13 researchers gave that advice to Eastern Health
14 that it could somehow link to the identity of
15 the patient?
16 MS. JONES:
17 A. That's right, individual patient.
18 CHAYTOR, Q.C.:
19 Q. And you don't know who those researchers were?
20 MS. JONES:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. And there was mention in this piece at one
24 point to John Harnett, who is John Harnett?
25 MS. JONES:

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1 A. John Harnett is a nephrologist who works
2 inside of Eastern Health, as well as he does
3 do research as well.
4 CHAYTOR, Q.C.:
5 Q. And was he consulted, do you know?
6 MS. JONES:
7 A. I consulted him myself after, when I made the
8 decision to release the information.
9 CHAYTOR, Q.C.:
10 Q. After you made that decision.
11 MS. JONES:
12 A. Well as part of my decision-making on whether
13 I would release or not. You will know from
14 documentation that the advice coming from
15 executive, as well as the regional quality
16 council, continued to say that this is
17 individual patient information, it's medical
18 information, that in fact we shouldn't be
19 releasing it, although people did know that we
20 had the privacy commissioner who had indicated
21 that we should release it, so in taking their
22 two particular decisions that they were
23 offering me advice, I then was at a stage
24 where I had to make that decision whether in
25 fact we would release that information, and at

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1 the time I called John and said, talk to me
2 about this issue. If I have two pieces of
3 information, what is the likelihood that I
4 will be able to identify an individual person
5 from those two pieces of information? And his
6 advice at that time was, personally he still
7 believes that it was health information and it
8 should not be released in this format, but
9 that the remoteness of being able to link two
10 pieces of information to an individual patient
11 was probably very remote, although it was
12 possible.
13 CHAYTOR, Q.C.:
14 Q. Okay, so you're saying he still believed that,
15 so was--is it Mr. Harnett or Dr. Harnett?
16 MS. JONES:
17 A. Dr. Harnett.
18 CHAYTOR, Q.C.:
19 Q. Was Dr. Harnett the person who was originally
20 giving that advice to Eastern Health?
21 MS. JONES:
22 A. He had not heard of the issue before, so it
23 wouldn't have been him.
24 CHAYTOR, Q.C.:
25 Q. Okay, not that he still believed it, it was

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1 his opinion that it could happen, but the
2 likelihood of that happening -
3 MS. JONES:
4 A. It could happen.
5 CHAYTOR, Q.C.:
6 Q. Was so remote -
7 MS. JONES:
8 A. Was remote but he still had the personal
9 opinion that it was medical information and as
10 medical information, then what individual
11 patient information, why would we be releasing
12 it.
13 CHAYTOR, Q.C.:
14 Q. So Dr. Harnett's advice to you was that -
15 MS. JONES:
16 A. It was a decision that I would have to make.
17 CHAYTOR, Q.C.:
18 Q. And that he felt that it was remote that it
19 could ever be linked back to any particular
20 patient.
21 MS. JONES:
22 A. And that's what I needed to hear.
23 CHAYTOR, Q.C.:
24 Q. Did you consult anyone else for advice on
25 making your decision?

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1 MS. JONES:
2 A. No, the executive discussed this inside of an
3 executive meeting and it was their advice to
4 me that we would not release and that we would
5 take this to the Supreme Court because
6 basically if we had denied this, we would have
7 ended up having to take it through the Court
8 process. Also the Regional Quality Council
9 that met that week as well, discussed this
10 information and the same issue was coming
11 forward, it was individual patient information
12 and why would we, as an organization
13 protecting health information be releasing
14 this to a reporter because of a Freedom of
15 Information request.
16 CHAYTOR, Q.C.:
17 Q. And who, on your executive, was against you
18 releasing this information?
19 MS. JONES:
20 A. It was general discussion and the consensus of
21 that group was that really it was health
22 information, there was a potential of being
23 able to link it to an individual patient and
24 based upon that, they would have been
25 continuing to say we should deny this and we

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1 should take it to Court to see if in fact,
2 based upon the fact that it was individual
3 patient information.
4 CHAYTOR, Q.C.:
5 Q. What was Dr. Howell's position?
6 MS. JONES:
7 A. I can't--I don't even know if Dr. Howell was
8 there at the meeting on that particular day.
9 I would have to look at the minutes on the 9th
10 or the 11th of July just to see who was in the
11 room at that time.
12 CHAYTOR, Q.C.:
13 Q. What was Pat Pilgrim's position?
14 MS. JONES:
15 A. I can't answer that. It was a generic
16 discussion.
17 CHAYTOR, Q.C.:
18 Q. But overall, the consensus of the group was,
19 so whoever was present, they were all against
20 this information being released?
21 MS. JONES:
22 A. Overall--they were all saying that based upon
23 our advice and based upon the discussion that
24 we have here, that they would be looking, this
25 was important to them.

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1 CHAYTOR, Q.C.:
2 Q. But advice of whom? Based on whose advice?
3 MS. JONES:
4 A. That's a collective wisdom of the executive.
5 CHAYTOR, Q.C.:
6 Q. Right, but they're basing it on the advice
7 they had, whose advice?
8 MS. JONES:
9 A. No, no, their own personal experience and what
10 they know about the ATIPP and what they--even
11 though we had a ruling about this, this was
12 collectively they were providing me with
13 advice and as you would probably see, there
14 was some discussion to move forward with it,
15 to take it to Court, but I sat back and I had
16 listened to the Regional Quality Council, I
17 had actually listened to the executive, then I
18 said, what is going on in Eastern Health right
19 now? We're an organization that everybody
20 believes will not share information. I have a
21 ruling from the privacy commissioner that
22 gives me the--tells me I have to do it, so
23 legally somebody is telling me that this is
24 information that should be released. I then
25 did go back to an individual who was a

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1 researcher, who was well known in our
2 organization to ask about whether in fact two
3 data points like this could be connected to an
4 individual patient, because if he had said
5 yes, it could be connected to an individual
6 patient, I probably would have been going back
7 to Phil Wall and making that point before I
8 would make a decision to move forward with or
9 not against.
10 CHAYTOR, Q.C.:
11 Q. I assume that argument had already been made,
12 though, before the privacy commissioner?
13 MS. JONES:
14 A. I'm not sure whether it was because this, this
15 submission I expect that would go forward and
16 the Commission would make a ruling on it, I
17 didn't actually look at what the content of
18 that submission was.
19 CHAYTOR, Q.C.:
20 Q. And Dr. Harnett, his professional opinion
21 regarding the two data points, he thought it
22 was very remote.
23 MS. JONES:
24 A. It was remote.
25 CHAYTOR, Q.C.:

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1 Q. Yes. Remote or very remote?
2 MS. JONES:
3 A. Just said remote, I don't remember -
4 CHAYTOR, Q.C.:
5 Q. Not likely to happen.
6 MS. JONES:
7 A. Not likely to happen, yeah.
8 CHAYTOR, Q.C.:
9 Q. Did you consult Heather Predham in making your
10 decision?
11 MS. JONES:
12 A. No.
13 CHAYTOR, Q.C.:
14 Q. You did not?
15 MS. JONES:
16 A. No. Just to give the whole story, I did call
17 the board chair and say I am making this
18 decision just to let her know that we were
19 moving forward with this and it was very
20 clear, I was in a role that I was there less
21 than four days. At this particular point in
22 time I had a deadline of having to respond by
23 the Friday, I knew that, and so I just said
24 given the controversy, particularly with the
25 media around this, my advice from my

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1 executive, as well as the Regional Quality
2 Council is is that we would take this to
3 Court. I am saying that I am not going to
4 take this to Court. This particular reporter
5 was really looking for the percentage of
6 change and regardless of how we would try to
7 explain percentages of change, we didn't have
8 a full database, we only had the database of
9 the negative and so I think what you see is in
10 the letter that went out, we did incorporate
11 some things into the letter to talk about, you
12 know, if you're looking at this and trying to
13 do a rate, then you really need to consider
14 these points.
15 CHAYTOR, Q.C.:
16 Q. So my question about conversations with
17 Heather Predham around the issue, did you have
18 conversations with Heather Predham prior to
19 releasing the information?
20 MS. JONES:
21 A. No, the person who manages ATIPP for us is
22 Marian Crowley and she is the person who does
23 all of the work behind these particular kinds
24 of requests. So whether Heather and Marian
25 were having any conversation, there would have

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1 been e-mails going back to sort of say we need
2 some information. Initially when I was going
3 to deny the request, I would have had to bring
4 in the legal people to say I'm denying the
5 request, where do we go from here? So I can't
6 recall whether that -
7 CHAYTOR, Q.C.:
8 Q. So initially when the request was denied -
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. Were you involved in that?
13 MS. JONES:
14 A. Only to the point of letting Marian Quinlan,
15 who is our ATIPP co-ordinator.
16 CHAYTOR, Q.C.:
17 Q. Quinlan or Crowley?
18 MS. JONES:
19 A. Crowley, sorry. Quinlan, I think that's her
20 maiden name. Only to say this is the decision
21 that I am going to make, generate whatever
22 letter it is. We had talked about including
23 in the letter something about trying to
24 calculate a rate based upon this, because this
25 was one of the particular pieces of

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1 information that he was looking at. And the
2 other point that was put in the letter that
3 went out was in these--under this
4 circumstance, we would allow this to go
5 forward.
6 CHAYTOR, Q.C.:
7 Q. Yes, I want to ask you about that. I just
8 want to understand who you consulted with and
9 so initially when the request was denied -
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. - you were involved at that stage?
14 MS. JONES:
15 A. I was--it was an executive committee meeting
16 and the pros and cons and we had decided that
17 we would move forward with denying it, based
18 upon the fact that it was individual patient
19 information and there was a likelihood to be
20 able to identify a patient.
21 CHAYTOR, Q.C.:
22 Q. And there was legal people, you said,
23 consulted at that time. Is that your in-house
24 legal people?
25 MS. JONES:

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1 A. No, it would have been Dan Boone, I do believe
2 in this instance because I think maybe on the
3 original request that he was the lawyer that
4 we were using at the time.
5 CHAYTOR, Q.C.:
6 Q. And he was the lawyer defending the class
7 action suit?
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. So my question whether or not Heather Predham,
12 you had discussions with Heather Predham
13 around -
14 MS. JONES:
15 A. Personally I can't recall that, but I wouldn't
16 think that I would have. She may have been in
17 on conversations where we were talking about
18 my decision is to move this way.
19 CHAYTOR, Q.C.:
20 Q. And when we had our interview, my reason for
21 specifically asking you about Heather Predham,
22 you identified to me Heather Predham and John
23 Harnett, so do you recall what discussion you
24 had with Heather Predham around the issue or
25 whether or not that was -

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1 MS. JONES:
2 A. I can't recall that right now, this is a few
3 months later, but I don't see in the e-mails,
4 other than if she is on the regular
5 distribution list as we're talking about this.
6 CHAYTOR, Q.C.:
7 Q. So you don't recall now if you had discussions
8 with Heather Predham or what the nature of
9 that would be?
10 MS. JONES:
11 A. No, but it wouldn't have been--this was very
12 clearly that we had a reply from the
13 commissioner that says we must release, okay,
14 so at the end of the day, I already had a
15 privacy commissioner who tells me that this
16 particular information had already been to
17 appeal and my only way--to continue to hold on
18 this particular one would be to go to the
19 Courts.
20 CHAYTOR, Q.C.:
21 Q. Yes. So you don't recall any discussions with
22 Heather Predham on this issue?
23 MS. JONES:
24 A. No, no.
25 CHAYTOR, Q.C.:

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1 Q. Who at--who is the chair of the Regional
2 Quality Council?
3 MS. JONES:
4 A. It would have been Pat Pilgrim who is the
5 chair of the Regional Quality Council.
6 CHAYTOR, Q.C.:
7 Q. And the position of the Regional Quality
8 Council was to take it further?
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. To go to the Supreme Court.
13 MS. JONES:
14 A. Yes, and the Regional Quality Council has
15 majority of executive, plus it has some
16 physicians on the council as well and I
17 clearly remember one of the physicians on the
18 council talking about it being medical
19 information.
20 CHAYTOR, Q.C.:
21 Q. And which physician was that?
22 MS. JONES:
23 A. I think it was Dr. Ingram at the time.
24 CHAYTOR, Q.C.:
25 Q. Sorry?

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1 MS. JONES:
2 A. Dr. Ingram sits on the council.
3 CHAYTOR, Q.C.:
4 Q. Dr. Ingram, yes. At any point did you consult
5 the board or Joan Dawe in making the decision?
6 MS. JONES:
7 A. No, I called Joan to say that this was a
8 decision that I was going to make and because
9 this particular one was the executive in the
10 discussion as well as the Regional Quality
11 Council were offering me different advice,
12 that I had in fact gone forward, talked to
13 John Harnett and based upon where the
14 organization was and based upon the
15 relationship that we had with the media at the
16 time, and based upon the relation--on the fact
17 that I already had privacy commissioner
18 telling me to release it, that it was going to
19 be my decision to release.
20 CHAYTOR, Q.C.:
21 Q. So you told Joan what you had done and the -
22 MS. JONES:
23 A. What I was doing.
24 CHAYTOR, Q.C.:
25 Q. - decision that you had come to?

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1 MS. JONES:
2 A. Yeah, this would have went out on a Friday, so
3 I would have probably talked to Joan on the
4 Thursday to say "this is what I'm going to do,
5 based upon -
6 CHAYTOR, Q.C.:
7 Q. Okay, so the decision is made. It wasn't to -
8 MS. JONES:
9 A. I made a decision.
10 CHAYTOR, Q.C.:
11 Q. - consult her for advice?
12 MS. JONES:
13 A. No.
14 CHAYTOR, Q.C.:
15 Q. So you viewed this as an operational decision,
16 I take it?
17 MS. JONES:
18 A. It was--oh, absolutely. This is an
19 operational decision.
20 CHAYTOR, Q.C.:
21 Q. And you did this, even though your executive
22 and the Regional Quality Council were against
23 it?
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. You had the authority to make the decision and
3 you made it?
4 MS. JONES:
5 A. That's right.
6 CHAYTOR, Q.C.:
7 Q. And if we scroll down, you quote from the
8 privacy commissioner.
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. Where it says "in his report received on June
13 28th, 2007, the information and privacy
14 commissioner recommended that 'Eastern Health
15 provide the applicant with a copy of the
16 response of records identified as the
17 documents containing the results of laboratory
18 tests and retests for hormone receptors
19 performed for 866 cancer patients of Eastern
20 Health, who subsequently had their samples
21 retested by Mount Sinai Hospital.'" So I take
22 it this was--this included--it says "cancer
23 patients of Eastern Health," but would this
24 also include patients from outside Eastern
25 Health?

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1 MS. JONES:
2 A. Yes, that was the word straight out of the
3 response from the privacy commissioner.
4 CHAYTOR, Q.C.:
5 Q. And did the -
6 MS. JONES:
7 A. It's always been deemed to be Eastern Health,
8 even though there were many results from
9 patients from outside of Eastern Health.
10 CHAYTOR, Q.C.:
11 Q. Did you consult with your colleagues at the
12 other regional authorities before releasing
13 the information?
14 MS. JONES:
15 A. No.
16 CHAYTOR, Q.C.:
17 Q. And did you think that that's something you
18 should do?
19 MS. JONES:
20 A. No, because this was a request of Eastern
21 Health and Eastern Health was the holder of
22 that information.
23 CHAYTOR, Q.C.:
24 Q. So in terms of any concern as to whether or
25 not people could be identified through the

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1 information, I take it you weren't concerned
2 to the extent that you would notify the other
3 regional boards?
4 MS. JONES:
5 A. No, and they would not have even been aware of
6 this request as an ATIPP request, an original
7 request that we had turned down.
8 CHAYTOR, Q.C.:
9 Q. Yes, but my question is, and particularly some
10 of those boards deal with people in very
11 remote rural areas.
12 MS. JONES:
13 A. In small regions, yes.
14 CHAYTOR, Q.C.:
15 Q. But you didn't discuss that with the other
16 boards or inform them that this was happening?
17 MS. JONES:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. And then we go on with the last paragraph and
21 this is where you say "we have made the
22 decision in the circumstances of this case to
23 follow the recommendations of the information
24 and privacy commissioner" and you were
25 presently in the process of collecting the

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1 information.
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And collating the results in a database, and
6 you've italicized the words "in the
7 circumstances of this case."
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. So presumably bringing, emphasizing that
12 point.
13 MS. JONES:
14 A. That's right.
15 CHAYTOR, Q.C.:
16 Q. And why is that? What are the circumstances
17 which are peculiar to this case?
18 MS. JONES:
19 A. Well, the thing about is it I go back to the
20 issue of the two data points. So if in fact
21 they were--we had other requests for de-
22 identified information, that in fact there may
23 have been other data points and people would
24 use an example and an example was used of if
25 in fact somebody asked for all of the

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1 hemoglobin A1C's which is for diabetics inside
2 of a particular community and results or
3 whatever, that just because it was de-
4 identified information, there may be other
5 circumstances where, in a smaller subset of
6 people, you may very well be able to identify
7 an individual client, depending upon the
8 request and the nature of the request that
9 might come in.
10 CHAYTOR, Q.C.:
11 Q. And I take it, in answering my questions, part
12 of your decision or a factor that influenced
13 you in making this decision was the fact that
14 you were cognizant of the perception, rightly
15 or wrongly, the perception of Eastern Health
16 in the public eye at this point in time?
17 MS. JONES:
18 A. Absolutely.
19 CHAYTOR, Q.C.:
20 Q. And that there was a perception that there had
21 been a failure to disclose?
22 MS. JONES:
23 A. That's right, and we were closed and we were
24 not open and transparent.
25 CHAYTOR, Q.C.:

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1 Q. And did you receive any advice from anyone
2 else in terms of public relations or
3 communications people -
4 MS. JONES:
5 A. No.
6 CHAYTOR, Q.C.:
7 Q. - in making the decision?
8 MS. JONES:
9 A. No, and the only thing that we did involve was
10 in terms of this crafting of the response with
11 the database associated with it, the content
12 of the bottom part about the error and how to
13 calculate and be sure that we--that you
14 understand what this is all about.
15 CHAYTOR, Q.C.:
16 Q. And I appreciate you're only in the job, at
17 this point in time, this is July 13th, so
18 you're in the job four days at this point in
19 time.
20 MS. JONES:
21 A. Four days.
22 CHAYTOR, Q.C.:
23 Q. That is a big -
24 MS. JONES:
25 A. And this is on the agenda on the Monday

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1 afternoon, the first day.
2 CHAYTOR, Q.C.:
3 Q. The first day. So is it fair to say that new
4 in the job, but you're taking somewhat of a
5 different approach to disclosure?
6 MS. JONES:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. Then if we look at the next exhibit is, I
10 believe, 0710, and this is a letter from the
11 office of the information and privacy
12 commissioner dated July 18th, 2007.
13 MS. JONES:
14 A. Yeah.
15 CHAYTOR, Q.C.:
16 Q. Addressed to yourself, and signed by Mr. Wall,
17 and he copies Mr. Quinn on the letter.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. And he indicates, in the first paragraph, that
22 he's pleased--"we are pleased that you have
23 decided to release the test and retest results
24 to the applicant," and he goes on with
25 basically just reiterating the timing that -

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1 MS. JONES:
2 A. The time line.
3 CHAYTOR, Q.C.:
4 Q. - needs to take place to allow for any further
5 appeal that may be required.
6 MS. JONES:
7 A. That's right.
8 CHAYTOR, Q.C.:
9 Q. So I take it that was the resolution to this
10 issue?
11 MS. JONES:
12 A. It was.
13 CHAYTOR, Q.C.:
14 Q. In that the information went to Mr. Quinn?
15 MS. JONES:
16 A. Yes, it did.
17 CHAYTOR, Q.C.:
18 Q. And I believe we have reference to the
19 executive minutes back at--we had that up
20 earlier. Let me see here.
21 MS. JONES:
22 A. The 11th of July probably.
23 CHAYTOR, Q.C.:
24 Q. The 11th of July, I believe it was, yes, thank
25 you. Maybe 48865, oh there it is. Thank you,

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1 Registrar. She is so good, and the right page
2 and everything. And this refers to the--this
3 is the--actually, it's July 25th.
4 MS. JONES:
5 A. Okay, July 25th.
6 CHAYTOR, Q.C.:
7 Q. So there's probably a reference, you're
8 thinking, too on July 11th as well.
9 MS. JONES:
10 A. Yeah.
11 CHAYTOR, Q.C.:
12 Q. But this one is July 25th.
13 MS. JONES:
14 A. This one says Burin radiology and I'm not
15 sure. When you put that up before -
16 CHAYTOR, Q.C.:
17 Q. Yes.
18 MS. JONES:
19 A. - we did have -
20 CHAYTOR, Q.C.:
21 Q. And this is under Burin radiology, you're
22 right.
23 MS. JONES:
24 A. Yes, right.
25 CHAYTOR, Q.C.:

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1 Q. So the one that we need then is -
2 MS. JONES:
3 A. Is the 11th.
4 CHAYTOR, Q.C.:
5 Q. - the 11th of July, yes, because this would
6 have already gone out at this point. So just
7 let me see. You're saying here it is
8 imperative that the executive update the board
9 and present a focus need with the possibility
10 of requesting that a consultant be engaged,
11 okay.
12 MS. JONES:
13 A. This is on the Burin radiology, right.
14 CHAYTOR, Q.C.:
15 Q. Okay. So we need the July 11th, please,
16 Registrar. Okay, so this is July 11th and
17 we'll just scroll through to see if we have
18 the ATIPP. It may not be in this excerpt. I
19 don't see it there.
20 MS. JONES:
21 A. Okay.
22 CHAYTOR, Q.C.:
23 Q. Okay, no, I don't see it.
24 MS. JONES:
25 A. The 9th.

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1 CHAYTOR, Q.C.:
2 Q. The 9th?
3 MS. JONES:
4 A. Yes, because--the 9th, then followed by the
5 10th, which was Regional Quality Council, so
6 it would have been in the 2:00 -
7 CHAYTOR, Q.C.:
8 Q. I think that's to radiation -
9 MS. JONES:
10 A. Yes, the 2:00 meeting on the 9th.
11 CHAYTOR, Q.C.:
12 Q. Okay. 288, page one. I think we had that one
13 up earlier.
14 MS. JONES:
15 A. Yeah, we did. Oh, okay.
16 CHAYTOR, Q.C.:
17 Q. Okay.
18 MS. JONES:
19 A. I thought I saw it too, Sandy, but -
20 CHAYTOR, Q.C.:
21 Q. That's fine, okay. All right, but it was
22 discussed at executive and your recollection
23 is that the executive was against disclosure?
24 MS. JONES:
25 A. That's right.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and once you went ahead and disclosed,
3 was there further discussion then with the
4 executive?
5 MS. JONES:
6 A. I would have called Oscar Howell and I would
7 have called Pat Pilgrim making--letting them
8 know that I had made the decision to disclose
9 and that would have been on the Thursday
10 before we went out on the Friday.
11 CHAYTOR, Q.C.:
12 Q. Okay.
13 MS. JONES:
14 A. And indicated that I would have talked to Dr.
15 Harnett at that time.
16 CHAYTOR, Q.C.:
17 Q. And you don't know who they had approached or
18 who had been approached in terms of the
19 researcher prior to?
20 MS. JONES:
21 A. No.
22 CHAYTOR, Q.C.:
23 Q. In making the -
24 MS. JONES:
25 A. I think that's just general knowledge, if

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1 there are two data points of which we had,
2 then, you know, there was common understanding
3 that you would be able to make the third point
4 and make the connection.
5 CHAYTOR, Q.C.:
6 Q. Okay. If we could have, please, 0730? And
7 this is a letter, September 19th 2007,
8 addressed to Ms. Marian Crowley -
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. - who you've just indicated is responsible for
13 ATIPP coordination.
14 MS. JONES:
15 A. That's right.
16 CHAYTOR, Q.C.:
17 Q. Quality and risk information coordinator
18 appears to be her title, according to the
19 letter, and the letter is signed by, who we
20 understand to be a group of physicians,
21 oncologists.
22 MS. JONES:
23 A. Yes, and surgeons as well.
24 CHAYTOR, Q.C.:
25 Q. And surgeons, yes, we have Dr. Kwan there.

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1 And it's cc'ed to you and of course, this is
2 no doubt in your capacity as CEO at this
3 point.
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. Okay, and perhaps you could tell us--we'll
8 just look at this letter and then you can tell
9 us what the background was to this letter.
10 "As the physicians who have been involved in
11 the ER/PR retesting issues, we would like to
12 express our concern with the inaccurate
13 information sent in the letter to breast
14 cancer patients and their families regarding
15 ER/PR retesting," and they say they've been
16 given a copy of the letter through their
17 patients.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. "The following statement," and in bold and in
22 quotation marks, "'those individuals whose
23 breast cancer screening test results converted
24 from clinically negative to clinically
25 positive' is false. This issue had nothing to

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1 do with the screening for breast cancer and is
2 completely misleading and confusing to
3 patients. Also, the letter was sent to many
4 patients who did not have a clinically
5 meaningful change in ER/PR testing results.
6 Therefore, we will not be responsible for
7 dealing with the anxiety generated and patient
8 queries resulting from the letter. All
9 patients will be referred back to you and we
10 will not answer any questions related to this
11 letter." What was that all about?
12 MS. JONES:
13 A. That was all about a Court ordered letter to
14 be sent out as part of the class action suit
15 and the letter was--we had the names in the
16 database and the Court did not have the names
17 in the database, so we were responsible to put
18 a letter that was provided through the
19 solicitors and mail it out to clients and that
20 would have been somewhere before the 19th of
21 September. It was in August sometime because
22 I remember it was over the summer, and then
23 you got into the fall of the year when, as it
24 says in here, that the physicians were
25 starting to deal with patients who had this.

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1 We were--who had this letter talking about the
2 class action suit.
3 The other thing is that we were very
4 clear, and they were very clear in lots of our
5 messages and our communication that this had
6 nothing to do with breast screening, and on a
7 couple of occasions, when we were doing media
8 releases and discussions around this
9 particular issue of ER/PR, breast screening we
10 would always say, this is not for breast
11 screening. So this, we really were just
12 creating the mailing list and addressing the
13 envelopes and putting the information that had
14 come from the Courts to move forward.
15 CHAYTOR, Q.C.:
16 Q. Okay. So the letter was Court ordered in the
17 class action?
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. This lands on your desk. It's a fairly -
22 MS. JONES:
23 A. Strong.
24 CHAYTOR, Q.C.:
25 Q. - strongly worded letter.

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1 MS. JONES:
2 A. Absolutely.
3 CHAYTOR, Q.C.:
4 Q. From a significant group of your physicians in
5 your hospital.
6 MS. JONES:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. Ms. Marian Crowley is an employee of yours.
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. What action did you take?
14 MS. JONES:
15 A. Well, I would have talked to Pat Pilgrim at
16 the time to say "what is this issue about?"
17 but we had heard that they were going to send
18 a letter, and that at the end of the day, we
19 would respond inside of that. I understood at
20 that point in time that the information that
21 was in the letter wasn't anything that Eastern
22 Health had generated.
23 CHAYTOR, Q.C.:
24 Q. So the information in the letter was generated
25 by whom? Somebody on behalf of Eastern

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1 Health?
2 MS. JONES:
3 A. No, no.
4 CHAYTOR, Q.C.:
5 Q. So who drafted the letter?
6 MS. JONES:
7 A. I have no idea who have drafted the letter,
8 but I think if you go to the next exhibit that
9 you have, which is Marian's answer.
10 CHAYTOR, Q.C.:
11 Q. 0731.
12 MS. JONES:
13 A. 0731, and there's a couple of points in here
14 that would have been discussed or said at the
15 time. We were notified by lawyers on the 8th,
16 under the Court order, a registered letter
17 must be sent to breast cancer patients whose
18 hormone receptor results converted from
19 clinically negative to clinically positive and
20 that, I guess, goes back to the point that
21 they're making at the end of the day, there
22 was not clinically significant changes.
23 CHAYTOR, Q.C.:
24 Q. And would that have been Eastern Health's
25 lawyers?

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1 MS. JONES:
2 A. I'm not sure who they were at the time,
3 whether it was actually--I'm thinking that it
4 probably came through Eastern Health's lawyer
5 in terms of the letter itself, but generated
6 by us, no. The content of it would have come
7 through the Court order. And then it talks
8 about the process that was used to identify
9 and on the 16th, we received a copy of the
10 cover letter to accompany the class action
11 notice, and the registered letters were in
12 place by the 17th.
13 CHAYTOR, Q.C.:
14 Q. And it says "we understood from our lawyers
15 that we could not change the wording of the
16 cover letter, which included the inaccurate
17 reference to screening."
18 MS. JONES:
19 A. Yeah, to screening.
20 CHAYTOR, Q.C.:
21 Q. So it looks like that Eastern Health was
22 aware, through its lawyers, prior to the
23 letters going out.
24 MS. JONES:
25 A. Through Dan, and this is class action, so this

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1 would have been Dan Boone.
2 CHAYTOR, Q.C.:
3 Q. Right. So Eastern Health was aware that there
4 would--the word "screening" was being used,
5 but you had been advised that you could not
6 change the wording?
7 MS. JONES:
8 A. That's--yeah, and I wouldn't have been
9 involved in that at the time.
10 CHAYTOR, Q.C.:
11 Q. Do you know whether or not there was any
12 discussion with the physicians to give them
13 the heads up that this letter was going out?
14 MS. JONES:
15 A. They would have probably been aware, and I
16 can't speak to that personally. You might
17 need to ask Pat Pilgrim on that. But we would
18 have known through the Court order and the
19 class action suit that there would have been a
20 letter, the Court ordered letter that had to
21 go out. So I'm thinking that Pat may have let
22 Kara Laing know, but maybe not anybody else,
23 that that was happening as part of that
24 process. The other thing that you would need
25 to know -

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1 CHAYTOR, Q.C.:
2 Q. And Kara Laing is one of the signators though
3 -
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. - to the letter that went to Ms. Crowley.
8 MS. JONES:
9 A. But she--but the letter may have just said
10 that there's a letter going out that we have
11 to send out. It may not have used the word
12 "screening." You'll have to, you know, go
13 further back.
14 CHAYTOR, Q.C.:
15 Q. So they may have been advised -
16 MS. JONES:
17 A. Aware of a letter.
18 CHAYTOR, Q.C.:
19 Q. - there was a letter going out, but not the
20 content of the letter and the misinformation
21 in terms of this being breast screening?
22 MS. JONES:
23 A. Yeah, and the other thing is that at that
24 period of time, I do know that Marian Crowley,
25 who is the ATIPP coordinator, and some people

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1 in quality were generating this list of
2 addresses and so we had the envelopes ready to
3 go. So when we got the letter, it was a
4 matter of putting those in and my recall at
5 the time was, after I talked to Pat, if in
6 fact Heather--Heather Predham, I think, may
7 have been on holidays at this particular time,
8 so would have known that we had a letter, we
9 had to generate the list of names and all of
10 that kind of thing, but may not have actually
11 seen the letter. So somebody like a Marian
12 Crowley or somebody else working in--would not
13 have been as sensitive to that particular
14 word, even if they had read the letter.
15 CHAYTOR, Q.C.:
16 Q. Okay. This goes on in Ms. Crowley's response
17 back to the physicians.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. And would this response be--would you have
22 seen this response before it went out?
23 MS. JONES:
24 A. No, I didn't.
25 CHAYTOR, Q.C.:

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1 Q. Would anybody have seen this response before
2 it was sent to the physicians?
3 MS. JONES:
4 A. Oh, I'm sure that it was, and you may have to
5 ask Mrs. Crowley herself, but given that there
6 was a fair amount of angst in the oncologists
7 that I am thinking that people like Sharon
8 Smith, who's the program director there, and
9 Pat Pilgrim, who's still responsible for the
10 cancer program, may have, in fact, seen some
11 draft of this as we were going out.
12 CHAYTOR, Q.C.:
13 Q. And this is, I take it, not a normal chain of
14 communication for the physicians to be
15 communicating directly with Ms. Crowley or
16 vice versa?
17 MS. JONES:
18 A. No, it wouldn't have been, but they were aware
19 that she was the one that was responsible for
20 having sent it out and done that.
21 CHAYTOR, Q.C.:
22 Q. And do you know whether or not the physicians
23 spoke to anyone prior to sending the letter to
24 Ms. Crowley?
25 MS. JONES:

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1 A. Only that they were very angry and that was
2 probably in discussion with Pat Pilgrim and as
3 well as Sharon Smith and even Oscar Howell
4 would have said "okay, if you want to write
5 this, and we will tell you exactly how and so
6 that you can understand how this happened,"
7 and that's where they would have gotten the
8 information for Marian.
9 CHAYTOR, Q.C.:
10 Q. So Pat Pilgrim and Dr. Howell -
11 MS. JONES:
12 A. Dr. Howell.
13 CHAYTOR, Q.C.:
14 Q. - would have been aware that the letter was
15 going to go to Marian Crowley?
16 MS. JONES:
17 A. Absolutely, I would think. Because these
18 physicians would not have known her name per
19 se.
20 CHAYTOR, Q.C.:
21 Q. But her name was on the letter?
22 MS. JONES:
23 A. Yeah.
24 CHAYTOR, Q.C.:
25 Q. Didn't she sign -

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1 MS. JONES:
2 A. Was it on the original letter?
3 CHAYTOR, Q.C.:
4 Q. - sign the letter that went out? I don't
5 know.
6 MS. JONES:
7 A. She was the one who coordinated sending out
8 the letters.
9 CHAYTOR, Q.C.:
10 Q. Yes. So perhaps her name was known through
11 that?
12 MS. JONES:
13 A. Yeah.
14 CHAYTOR, Q.C.:
15 Q. But it's your understanding -
16 MS. JONES:
17 A. I didn't see the letters.
18 CHAYTOR, Q.C.:
19 Q. Your understanding in having conversations
20 with people following this being brought to
21 your attention that the physicians did speak
22 to Dr. Howell and Pat Pilgrim prior to sending
23 -
24 MS. JONES:
25 A. Well, Dr. Howell and Pat Pilgrim were well

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1 aware of it.
2 CHAYTOR, Q.C.:
3 Q. Yeah. And in the response that Ms. Crowley
4 sends back to Doctors McCarthy, Laing, Kwan,
5 Zulfiqar, and Ganguly, in that response she
6 indicates in the third bullet that "Staff of
7 the quality and risk management department
8 coordinate the logistics of getting the letter
9 out."
10 MS. JONES:
11 A. Yeah.
12 CHAYTOR, Q.C.:
13 Q. "Including consulting with physicians."
14 MS. JONES:
15 A. Um.
16 CHAYTOR, Q.C.:
17 Q. "And others to confirm which patients should
18 be included and getting MCP numbers" etcetera.
19 MS. JONES:
20 A. Yes, and labels.
21 CHAYTOR, Q.C.:
22 Q. "We eventually determined that the patients
23 who were panelled by the ER/PR physician
24 review panelling met the legal definition of
25 patients who converted from clinically

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1 negative to clinically positive."
2 MS. JONES:
3 A. Yes. And that was an issue for them right
4 from the beginning, who gets these letters,
5 because -
6 CHAYTOR, Q.C.:
7 Q. So do I understand from reading that that the
8 only people who received the letter were
9 people who had been panelled by the physician
10 review panelling group and had converted from
11 clinically negative to clinically positive by
12 definition according to that group?
13 MS. JONES:
14 A. And I think that if you read that, that's
15 exactly, because we didn't have--like, the
16 discussion was there was nothing in the court
17 order that says, you know, 10 to 30 or 10 to
18 50 or whatever and what does clinically
19 negative and clinically positive mean. And so
20 therefore they would have sought direction and
21 then ended up having to make that
22 determination inside of Eastern Health by
23 clinically negative to clinically positive has
24 no, has no reference point.
25 CHAYTOR, Q.C.:

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1 Q. So if there were people who were not panelled
2 who had a conversion, but for whatever reason
3 didn't go through the panelling process, they
4 would not have received the letter?
5 MS. JONES:
6 A. And you would have to talk to Mrs. Crowley and
7 the physicians that they talked to because you
8 see that there was a lot of who it was, who
9 should be included, that kind of thing.
10 CHAYTOR, Q.C.:
11 Q. Okay. But according to this letter it appears
12 it was only -
13 MS. JONES:
14 A. That was -
15 CHAYTOR, Q.C.:
16 Q. - people who were panelled?
17 MS. JONES:
18 A. That was the decision that--yeah.
19 CHAYTOR, Q.C.:
20 Q. And who would have made that decision?
21 MS. JONES:
22 A. Well, you can see here who made that decision,
23 the physicians had identified -
24 CHAYTOR, Q.C.:
25 Q. But who would they be?

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1 MS. JONES:
2 A. Well, they would have been probably the Kara
3 Laings of the world or whoever was around at
4 that time. It may have even been pathologists
5 at the time. But this is clinically negative
6 to clinically positive versus an absolute
7 number which is the way the pathologists deal
8 with it.
9 CHAYTOR, Q.C.:
10 Q. Those who were panelled by the review panel -
11 MS. JONES:
12 A. Yeah.
13 CHAYTOR, Q.C.:
14 Q. - who were deemed to be clinically negative -
15 MS. JONES:
16 A. Negative to clinically positive.
17 CHAYTOR, Q.C.:
18 Q. - to clinically positive?
19 MS. JONES:
20 A. Yeah.
21 CHAYTOR, Q.C.:
22 Q. Okay. And so what was the aftermath of then
23 this letter goes out to the physicians?
24 MS. JONES:
25 A. Um.

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1 CHAYTOR, Q.C.:
2 Q. And was the issue satisfactorily resolved from
3 their point of view?
4 MS. JONES:
5 A. We didn't hear from them after. They were
6 really upset with it and continued to believe
7 that people didn't understand what this issue
8 was all about.
9 CHAYTOR, Q.C.:
10 Q. Were you concerned with it from your point of
11 view in reading this and knowing that there
12 has been this issue, as we talked about in
13 answer to a previous question, this perception
14 of, you know, a reluctance to disclose
15 information and there's also information that
16 may not necessarily be perceived as being
17 accurate out there, were you concerned, as
18 CEO, in reading this, in thinking that more
19 misinformation may be out there?
20 MS. JONES:
21 A. Well, this is the letter and the orders were
22 court ordered, okay. So there was nothing
23 that we were going to do or could do about
24 what the wording of that particular court
25 order had been. So from my perspective we

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1 were acting, we were an agent. I do remember
2 having discussion with Dan Boone and saying,
3 "Here we are, Eastern Health, caught in this
4 again. We have the names of the database and
5 we then are perceived, particularly by our
6 physicians, to have actioned a court order
7 that, in fact, is problematic." So it was I
8 have no idea how the court could have been
9 able to do that, but there should be some
10 provision somewhere that they would have been
11 able to do a mass mail out on the class action
12 suit. So, like, that was the discussion.
13 Here Eastern Health, again, is caught because
14 of somebody else's action that we had--
15 something that we had to action on behalf of
16 somebody else.
17 CHAYTOR, Q.C.:
18 Q. Yes, and I appreciate your concern in terms of
19 the fallout to your physicians.
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. But what about the fallout to your patients?
24 MS. JONES:
25 A. And the fallout to the patients, as well,

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1 because what it clearly is is that the
2 individuals inside, the oncologists were
3 dealing an already existing workload and then
4 having to deal with misinformation that we had
5 as Eastern Health attempted to be trying to
6 say it is not a screening test, and that it is
7 a test not in terms of screening.
8 CHAYTOR, Q.C.:
9 Q. Yes, but the physicians' concern, I think,
10 was, you know, as it's articulated in their
11 letter appears to be greater than just fallout
12 to them or the workload. Now, maybe that was
13 the issue. But they clearly articulated the
14 anxiety that it was generating too to the
15 patients.
16 MS. JONES:
17 A. Yes, absolutely.
18 CHAYTOR, Q.C.:
19 Q. So were you concerned about the fallout of
20 this misinformation to your patients?
21 MS. JONES:
22 A. Absolutely and continued to be concerned about
23 the affects of the ER/PR retesting, the issue-
24 -on our patients it's profound. And it really
25 is unacceptable the way that this whole thing

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1 has moved forward.
2 CHAYTOR, Q.C.:
3 Q. And what, if anything, did Eastern Health do
4 to try and correct this misinformation that
5 had gone out in this letter?
6 MS. JONES:
7 A. We went back to the courts but we couldn't--we
8 didn't do anything with the individual
9 patients.
10 CHAYTOR, Q.C.:
11 Q. So they weren't re-contacted, you didn't send
12 out another letter or put any public
13 announcement in the newspaper, nothing like
14 that?
15 MS. JONES:
16 A. No.
17 CHAYTOR, Q.C.:
18 Q. Okay. So there was nothing taken to try and
19 correct it from Eastern Health's point, no
20 action taken?
21 MS. JONES:
22 A. No. And if we had gotten calls, as you've
23 seen, you know, the individual oncologists
24 indicated that they weren't having anything to
25 do with it, that automatically if they

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1 wouldn't--were not dealing with it, they would
2 come back to our quality department and we
3 would have explained how we ended up being the
4 sender out of information that came from a
5 court order.
6 CHAYTOR, Q.C.:
7 Q. And do that actually happen, that the
8 oncologists refuse to talk to patients?
9 MS. JONES:
10 A. They wouldn't, at the end of the day they
11 would not. We know that from working with
12 them for years that, in fact, if, in fact, a
13 patient is in front of them, that they will
14 absolutely answer and clarify.
15 CHAYTOR, Q.C.:
16 Q. Yes. So they didn't actually--I realize that
17 was -
18 MS. JONES:
19 A. No. This is anger on their -
20 CHAYTOR, Q.C.:
21 Q. - stated and threatened in the letter -
22 MS. JONES:
23 A. That's right.
24 CHAYTOR, Q.C.:
25 Q. But I take it there wasn't -

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1 MS. JONES:
2 A. They were dealing with it.
3 CHAYTOR, Q.C.:
4 Q. They dealt with the patients?
5 MS. JONES:
6 A. That's right.
7 CHAYTOR, Q.C.:
8 Q. So were there phone calls then that had to be
9 directed through the quality department?
10 MS. JONES:
11 A. Best to ask the quality or whatever. I don't
12 know the actual fallout in terms of did we
13 actually get calls ourselves into the quality
14 department, that level of detail I wouldn't
15 know.
16 CHAYTOR, Q.C.:
17 Q. But it's your understanding that the
18 oncologists did deal with their patients?
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. They didn't -
23 MS. JONES:
24 A. No.
25 CHAYTOR, Q.C.:

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1 Q. - reroute the inquiries to the quality
2 department?
3 MS. JONES:
4 A. They were upset about it.
5 CHAYTOR, Q.C.:
6 Q. Yes.
7 MS. JONES:
8 A. And they dealt with them, even though they
9 said that they would not deal with them. I
10 know and personally even been speaking with
11 them, they will not let their patients--they
12 will deal with their patients in front of
13 them. We may have had patients who didn't
14 have an oncologist who would have called our
15 help line.
16 CHAYTOR, Q.C.:
17 Q. Okay. Could we have P-0488, please, page 65?
18 And this is executive management, November--
19 sorry, September 19th.
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. 2007. And you are in your position as interim
24 president?
25 MS. JONES:

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1 A. Um.
2 CHAYTOR, Q.C.:
3 Q. And Dr. Oscar Howell, Pat Pilgrim?
4 MS. JONES:
5 A. Yeah.
6 CHAYTOR, Q.C.:
7 Q. Are in attendance at this meeting.
8 MS. JONES:
9 A. Okay.
10 CHAYTOR, Q.C.:
11 Q. And I say those names because they're who we
12 understand to be the people involved mostly in
13 the ER/PR issue?
14 MS. JONES:
15 A. Yes, that's right.
16 CHAYTOR, Q.C.:
17 Q. The deceased patients.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. "There are approximately 21 families of
22 deceased patients that have not been
23 contacted. There was a conscious decision to
24 wait until the clinical significance component
25 was completed prior to contacting families of

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1 the deceased. However, in light of the delay
2 due to the compensation issue for physicians a
3 decision has to be made to review the 25 files
4 in question and how we will proceed." And you
5 and -
6 MS. JONES:
7 A. Can you go back -
8 CHAYTOR, Q.C.:
9 Q. - Dr. Howell are tasked with that.
10 MS. JONES:
11 A. Can you go back? That is Burin radiology.
12 CHAYTOR, Q.C.:
13 Q. Is that Burin radiology?
14 MS. JONES:
15 A. Yes, it is.
16 MR. SIMMONS:
17 Q. Is that--Commissioner, we had some discussion
18 about that minutes, you're looking at the
19 redactions. And the previous page I had
20 understood was supposed to be left in to
21 indicate that that's the continuation of a
22 discussion regarding Burin radiology.
23 MS. JONES:
24 A. Burin radiology.
25 MR. SIMMONS:

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1 Q. Not the ER/PR testing.
2 CHAYTOR, Q.C.:
3 Q. This is the previous page is there.
4 MR. SIMMONS:
5 Q. No, that's the previous page.
6 CHAYTOR, Q.C.:
7 Q. Oh, okay. So this is what was -
8 THE COMMISSIONER:
9 Q. Okay.
10 CHAYTOR, Q.C.:
11 Q. Oh, okay, page 4.
12 MR. SIMMONS:
13 Q. Page 3 is not there.
14 CHAYTOR, Q.C.:
15 Q. Sorry, I didn't have those discussions, I
16 wasn't aware of that.
17 THE COMMISSIONER:
18 Q. All right, we'll have that resolved.
19 CHAYTOR, Q.C.:
20 Q. Page 64. Okay. All right, so this is
21 regarding -
22 THE COMMISSIONER:
23 Q. You can go back to the original.
24 CHAYTOR, Q.C.:
25 Q. This is not the deceased patients?

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1 MS. JONES:
2 A. No, this is Burin radiology.
3 CHAYTOR, Q.C.:
4 Q. This is not the deceased patients in ER/PR?
5 MS. JONES:
6 A. No. This is Burin radiology.
7 CHAYTOR, Q.C.:
8 Q. Okay. And so any delay on the compensation
9 issue for physicians, that's not--did such an
10 issue also arise regarding the ER/PR issue?
11 MS. JONES:
12 A. No, there was no issues around compensation
13 with ER/PR.
14 CHAYTOR, Q.C.:
15 Q. Okay. If we could have, then, please, P-0745?
16 Okay, Ms. Jones, this is the accreditation
17 survey report from the most recent
18 accreditation.
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. Took place, according to the document,
23 September 23rd to 28th, 2007?
24 MS. JONES:
25 A. Um.

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1 CHAYTOR, Q.C.:
2 Q. Perhaps you could tell us what does it mean
3 for Eastern Health to be accredited?
4 MS. JONES:
5 A. This is a national voluntary process that we
6 would be part of. There are national
7 standards set where an organization would
8 invite accreditors in from all across the
9 country to review and see our compliance with
10 national standards. It is not mandatory,
11 although all health care organizations that
12 I'm aware of would move forward with
13 accreditation and have been involved. Our
14 legacy organizations have been involved in
15 accreditation for a long time.
16 CHAYTOR, Q.C.:
17 Q. Okay. And so how often would Eastern Health
18 go through this process?
19 MS. JONES:
20 A. If you have accreditation, then the time line
21 for accreditation is three years. So this
22 body, if you were accredited, would be back in
23 three years and reschedule in three years.
24 There are a level--you can be accredited and
25 you can be accredited with some

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1 recommendations that you may have to provide
2 reports on in terms of progress over a period
3 of time, and there are different levels of
4 accreditation. But in this instance Eastern
5 Health was accredited with two reports to go
6 in June and December of this year. If--there
7 is another category of accreditation with
8 visit, okay, so if, in fact, the accreditors
9 need to come back and see where you are with a
10 particular area, then that would be a step up
11 from a report, and then there's an
12 unaccredited status.
13 CHAYTOR, Q.C.:
14 Q. And so the last accreditation that Eastern
15 Health had gone through would have been in
16 2004?
17 MS. JONES:
18 A. There would have been Eastern Health -
19 CHAYTOR, Q.C.:
20 Q. I guess it would have been Health Care
21 Corporation.
22 MS. JONES:
23 A. The legacy organizations would have been in
24 2003 or 4. We had some interim surveys,
25 particularly with our cancer care program, and

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1 I believe it was Carbonear Peninsula areas
2 that we had to do interim surveys to bring us
3 all to the same platform to be able to be
4 accredited as a single organization in 2007.
5 So the old Health Care Corporation was 2004,
6 so this is the natural three-year cycle.
7 CHAYTOR, Q.C.:
8 Q. Okay. And who--the Canadian Council on Health
9 Services accreditation, who are they?
10 MS. JONES:
11 A. They're a national body.
12 CHAYTOR, Q.C.:
13 Q. Yeah.
14 MS. JONES:
15 A. That is--that have been in existence since the
16 1950s who set standards that organizations
17 would abide by and they have been moving many
18 agendas with respect to health services. It
19 used to be hospital accreditation, they've
20 moved into community, they've moved into long-
21 term care over the years. So they are a set
22 of agreed upon standards that we would want to
23 be accredited by.
24 CHAYTOR, Q.C.:
25 Q. Okay. And who makes the decision, who agrees

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1 as to what the criteria should be?
2 MS. JONES:
3 A. There is, generally when there's a set of
4 standards, they've been through a couple of
5 different ways of doing accreditation.
6 They're moving into another new way of doing
7 the actual reporting and that, that there is a
8 group of experts from across the country that
9 come together to develop standards. They're
10 generally feed out to the system to determine,
11 you know, their feasibility and that and then
12 they're adopted by their board as being the
13 standards that this particular organization
14 would have accreditation by. There are other
15 bodies that accredit throughout the world,
16 there's Jayco in the United States and then we
17 have the United Kingdom and that and the
18 standards generally are, at least in this kind
19 of venue, are the same. And the Canadian
20 Council on Health Services Accreditation has
21 been used internationally to develop places
22 like Ireland, the standards come from Canada
23 and adapted to the Irish. And they have other
24 international partners, as well, that they
25 work with.

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1 CHAYTOR, Q.C.:
2 Q. So, I'm sorry, so standards that would come
3 from Ireland?
4 MS. JONES:
5 A. No, that the Canadian standards would have--
6 they would have worked with the Irish -
7 CHAYTOR, Q.C.:
8 Q. To help them develop, you're saying -
9 MS. JONES:
10 A. - accrediate (sic.)--to help them accredit -
11 CHAYTOR, Q.C.:
12 Q. So not the other way, okay.
13 MS. JONES:
14 A. - and--not the other way. And then the
15 Canadian surveyors would have assisted in
16 Ireland to do their original accreditations
17 and to bring their surveyors up to scratch in
18 the accreditation process.
19 CHAYTOR, Q.C.:
20 Q. And you've told us, I think, yesterday, you
21 are--are you a surveyor?
22 MS. JONES:
23 A. I'm a surveyor.
24 CHAYTOR, Q.C.:
25 Q. You are a surveyor, so you go to other

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1 institutions -
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. - across the country?
6 MS. JONES:
7 A. It is usual -
8 CHAYTOR, Q.C.:
9 Q. And help in their process?
10 MS. JONES:
11 A. Well, the surveyors, you usually have
12 individuals who work in the field, who
13 accredit in the field. And so we have a
14 minimum of two weeks of surveying that you
15 have to do a year. There are a couple, they
16 have moved now to having some full-time
17 surveyors on staff, as well, for periods of
18 time. So it's a peer survey system. The
19 standards are developed inside of Canada and
20 adopted. And many things that the Health
21 Services, the council has done over the years
22 has moved many issues forward, whether in the
23 early '90s it would have been infection
24 control, then they moved on to quality agenda,
25 now it's on the required organizational

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1 practices. So they're always putting the bar
2 higher to move organizations along in terms of
3 quality.
4 CHAYTOR, Q.C.:
5 Q. Okay. And so the people who would have come
6 to St. John's in September of 2007, the
7 surveyors?
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. How many would have come?
12 MS. JONES:
13 A. We probably had 10 surveyors to do the region
14 and in the lab there were six or seven
15 surveyors to do the lab alone.
16 CHAYTOR, Q.C.:
17 Q. And we'll talk about that because that's a new
18 process, I understand, for the lab.
19 MS. JONES:
20 A. That's a new process.
21 CHAYTOR, Q.C.:
22 Q. And so they would have been people similar to
23 yourself who are involved in other
24 institutions across the country.
25 MS. JONES:

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1 A. Other institutions across the country. You
2 generally have a mix of physician surveyors as
3 well as general admin surveyors as well as
4 nursing surveyors. And depending upon the
5 team, you could have other clinical areas
6 represented as well.
7 CHAYTOR, Q.C.:
8 Q. And the people who came to do the lab, in
9 particular, what area of expertise did they
10 have?
11 MS. JONES:
12 A. They are specific lab. They have solicited
13 inside of council a number of individuals with
14 expertise in lab. And so they only do the lab
15 surveys. They don't do any other part of the
16 general system survey, as we call it.
17 CHAYTOR, Q.C.:
18 Q. So, would have they have been physicians,
19 administrators, technologists, what -
20 MS. JONES:
21 A. They would have been physicians. I know there
22 was at least two physicians on that team.
23 CHAYTOR, Q.C.:
24 Q. So, pathologists?
25 MS. JONES:

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1 A. As well as--I'm not sure if there were
2 pathologists, but they were director of
3 medical laboratories.
4 CHAYTOR, Q.C.:
5 Q. Okay, yes.
6 MS. JONES:
7 Q. And there would have been management
8 kinds of people and I'm not sure because
9 we had an individual who ended up not
10 being able to come right at the last
11 minute, so we had to do our blood bank
12 survey in December. Our blood survey in
13 December versus through the regular
14 accreditation. But there was a
15 consultant who works with labs as well
16 who was part or the original team.
17 CHAYTOR, Q.C.:
18 Q. Okay. And so how then--and I guess you have
19 personal experience with it, but how do they
20 go about the process? Who do--you've have
21 experience on both ends.
22 MS. JONES:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. The person who was going through the

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1 accreditation as well as a surveyor for other
2 organizations.
3 MS. JONES:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. So, how does the process work? When you come
7 into an institution, who do you consult with?
8 What sources of information do you seek? Do
9 you carry out interviews? Do you look at
10 documentation? How does it work?
11 MS. JONES:
12 A. Prior to any survey being on the ground in
13 this particular process and it is changing for
14 this year, there's a new process started in
15 2008. What you actually have is the standards
16 document that is completed and sent to council
17 prior to. So, there is a documentation that's
18 completed by the team that's looking to be
19 accredited. And in this instance, it would
20 have been lab teams or a surgery team or a
21 child youth and family services team. I think
22 we had 23 teams plus the lab teams. So, there
23 is documentation that goes in and there is a
24 self rating of where you are on a scale of 1
25 to 7. And that rating is pretty uniform as to

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1 what those 1 to 7 would mean. Seven is top
2 performance in the country, best practice.
3 Six is everything that you would have in place
4 and be constantly reviewing it from a quality
5 perspective. Five would be that you would
6 have standards in place or your policies in
7 place, but you haven't got a full cycle of
8 quality improvement going on. And then you've
9 got your four and three and it works its way
10 down.
11 So, that is documentation that the
12 surveyors receive before they come on site.
13 When they come on site, they actually start
14 with--in this instance, they would have
15 started with the board and management team and
16 the leadership and partnership interview. And
17 then they go out and they do tours of the
18 areas as well as they do interviews with the
19 team that completed the self assessment. And
20 they do their ranking, they also look at
21 documentation whether it's policies,
22 procedures, client satisfaction, anything that
23 you've provided to them as part of evidence to
24 support why you rated yourself on a particular
25 standard. And in instances where there's

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1 client issues or clients, like, in long term
2 care or acute care or whatever, they do
3 interview clients around their service
4 provision. And there was a significant number
5 of focus groups that were done in this
6 particular survey which I hadn't seen before
7 and that was focus groups with families and
8 with clients throughout all parts of Eastern
9 Health. And there's also a focus group with
10 staff and there's a focus group with community
11 partners. So, they do that all in the period
12 of time that they're here. They visit, pretty
13 much, all of the sites and then they do a
14 debriefing when they finish. And then in
15 about six weeks time you get a result of their
16 assessment of what they believed your
17 organization, where it ranked in terms of
18 national standards.
19 CHAYTOR, Q.C.:
20 Q. Okay. And who attends the debriefing?
21 MS. JONES:
22 A. Debriefing is an open debriefing, okay. So,
23 anybody can attend that. We had it in the
24 Health Sciences auditorium, but we were a
25 conference call hook up to all of the sites

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1 around, you know, Burin, Carbonear, whatever,
2 so people didn't have to travel to St. John's
3 to hear the debriefing. And we probably had
4 between all of sites and in St. John's maybe
5 eight of nine board members present for the
6 debriefing.
7 CHAYTOR, Q.C.:
8 Q. So, I take it you attended the debriefing?
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. So, the surveyors would actually be in
13 attendance in St. John's and everybody else
14 hooked up by conference call?
15 MS. JONES:
16 A. That's right.
17 CHAYTOR, Q.C.:
18 Q. So, the surveyors attended in Clarenville and
19 Burin, Carbonear, all of your other sites and
20 St. John's.
21 MS. JONES:
22 A. Yes, all of the other--that's right.
23 CHAYTOR, Q.C.:
24 Q. So, they attended everywhere. Did they
25 laboratory medicine program, did that aspect

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1 also includes the sites outside St. John's?
2 MS. JONES:
3 A. Yes, it did. And this program is new and it's
4 a little bit different. The process is the
5 same in terms of self evaluation and then
6 interviews and tours. But for the lab, there
7 were six surveyors to do the lab and in the
8 other part of the organization there would
9 have been about ten surveyors to do all of the
10 other aspects of Eastern Health. So, the lab
11 accreditation is very much different in terms
12 of the comprehensiveness of it compared to
13 what we would see in some of the other areas.
14 CHAYTOR, Q.C.:
15 Q. And I take it that was a conscious decision by
16 Eastern Health in going through this process?
17 MS. JONES:
18 A. A conscious decision to enter into the pilot
19 where the standards were new. Okay. We had
20 not had standards before. And so, we had
21 worked through the standards, did a self
22 assessment with that and then invited the
23 surveyors in to look at our labs.
24 CHAYTOR, Q.C.:
25 Q. And why did Eastern Health do that at this

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1 stage?
2 MS. JONES:
3 A. Because we believed that we wanted to have an
4 external review, even though there was lots of
5 things going on, a lab accreditation will be a
6 mandatory part of accreditation starting this
7 year. It was not in 2007 and the standards
8 were probably less that a year old by the
9 time--and nobody in the country had seen them
10 except through the original pilot phase as
11 they were being developed.
12 CHAYTOR, Q.C.:
13 Q. So, this was a pilot phase for the CCHSA.
14 MS. JONES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. And however, for their process for you to
18 avail of accreditation from them in the
19 future, laboratory is -
20 MS. JONES:
21 A. Will be -
22 CHAYTOR, Q.C.:
23 Q. - mandatory.
24 MS. JONES:
25 A. That's right. And what would happen in this

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1 particular accreditation is that the results
2 of your lab would not be in your overall
3 general award, would not influence your
4 overall general award. So, this is the way
5 that the pilots go in terms of they're
6 continuing to refine the standards. They may
7 not be the actual standards that are coming
8 out in 2008 because as their surveyors get
9 more used to the surveys and what can be done
10 and what can't be done, they add to and remove
11 based upon the redundancy that may be in the
12 existing standards and to move the issue of
13 accreditation forward.
14 CHAYTOR, Q.C.:
15 Q. So, could you have asked to have the lab done
16 prior to now?
17 MS. JONES:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. There was nothing available?
21 MS. JONES:
22 A. Nothing available.
23 CHAYTOR, Q.C.:
24 Q. So, in other jurisdictions like Ontario, where
25 that happens -

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1 MS. JONES:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. They use other than CCHSA?
5 MS. JONES:
6 A. CCHSA, there is not--in a number of other
7 provinces, there's a provincial accreditation
8 for labs.
9 CHAYTOR, Q.C.:
10 Q. Yes.
11 MS. JONES:
12 A. The Maritimes generally doesn't have it and we
13 don't have laboratory accreditation and this
14 province doesn't have laboratory
15 accreditation.
16 CHAYTOR, Q.C.:
17 Q. And is there another organization then other
18 than the Council that you could use to have
19 your accreditation, if you had wanted to have
20 the lab accredited?
21 MS. JONES:
22 A. We have--I think you will hear from Dr.
23 Williams that we had talked about looking at
24 lab accreditation for while and explored some
25 possibilities. But every other jurisdiction

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1 in Canada that has it is provincial
2 accreditation. So, in order to do an
3 accreditation or come into--if we wanted to
4 have a review of our lab, they wouldn't have
5 had jurisdiction. It would have been, like, a
6 private contractor to come in. And at this
7 point in time there is no provision, I guess
8 and probably people hadn't asked them to
9 consider doing labs other than in their own
10 provinces.
11 CHAYTOR, Q.C.:
12 Q. So, there's a jurisdictional issue? You could
13 hire anyone when you had QMPLS in December -
14 MS. JONES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. You could hire someone to come in to do, but
18 not to get an accreditation.
19 MS. JONES:
20 A. Not to get an accreditation.
21 CHAYTOR, Q.C.:
22 Q. Okay.
23 MS. JONES:
24 A. But we had been exploring and I think Dr.
25 Williams will say to you, because Ontario is a

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1 well established accrediting for their
2 province, that we had started to have some
3 discussion about whether, in fact, they would
4 be interested in doing individual
5 organizational accreditation because we didn't
6 have a vehicle inside the province to be able
7 to look at it.
8 CHAYTOR, Q.C.:
9 Q. And the organizations in Ontario or other
10 places would have only had jurisdiction to
11 give accreditation within their own province
12 is what you're saying.
13 MS. JONES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. And how far back was it that Dr. Williams had
17 thought of the idea of looking at having lab
18 accredited?
19 MS. JONES:
20 A. I'm not sure how far back, but I do remember
21 that Dr. Cindy Whitman who used to be the
22 chair of MAC in St. John's through the old
23 health care corporation of St. John's, had
24 talked about, you know, really if we're going
25 to move everything forward, then we really

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1 need to be looking at lab accreditations.
2 There are speciality accreditations in not
3 just lab, vascular labs is one and there's
4 lots of speciality accreditations, but they're
5 generally done by national bodies.
6 CHAYTOR, Q.C.:
7 Q. Yes.
8 MS. JONES:
9 A. In lab there isn't a national body for
10 speciality accreditations. So, given that
11 there was no provincial body, it was, sort of,
12 how can we explore and that's probably two
13 years or so, two to three years where that
14 idea of floating about accreditation for the
15 lab. What could we do? Are there people who
16 could do something like that?
17 CHAYTOR, Q.C.:
18 Q. So, it's post ER/PR issue?
19 MS. JONES:
20 A. No, no, it's pre.
21 CHAYTOR, Q.C.:
22 Q. It came up before that?
23 MS. JONES:
24 A. Yes, it would have been before -
25 CHAYTOR, Q.C.:

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1 Q. So, two years would have been post ER/PR.
2 MS. JONES:
3 A. Yeah and I had indicated Cindy was the chair
4 of the MAC in St. John's.
5 CHAYTOR, Q.C.:
6 Q. Yes.
7 MS. JONES:
8 A. And the MAC in St. John's was the health care
9 corporation's MAC. So, she would -
10 CHAYTOR, Q.C.:
11 Q. So, this issue had come up prior to the ER/PR
12 issue arising?
13 MS. JONES:
14 A. In terms of how or is there a vehicle? There
15 is no national vehicle? Can we explore?
16 CHAYTOR, Q.C.:
17 Q. And what is the rationale that it's only now
18 that the council is getting around to
19 including laboratory services as part of the
20 accreditation process?
21 MS. JONES:
22 A. Because many of the lab, many of the provinces
23 had their own particular accreditation. There
24 were provinces who don't have. And so, at the
25 end of the day, council would have been

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1 approached to look at developing an
2 accreditation component. I would expect that
3 at the end of the day and I don't know what
4 discussion they're having at council, but
5 areas that have specific accreditation inside
6 their province, how that will work inside of
7 CCHSA accreditation.
8 CHAYTOR, Q.C.:
9 Q. And to your knowledge, had eastern health or
10 the predecessor legacy organizations every
11 approach government to ask that there -
12 MS. JONES:
13 A. I can't speak to that.
14 CHAYTOR, Q.C.:
15 Q. - be legislation be put in place?
16 MS. JONES:
17 A. I can't speak to that.
18 CHAYTOR, Q.C.:
19 Q. So, not to your knowledge?
20 MS. JONES:
21 A. Yeah.
22 CHAYTOR, Q.C.:
23 Q. You're not aware of it.
24 MS. JONES:
25 A. I'm not aware of it.

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1 CHAYTOR, Q.C.:
2 Q. I had read somewhere in the documentation that
3 the lab had been accredited back in the late
4 '90s. Did you see that?
5 MS. JONES:
6 A. I've been an accreditor since 199--yeah, it
7 says pre 1995. We used to go in and--
8 accreditation is moved from a client centre to
9 a more systems approach. And there's been
10 different iterations in terms of the
11 standards. Every two or three years, the
12 standards are changing; they're evolving.
13 There's more added into the standards.
14 There's more push on quality and you can see
15 that if you look at the standards over a
16 period of time. In the early 1990s we would
17 have done a physical tour of the lab to
18 physically go in and look for certain things.
19 But as calling that an accreditation of the
20 lab, not in the way that this is an
21 accreditation or in the way that the other
22 provinces have mandatory accreditation for
23 their labs. So, there was a component that
24 would have been a lab. When we moved,
25 probably, it says 1995 and I couldn't verify

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1 if it was 1995 or so, there would have been
2 what we call sections of standards that would
3 have lab and diagnostic imaging and pharmacy
4 that would have had to have been complete.
5 When we moved to client centred, those
6 sections and they are standards, maybe 13, 14
7 whatever, there's generally 17 sets of
8 standards inside each team. There would have
9 been a section on diagnostics and lab and a
10 section on the pharmacy, but they would have
11 bene in an inter-disciplinary team aspect
12 versus the lab filling out their set of
13 standards in that particular area and the
14 diagnostic imaging and the pharmacy. So, it's
15 more of a integrated approach versus a
16 specific lab standards.
17 CHAYTOR, Q.C.:
18 Q. It just seems, from a laypersons point of view
19 that the lab can affect every area within the
20 institution. So, I was just curious about
21 omission in that not being part of what the
22 council would be looking for because it can
23 have an impact on just about every area.
24 MS. JONES:
25 A. And I think that I just explained that the

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1 standards that would have related to safe
2 distribution and machines and preventative
3 maintenance and all of those kinds of things
4 are inside of 17 kind of individual areas of
5 standards and you might actually see them in
6 here. There is a section specifically for lab
7 and diagnostics. It's called the diagnostics.
8 And there's a section for pharmacy, but they
9 would be part of an inter-disciplinary team.
10 CHAYTOR, Q.C.:
11 Q. So, that would have been happening -
12 MS. JONES:
13 A. That would have been happening -
14 CHAYTOR, Q.C.:
15 Q. - throughout.
16 MS. JONES:
17 A. - throughout.
18 CHAYTOR, Q.C.:
19 Q. So, the accreditors coming in would be looking
20 at the equipment in the lab and making sure
21 there were maintenance records, maintenance
22 checks carried out.
23 MS. JONES:
24 A. Yes. And that there was qualified staff and
25 utilization processes and those kinds of

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1 things.
2 CHAYTOR, Q.C.:
3 Q. So, that would have been happening before
4 2007?
5 MS. JONES:
6 A. Absolutely.
7 CHAYTOR, Q.C.:
8 Q. So, they would have come in and checked the
9 lab, machinery, equipment, made sure there was
10 documentation verifying that quality assurance
11 was happening?
12 MS. JONES:
13 A. The actual--what would have to happen is, is
14 that whatever was inside the documentation on
15 that particular standard and the rating, the
16 accreditor would have had to convince
17 themselves, assure themselves that that rating
18 was appropriate. So, it would be looking at
19 extra documentation that may have been
20 provided around those areas and going back and
21 looking at policies if there was something
22 specific that they wanted to assure
23 themselves.
24 CHAYTOR, Q.C.:
25 Q. So, they wouldn't look at every single piece

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1 of equipment -
2 MS. JONES:
3 A. No.
4 MS. JONES:
5 A. - and get the documents on every piece of
6 equipment.
7 MS. JONES:
8 A. No.
9 CHAYTOR, Q.C.:
10 Q. Do you know whether or not they looked at all
11 at the equipment in the IHC lab?
12 MS. JONES:
13 A. I wouldn't know that from a 2004 survey or
14 earlier than that.
15 CHAYTOR, Q.C.:
16 Q. And how would we figure that out?
17 MS. JONES:
18 A. You wouldn't figure it out from the
19 accreditation report.
20 CHAYTOR, Q.C.:
21 Q. So, you wouldn't know if there -
22 MS. JONES:
23 A. No, there's no way to know that level of
24 detail.
25 CHAYTOR, Q.C.:

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1 Q. Okay.
2 THE COMMISSIONER:
3 Q. Excuse me, but you just said something that
4 caused me to think I didn't understand an
5 earlier response. When somebody does an
6 accreditation, by what are you being judged?
7 Are you being judged by what you have said
8 your numbers should be or are you being judged
9 by some kind of other standard which might be
10 determined by someone to be appropriate to
11 your particular institution?
12 MS. JONES:
13 A. No, there is--the self assessment is meant to
14 be a process where the teams will actually
15 review themselves against the standards,
16 identify where they may have areas and then
17 put in plans to move them towards the
18 standard. So, that is part of the self
19 assessment and ongoing quality improvement.
20 And lots of that ends up happening--we keep
21 these teams together other than just for
22 accreditations. So, they, in lots of areas,
23 become the quality team and work on issues
24 that arise out of the accreditation and the
25 standards. So, many times, by the time the

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1 surveyor comes into, they may have rated
2 themselves as a four just starting to think
3 about this, but you know, six months later
4 when the accreditors get in, they may actually
5 have a fair amount of work done to address an
6 issue that they had identified.
7 So, the surveyors themselves come with
8 the rating, the one to seven rating, but then
9 they have to assure themselves through the
10 documentation and the discussion that they had
11 at the team interview and either the
12 discussion with patients, looking at surveys,
13 those kinds of things, or there may have been
14 other reports like when we look at leadership
15 and partnership and that, there may very well
16 be HIROC are ensure, those risks issue, if we
17 had already done some kind of assessment, then
18 those kinds of things. All of that
19 documentation would be provided to the
20 surveyor and then based upon their knowledge
21 of the area and their peer surveyors coming in
22 from all across the country who are trained in
23 doing this, then they would make a rating.
24 THE COMMISSIONER:
25 Q. So, by what standard are you judged? Is the -

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1 MS. JONES:
2 A. The national standard.
3 THE COMMISSIONER:
4 Q. Is there one national standard for everybody?
5 MS. JONES:
6 A. Yes.
7 THE COMMISSIONER:
8 Q. So, the standard applied to the hospital in
9 Burin is the same on that's applied to Mount
10 Sinai.
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. Except obviously the hospital in Burin does
15 much less work. Well, unless people are
16 moving into Burin for the purposes of getting
17 health care. They would do much less variety,
18 I would think, of services -
19 MS. JONES:
20 A. That's right, but the core services that they
21 would provide, whether it's laboratory
22 services or blood bank or surgery or whatever,
23 would have to be to the same standard. So, it
24 is an assessment of clients. It would be the
25 development of a care plan. It would be the

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1 teaching of clients. It would be having
2 appropriate diagnostics to support that
3 particular client and what was happening in
4 that environment and that's how the standards
5 revolve out.
6 THE COMMISSIONER:
7 Q. So, would the accreditation standards get
8 involved in, for example, what equipment you
9 have in a hospital?
10 MS. JONES:
11 A. It would look at equipment and deem it would
12 be appropriate equipment for the level of
13 service that you were providing. If you were
14 in a small hospital and I was accrediting in a
15 small area across the country, I may not
16 expect to see a CAT scan, but I may expect
17 that if a CAT scan was required, that there
18 would be a referral process to a centre that
19 had and that was timely and that there were no
20 roadblocks to actually getting a service that
21 an individual client would require.
22 THE COMMISSIONER:
23 Q. So, is there something which says how big you
24 have to be to get a CAT scan?
25 MS. JONES:

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1 A. No.
2 THE COMMISSIONER:
3 Q. The surveyor judges that in the--that's a
4 discretionary matter within the purview of a
5 surveyor who happens to be doing it on that
6 occasion.
7 MS. JONES:
8 A. On that occasion based upon the kinds of
9 service at that particular facility because we
10 have tertiary facilities, we have secondary
11 facilities and we have primary facilities.
12 And so based upon what level of service you
13 would expect in that kind of facility and the
14 kind of work that they were doing, that would
15 be what you would be looking at.
16 THE COMMISSIONER:
17 Q. So, is it the classification which determines
18 what you would expect to find?
19 MS. JONES:
20 A. The service provision in the area. There is -
21 THE COMMISSIONER:
22 Q. So, if--as I understand it, the hospital which
23 is located just across the road is the one
24 that's considered the tertiary care hospital?
25 MS. JONES:

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1 A. Yes.
2 THE COMMISSIONER:
3 Q. You would not consider Burin Hospital -
4 MS. JONES:
5 A. No.
6 THE COMMISSIONER:
7 Q. - because it happens to be in your
8 organization to be tertiary care.
9 MS. JONES:
10 A. No, no.
11 THE COMMISSIONER:
12 Q. So, I'm assuming therefore, that if you have
13 that kind of operation, one would expect to
14 find, in a tertiary care operation, types of
15 service, equipment, expertise that you would
16 not expect to find in Burin? I'm not
17 particularly picking on Burin -
18 MS. JONES:
19 A. No.
20 THE COMMISSIONER:
21 Q. - it's just happens to be at the end of your
22 spectrum. So, when you walk in as an
23 accreditor, as a surveyor -
24 MS. JONES:
25 A. Surveyor, yes.

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1 THE COMMISSIONER:
2 Q. - is your mind set, I'm walking into a
3 tertiary care institution, therefore, if
4 they're going to come up to snap, as it were,
5 they must have certain things.
6 MS. JONES:
7 A. Yes. And the surveyors would be peer
8 surveyors. So, when we look at the surveyors
9 who actually would accredit inside of the
10 Health Sciences and St. Clare's, they would
11 come from similar sized organizations. And we
12 would have a mix of individuals on the team
13 that would come from small organizations as
14 well who were used to that level of primary or
15 secondary care. So, there's a mix of
16 expertise on the team and the teams work in
17 twos. Okay. The surveyors work in pairs so
18 that they lead the survey and then they do the
19 documentation. So, there's always the benefit
20 of having two people, not just one person and
21 the consensus is the two people will come
22 together to determine what the actual rating
23 is on any particular component of a standard
24 or a standard.
25 THE COMMISSIONER:

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1 Q. Okay, but is it written down somewhere in the
2 master list of the Canadian Council on Health
3 Service Accreditation that thou shalt have X,
4 Y, Z, if you are a tertiary care hospital, if
5 you want to get accreditation?
6 MS. JONES:
7 A. No.
8 CHAYTOR, Q.C.:
9 Q. So, if I, as a stranger wanted to know what's
10 required to get accreditation, I couldn't
11 figure that out because I'd really have to
12 have the inside knowledge to figure out what
13 accreditation requires.
14 MS. JONES:
15 A. And what you would be looking at is the actual
16 standards, the actual standard of which the
17 organization was held to in terms of flow of
18 patients, in terms of feedback, what
19 operations were set in place and that. And
20 that's the reason why I say this is a health
21 systems accreditation and accreditation from
22 very specialty organizations like we do have
23 accreditations for like the vascular lab and
24 the dental service and that, and they're very,
25 very specific, much like what QMPLS does for

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1 lab, and they would be at the very nut and
2 bolt of everything that goes on in that
3 particular area or discipline or service.
4 THE COMMISSIONER:
5 Q. Do I take it then that the accreditation done
6 by the Canadian Council on Health Services
7 Accreditation would not be that same kind of
8 nuts and bolts?
9 MS. JONES:
10 A. No, it is not.
11 THE COMMISSIONER:
12 Q. Why does one get accredited? What's the
13 advantage?
14 MS. JONES:
15 A. Well, the advantage of accreditation is
16 knowing that, from a peer review and coming
17 inside your organization that you're meeting a
18 set of national standards that many of the
19 things that has happened in accreditation
20 since the 50s have moved issues forward, like
21 infection control, like quality. These things
22 probably wouldn't be in the Canadian environ
23 if it wasn't for the Canadian Council on
24 Health Services Accreditation and it is moving
25 the bar higher and higher all the time. So

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1 when we talk about safer health care now and
2 particular projects and things that have been
3 identified from a perspective of having an
4 impact on patients like positive patient
5 identification, making sure that the patient
6 that you're administering the meds to is
7 exactly. There is some best practice around
8 that. Med reconciliation, hand washing, those
9 kinds of things, those would be what we call,
10 in today's environment, required
11 organizational practice. They have to be in
12 place, and in fact, you know, if you don't
13 have them in place, then it affects your
14 accreditation.
15 THE COMMISSIONER:
16 Q. Yes, okay. Are there down sides to not being
17 accredited?
18 MS. JONES:
19 A. No, there is no down side to not being
20 accredited, but in the early days of
21 accreditation, from a teaching environment,
22 used to be, and it's a long time, it's not in
23 my day, that you would not be able to be a
24 training program for medical schools unless
25 you were accredited. So you know, that goes

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1 way back to the 60s and probably the 70s.
2 THE COMMISSIONER:
3 Q. And how is this organization financed?
4 MS. JONES:
5 A. It's financed through the accreditation
6 process itself. So we pay.
7 THE COMMISSIONER:
8 Q. So you pay the actual cost of having the
9 people come to do it?
10 MS. JONES:
11 A. We pay the actual cost for the accreditation.
12 THE COMMISSIONER:
13 Q. All right, thank you.
14 CHAYTOR, Q.C.:
15 Q. And I understand, Ms. Jones, on that point
16 that it is not an insignificant cost?
17 MS. JONES:
18 A. No, it's not an insignificant cost.
19 CHAYTOR, Q.C.:
20 Q. And how much would it cost?
21 MS. JONES:
22 A. I can't speak to that, but we're talking -
23 CHAYTOR, Q.C.:
24 Q. Six figures?
25 MS. JONES:

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1 A. Oh, six, yeah.
2 CHAYTOR, Q.C.:
3 Q. Hundred thousand?
4 MS. JONES:
5 A. Yes, over that, more than that, and that goes-
6 -that supports the development of the
7 standards and the programming around it and
8 then during your accreditation year, you
9 actually pay for the accreditors to come in.
10 CHAYTOR, Q.C.:
11 Q. If we could go, please, to 0488, page 13?
12 0488, please. We'll come back to 0745 in a
13 moment.
14 REGISTRAR:
15 Q. Page number?
16 CHAYTOR, Q.C.:
17 Q. 13. This is again executive management
18 meeting. This one is June 13th '07. My page
19 number is wrong. It's supposed to be page 13,
20 please.
21 MS. JONES:
22 A. February the 7th.
23 CHAYTOR, Q.C.:
24 Q. Okay, and this one is February 7th, 2007.
25 That's better.

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1 MS. JONES:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. Okay, and this is dealing with the "a warm
5 welcome being given to Carla Williams, the
6 accreditation manager and Lisa Browne,
7 planning specialist." Who are those people?
8 MS. JONES:
9 A. Carla Williams is, as it says, we have a full-
10 time manager for accreditation that prepares -
11 CHAYTOR, Q.C.:
12 Q. So your in-house people?
13 MS. JONES:
14 A. These are my in-house people, and Lisa Browne
15 is a planning specialist who assisted in
16 pulling together the, as it says here, the
17 documentation for the leadership and
18 partnership.
19 CHAYTOR, Q.C.:
20 Q. So apart from the cost too to the Council,
21 there's obviously costs within your
22 organization?
23 MS. JONES:
24 A. That's right, of bringing teams together to
25 discuss the actual standards, what is our

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1 response to the standards, where is the
2 documentation, how can we validate that
3 particular point.
4 CHAYTOR, Q.C.:
5 Q. And it's a time consuming process, I would
6 think, for your staff.
7 MS. JONES:
8 A. Yes, it is.
9 CHAYTOR, Q.C.:
10 Q. And you have people actually on staff, hired
11 to deal with this?
12 MS. JONES:
13 A. We have one person and then in the teams,
14 there's generally a team leader, like a
15 surgery team leader is probably the program
16 director for surgery, who brings together a
17 quality team to work through the standards
18 throughout the year and then in the instance
19 that we are now, we keep those teams going,
20 not just for accreditation.
21 CHAYTOR, Q.C.:
22 Q. So this would be though, for Carla Williams, a
23 full-time position?
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. And they came in obviously to give a
3 presentation?
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. On the CCHSA and there was an internal review
8 committee set up. The following points were
9 highlighted during the presentation, and it
10 says that ten surveyors will be visiting, and
11 the second bullet, "laboratory services will
12 participate on a voluntary basis. The outcome
13 of the findings will not affect the outcome of
14 the accreditation."
15 MS. JONES:
16 A. That's right.
17 CHAYTOR, Q.C.:
18 Q. So whatever was found regarding the lab and
19 the lab services, that was not going to affect
20 the overall rating of the institution?
21 MS. JONES:
22 A. The overall accreditation, no.
23 CHAYTOR, Q.C.:
24 Q. Of the organization.
25 MS. JONES:

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1 A. That's right.
2 CHAYTOR, Q.C.:
3 Q. I take it, you told us you attended the
4 debriefing?
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. And what was the outcome of the accreditation
9 this year overall?
10 MS. JONES:
11 A. The comments during the debriefing were quite
12 positive, that they were very complimentary to
13 the organization. We were a new organization
14 that had done a lot of work over the period of
15 time and there was a lot of work to continue
16 to be done from an integration perspective.
17 There were issues with capital infrastructure
18 that were addressed. So what happens in a
19 debriefing, at this point in time, is every
20 team that is interviewed, there is a small
21 synopsis of what the team was like or, you
22 know, whether there would be recommendations
23 or what. What were the strengths of the team
24 and what areas for improvement, and generally
25 they would talk about every single team.

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1 CHAYTOR, Q.C.:
2 Q. Okay, and what was the outcome, in general, or
3 overall in terms of laboratory services?
4 MS. JONES:
5 A. The laboratory services, they basically--and
6 remember, we were only reporting on two teams
7 because the third team was not able to be
8 done.
9 CHAYTOR, Q.C.:
10 Q. Was the IHC laboratory included?
11 MS. JONES:
12 A. The IHC was included. It would have been
13 included in the--the team that was not able to
14 be done in September involved the blood bank
15 area, and they came back and -
16 CHAYTOR, Q.C.:
17 Q. So it was included in what you were debriefed
18 on in September?
19 MS. JONES:
20 A. Debriefed on in September. So you know,
21 overall, talked about, you know, the
22 commitment to quality moving forward, that we
23 were doing a lot of work and thanked us for
24 being part of and openly shared on what their
25 issues were and where they were moving--what

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1 work was ongoing.
2 CHAYTOR, Q.C.:
3 Q. Okay, so what do we take from that? Overall,
4 what was the outcome of the review of lab
5 services?
6 MS. JONES:
7 A. You will note that there is a--in the actual
8 debrief that we saw, there was a fair number
9 of recommendations, but if you look at them,
10 they were in the two teams and the areas that
11 were looked at, each one of the teams had
12 similar types of recommendations around
13 documentation standards, standard area of
14 practice, those kinds of things, and they
15 would have been three--if you boil them down,
16 there were probably 12 or 13 core
17 recommendations that went to all of the lab
18 areas. And I would say to you whenever
19 there's a new set of standards and there's
20 always an evolution of the standards, that at
21 the end of the day there's generally a lot of
22 recommendations on new standards as people are
23 working with and putting things in place to
24 meet the standards. And then over time what
25 happens is is that as people know what the

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1 standards are and become used to them, then
2 that becomes part of the normal process, the
3 normal update, those kinds of things.
4 CHAYTOR, Q.C.:
5 Q. Yes. And you've read Trish Wegrynowski's
6 reports now?
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And documentation, standards of practice -
11 MS. JONES:
12 A. That's right, they're -
13 CHAYTOR, Q.C.:
14 Q. Those were key issues addressed by her -
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. - back in 2005 when she did her review?
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. So those are some of the same issues that
23 we're seeing in the accreditation?
24 MS. JONES:
25 A. Some of the same issues. And what you see,

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1 though, is is that the pathology lab or the
2 IHC lab that you're talking about was one
3 component of a larger team, right.
4 CHAYTOR, Q.C.:
5 Q. Yes. I just want to take you through a few
6 points. If we could go back, please, to 745,
7 page 10? And this seems to be a synopsis of
8 the successes and challenges of the
9 organization.
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. And it begins with saying that "The successes
14 of the organization are numerous and varied."
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. And just a few are mentioned here. "In its
19 short existence the Eastern Health," they have
20 "EHA" "has developed a strong board which is
21 well on the way to full development of its
22 policy governance model." And it indicates in
23 the next paragraph that "There is a good
24 relationship with the ministry of health." So
25 would they have had any discussions with the

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1 Department of Health in doing this?
2 MS. JONES:
3 A. They would have, in their leadership and
4 partnership team there would have been
5 somebody from the--not team. In the focus
6 group with leadership and partnership--focus
7 group of stakeholders, sorry, there would have
8 been somebody from the Department of Health.
9 And you can anticipate that these people were
10 probably from Ontario because they call it
11 ministry. But there would have been one
12 person on that focus group that they would
13 have talked to.
14 CHAYTOR, Q.C.:
15 Q. Okay. You don't know who that person is?
16 MS. JONES:
17 A. I wouldn't be able to recall right now.
18 CHAYTOR, Q.C.:
19 Q. Okay. And they certainly are complimentary.
20 "The ethics services and policy framework is
21 exemplary."
22 MS. JONES:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. "There's a strong culture of emergency

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1 planning." "Fiscal year 2006, 2007 saw a
2 balanced budget with some debt repayment."
3 MS. JONES:
4 A. Um.
5 CHAYTOR, Q.C.:
6 Q. So is that part of what goes into getting a
7 good accreditation?
8 MS. JONES:
9 A. No.
10 CHAYTOR, Q.C.:
11 Q. Okay.
12 MS. JONES:
13 A. No. These are just comments that they would
14 make overall.
15 CHAYTOR, Q.C.:
16 Q. Okay. "New regional policies tools such as
17 the operational planning handbook and the
18 quality and risk management framework guide
19 managers and staff. Resources have been
20 designated for quality and risk management and
21 clinical efficiency staff have been hired."
22 MS. JONES:
23 A. Um.
24 CHAYTOR, Q.C.:
25 Q. And then the next paragraph in particular on

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1 the bottom it says, "Recently a position paper
2 has been submitted on the best methods of
3 hearing the voice of patients and families."
4 What is that, what's that referring to?
5 MS. JONES:
6 A. I'm not quite sure what that is. It may be
7 later on you will see that there is a good
8 practice, which means best in the country, but
9 I'm not sure what that is. And really, to say
10 what it is or synopsis what they've said, I'm
11 not--that one escapes me. And this is
12 somebody else interpreting what they heard.
13 CHAYTOR, Q.C.:
14 Q. Right, yes.
15 MS. JONES:
16 A. As we go through.
17 CHAYTOR, Q.C.:
18 Q. Okay. So that's--well, maybe you could ask
19 for us and just let us know if it's anything
20 of any relevance?
21 MS. JONES:
22 A. Yeah.
23 CHAYTOR, Q.C.:
24 Q. And what that is, because it says it's recent.
25 MS. JONES:

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1 A. Um.
2 CHAYTOR, Q.C.:
3 Q. And it continues on the next paragraph and
4 indicates that "Resources are available for
5 staff to attend relevant educational
6 offerings."
7 MS. JONES:
8 A. Yeah.
9 CHAYTOR, Q.C.:
10 Q. "The organization participates in the
11 initiative Safer Health Care Now."
12 MS. JONES:
13 A. Um.
14 CHAYTOR, Q.C.:
15 Q. "In several collaborative endeavours and has
16 achieved good outcomes." And that's the
17 initiative of CPSI, is it?
18 MS. JONES:
19 A. No.
20 CHAYTOR, Q.C.:
21 Q. No.
22 MS. JONES:
23 A. Yeah, Safer Health Care Now, yes, comes under
24 the CPSI and they have a number of initiatives
25 that we're involved in, yes.

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1 CHAYTOR, Q.C.:
2 Q. Okay. And then in dealing with the ongoing
3 challenges, refers to "The matrix structure
4 and multiple levels of accountability slows
5 decision making."
6 MS. JONES:
7 A. Um.
8 CHAYTOR, Q.C.:
9 Q. Was that discussed, do you know what that's
10 referring to?
11 MS. JONES:
12 A. I would expect that is as we're a new
13 organization, we're still putting together I
14 call them the plug ins. We have regional
15 programming, particularly on lab, diagnostics,
16 human resources and that, and then we have
17 some site specific, as well. So it is how do
18 the organization make--who's responsible for
19 the decision if we're talking about the lab
20 in--and how we communicate that on the Burin
21 Peninsula, when in fact the lab manager is a
22 centralized manager with an individual who
23 works on the Burin Peninsula. So those kinds
24 of things are still, as people are in jobs and
25 working through, so it's the matrix aspect of

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1 some of the relationships that we do have.
2 CHAYTOR, Q.C.:
3 Q. Right. And I take it that wouldn't come as any
4 surprise to you, that's a challenge that -
5 MS. JONES:
6 A. No.
7 CHAYTOR, Q.C.:
8 Q. - you're dealing with?
9 MS. JONES:
10 A. That's right.
11 CHAYTOR, Q.C.:
12 Q. Right. It goes on to say, "Care must be taken
13 to avoid a sense of powerlessness among
14 community partners and staff alike. Community
15 partners feel strongly that they should be
16 included earlier in the strategic planning
17 process." Who would this be, who are your
18 community partners in this context?
19 MS. JONES:
20 A. In this context it would have been the
21 partners group and it would have been people
22 like maybe the Canadian Mental Health
23 Association, Heart and Stroke, it would have
24 been the school board, those kind of
25 individuals.

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1 CHAYTOR, Q.C.:
2 Q. Does it include the Canadian Cancer Society?
3 MS. JONES:
4 A. May have been there. Generally we would have
5 had a 12 to 15 people that we would have put
6 together for them and some may have been
7 available. This particular one was probably
8 on a Sunday afternoon, so I'm not sure who the
9 actual partners were in the room at that day.
10 CHAYTOR, Q.C.:
11 Q. So you don't know if the Canadian Cancer
12 Society took part or not?
13 MS. JONES:
14 A. No, I can't tell you that one, Sandy.
15 CHAYTOR, Q.C.:
16 Q. Do you know if they were invited?
17 MS. JONES:
18 A. I wouldn't have known that.
19 CHAYTOR, Q.C.:
20 Q. You don't know?
21 MS. JONES:
22 A. Right.
23 CHAYTOR, Q.C.:
24 Q. "Evaluation of the board governance model, the
25 board and programs is an area to work on."

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1 MS. JONES:
2 A. Um.
3 CHAYTOR, Q.C.:
4 Q. "There needs to be an increased emphasis on
5 outcome" -
6 MS. JONES:
7 A. Outcomes.
8 CHAYTOR, Q.C.:
9 Q. - "indicators in the team's quality
10 reporting." What does that mean?
11 MS. JONES:
12 A. That is what I had said to you, it's
13 particularly around--they don't talk about it
14 as governance model, but in terms of the ELs
15 and reporting to the board in terms of
16 indicators and outcomes. All of our teams are
17 looking to try to not just give you process
18 indicators, we did this, this is what we
19 counted, it is what is the impact that it has
20 had at the end of the day. So that's the
21 outcome of your work and not necessarily the
22 process of how you did your work. So this
23 particular outcome indicators, there is a lot
24 of work and there's been a lot of angst across
25 the country in terms of trying to find the

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1 most appropriate indicator to actually
2 determine that the work that you're doing is
3 having an effect.
4 CHAYTOR, Q.C.:
5 Q. Okay. And then next paragraph talks about
6 "Continued attention needing to be paid to
7 integration and standardization of policies,
8 procedures and care plans," sorry, "across the
9 region, both rural and urban."
10 MS. JONES:
11 A. "Urban."
12 CHAYTOR, Q.C.:
13 Q. "And a bill of rights needs to be developed."
14 What, bill of rights for whom, is that for
15 patients?
16 MS. JONES:
17 A. That's a patient bill of rights. In the old
18 standards, although it hasn't been in
19 standards for, not this round of standards for
20 five years, there used to be a standard that
21 said a bill of rights.
22 CHAYTOR, Q.C.:
23 Q. I saw that in earlier accreditations where the
24 organization did have a bill of rights.
25 MS. JONES:

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1 A. That's right. And so it's not--in the
2 standards and the points under the standards
3 it doesn't talk about a bill of rights any
4 more. Some people still refer to it as a bill
5 of rights. But it is--and you would see a
6 bill of rights lots of times in the long-term
7 care, what is expected, the resident expect
8 and what we expect. So a bill of rights
9 really ends up having to be two sides of the
10 equation, what we will provide and what expect
11 from patients and clients.
12 CHAYTOR, Q.C.:
13 Q. So does Eastern Health currently have a
14 patient bill of rights?
15 MS. JONES:
16 A. No, we don't.
17 CHAYTOR, Q.C.:
18 Q. Okay. But the Health Care Corporation did?
19 MS. JONES:
20 A. The Health Care Corporation had one but it
21 hadn't been revised in awhile.
22 CHAYTOR, Q.C.:
23 Q. Okay. So that wouldn't have carried over as
24 other policies carried on from the legacy
25 organization?

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1 MS. JONES:
2 A. This has been there. This would be something
3 that you would be build up through your ethics
4 and your pastoral care side. And we have not
5 gotten to that piece of work, we've had other
6 priorities in terms of work that was ongoing
7 in policy. But that is one of the areas that
8 is on the list for pastoral care and ethics as
9 it moves forward to--because we talk about
10 everything from acute care and long-term care
11 and community services, it's a very different
12 bill of rights if we're talking about it for
13 the entire Eastern Health.
14 CHAYTOR, Q.C.:
15 Q. Yes, I understand that.
16 MS. JONES:
17 A. Than what we currently have in either one of
18 the sectors.
19 CHAYTOR, Q.C.:
20 Q. Yes. But the one that, in any event, that had
21 been in place for the acute care sector -
22 MS. JONES:
23 A. Yes. Still, still there.
24 CHAYTOR, Q.C.:
25 Q. It's still there?

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1 MS. JONES:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. But it had not been revised for quite some
5 time?
6 MS. JONES:
7 A. That's right.
8 CHAYTOR, Q.C.:
9 Q. And why is that?
10 MS. JONES:
11 A. Because we moved into a new organization. It
12 would have been pre 2004, which is what it
13 would have been referenced on. We came into
14 Eastern Health in 2005 and policies and
15 procedures and standards across Eastern Health
16 we're in the process of doing that and that
17 doesn't happen overnight.
18 CHAYTOR, Q.C.:
19 Q. So that's something, I take it, that's been
20 worked on since the accreditation?
21 MS. JONES:
22 A. It is on the list of things that we have to
23 do, yes.
24 CHAYTOR, Q.C.:
25 Q. And what does a bill of rights do in terms of

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1 for a patient, what kinds of things would you
2 expect to see in a bill of rights?
3 MS. JONES:
4 A. It would--it's almost like before you get to
5 your bill of rights you really have to get
6 your values an those kinds of things that
7 you're holding yourself out as an organization
8 down and solid. And then you would look to
9 what is it that we would provide and, you
10 know, we would expect that we would be open
11 and transparent and that you would provide us
12 with all of the information, not hold back if,
13 in fact, you're seeking care in that from us.
14 So before you would even go to a bill of
15 rights, you need to have your, what we would
16 call your foundational documents well
17 articulated and then move with that and then
18 move into developing a bill of rights for your
19 client population.
20 CHAYTOR, Q.C.:
21 Q. Okay. And you do have a bill of rights or the
22 Health Care Corporation had a bill of rights?
23 MS. JONES:
24 A. Yes, that's right.
25 CHAYTOR, Q.C.:

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1 Q. Albeit perhaps somewhat dated now?
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And so what kinds of things would be in the
6 bill of rights?
7 MS. JONES:
8 A. It would have some of the things that I would
9 have just said to you, that there would be an
10 open relationship, that if there were
11 information -
12 CHAYTOR, Q.C.:
13 Q. On both sides of the equation?
14 MS. JONES:
15 A. On both sides, right. And that you can expect
16 us to treat you with respect, all right, and
17 that we will do the best in our power to be
18 able to serve your needs, that kind of thing,
19 so. And you usually, sometimes you see a bill
20 of rights and you see it posted in entrances
21 of hospitals and that, and it really is what
22 the patient can expect. Usually we would have
23 some of it probably in handbooks, you know, on
24 admission, but that's admission to acute care.
25 In long-term care they would have had a

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1 different way of talking about a bill of
2 rights. In community-based services is
3 another different thing.
4 CHAYTOR, Q.C.:
5 Q. But it would set the parameters of what a
6 patient could expect in taking care of from
7 the organization?
8 MS. JONES:
9 A. And what we expect from them.
10 CHAYTOR, Q.C.:
11 Q. And what you expect back?
12 MS. JONES:
13 A. Yeah.
14 CHAYTOR, Q.C.:
15 Q. And which would include an open and
16 transparent relationship?
17 MS. JONES:
18 A. That's exactly it.
19 CHAYTOR, Q.C.:
20 Q. If we continue on then, we have "Medical
21 staff," the last sentence to this paragraph,
22 "Medical staff credentialing and privileging
23 is fragmented and inconsistent and there is no
24 evidence of performance appraisals for this
25 group." What's that about and what action, if

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1 any, is being taken to address that issue?
2 MS. JONES:
3 A. Well, the medical credentialing and
4 privileging, we still have or old medical
5 staff MACs in place and we have been waiting
6 for--the province wants to move forward with a
7 single set of bylaws, a provincial set of
8 bylaws for medical staff. There's been a lot
9 of work done in the province in the last two
10 years involving Newfoundland and Labrador
11 Medical Association as well as the physicians.
12 We've had a--that has gone out to physicians.
13 There's been focus groups across the province
14 on it. And that is--that fundamental work
15 would need to be done because there's a major
16 change in the way credentialing would happen
17 in the province. Credentialing underneath
18 most the way it's done is a board will
19 actually approve credentials. Inside of this
20 particular set of model bylaws or whatever you
21 want to call it the credentialing comes
22 through and the responsibility is the CEO
23 versus the board. So that is a discussion
24 that has offered some debate in this province
25 about the authority of the CEO and the lineup

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1 of the board inside of--the MAC to the board.
2 THE COMMISSIONER:
3 Q. Ms. Chaytor, whenever you can find an
4 appropriate spot.
5 CHAYTOR, Q.C.:
6 Q. Okay. I'll just finish up then on this point.
7 So is the fragmented issue because you are--
8 because of the legacy organizations that came
9 together in 2005, is -
10 MS. JONES:
11 A. And we have not pulled together a single MAC
12 for Eastern Health. We still have local MACs.
13 We have--there would have been a meeting in
14 March, but it was a snow storm. It was the
15 first time that we were going to bring
16 together a regional approach to MAC.
17 CHAYTOR, Q.C.:
18 Q. Okay. But in terms of the credentialing and
19 privileging of the physicians, that would
20 still be happening, I would take it?
21 MS. JONES:
22 A. That's still happening under the old bylaws.
23 CHAYTOR, Q.C.:
24 Q. But it's just that it's not--under the old
25 bylaws?

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1 MS. JONES:
2 A. Under the old bylaws.
3 CHAYTOR, Q.C.:
4 Q. It's still happening, but it's probably not
5 being done consistently throughout all of your
6 sites?
7 MS. JONES:
8 A. It's not being done in the same way.
9 CHAYTOR, Q.C.:
10 Q. In Carbonear or Burin or St. John's?
11 MS. JONES:
12 A. It's a different process in St. John's -
13 CHAYTOR, Q.C.:
14 Q. Is that the issue?
15 MS. JONES:
16 A. - as Carbonear as -
17 CHAYTOR, Q.C.:
18 Q. But it's happening?
19 MS. JONES:
20 A. It's happening.
21 CHAYTOR, Q.C.:
22 Q. Okay. By the individual MACs?
23 MS. JONES:
24 A. Individual MACs and approved at the board, the
25 Eastern Health Board.

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1 CHAYTOR, Q.C.:
2 Q. Do I read into this, though, that the
3 credentialing and privileging of one may not
4 be the same standard as another?
5 MS. JONES:
6 A. No, because basically you have to have
7 licensure from the College of Physicians and
8 Surgeons. There is a process for references,
9 as well. So the elements of the process would
10 be similar, but how it is actually articulated
11 in each one of the legacy organizations may be
12 a little bit different.
13 CHAYTOR, Q.C.:
14 Q. And was there any issue raised that in use of
15 the word "inconsistent" that credentialing and
16 privileging was not happening on as regular
17 basis as it should be happening?
18 MS. JONES:
19 A. No. It's, in fact, happening in the same
20 manner as it was happening in the legacy
21 organizations, then brought together. So we
22 have four, I think it is, MAC reports rather
23 than one MAC report that goes to board and
24 board deals with each one of those reports
25 separately, and credentialing and privileging

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1 would be inside of each one of those reports.
2 CHAYTOR, Q.C.:
3 Q. So I understand how it's fragmented.
4 MS. JONES:
5 A. Yeah.
6 CHAYTOR, Q.C.:
7 Q. But I guess I'm not understanding how it's
8 inconsistent across the region.
9 MS. JONES:
10 A. That would be a word that they would have used
11 so--but the elements of the credentialing
12 process would be the same.
13 CHAYTOR, Q.C.:
14 Q. And the last part of the sentence, "There is
15 no evidence of performance appraisals for this
16 group."
17 MS. JONES:
18 A. Remember I mentioned yesterday that we're
19 getting a lot more documentation and moving
20 forward with documentation on physician,
21 physician performance, whether it's the
22 utilization issues, what is their CME, those
23 kinds of things. A little bit more
24 sophisticated in St. John's than it is in
25 other parts of the region. And Dr. John Guy,

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1 who is the director of medical services, has
2 this particular piece of pulling together the
3 regional MAC, the bylaws and looking at
4 performance appraisals so we have a standard
5 template across the organization.
6 CHAYTOR, Q.C.:
7 Q. So you were aware that performance appraisals
8 were not being carried out on the physicians?
9 MS. JONES:
10 A. Not in all, on all physicians. But every
11 time, remember I said yesterday, every time
12 the person has to come in for re-credential,
13 their privileges have to be reaffirmed in
14 whatever cycle that the previous boards had.
15 There would have been recommendations and
16 review from the clinical chief or the chief of
17 staff or whatever the legacy board had which
18 actually reviewed and brought forward to the
19 board that, in fact, that this was an
20 individual who--that their qualifications and
21 their work performance was appropriate and
22 they wanted to be credentialed for an
23 additional three or five years.
24 CHAYTOR, Q.C.:
25 Q. But the fact that the surveyors are saying

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1 there's no evidence of that, I take it there's
2 nothing in writing?
3 MS. JONES:
4 A. There's not consistently throughout Eastern
5 Health, but there is performance appraisals on
6 individuals sporadically throughout Eastern
7 Health.
8 CHAYTOR, Q.C.:
9 Q. And is that true of the pathologists?
10 MS. JONES:
11 A. I can't speak to--you might very well want to
12 ask Dr. Howell, that might be a sporadic.
13 CHAYTOR, Q.C.:
14 Q. Okay.
15 MS. JONES:
16 A. But there are some--there are some clinical
17 chiefs in St. John's who actually have
18 performance appraisals on pretty much everyone
19 of the physicians that work in or have
20 documented discussions with the physicians
21 that work in their area.
22 CHAYTOR, Q.C.:
23 Q. So whether it's been done and over what time
24 period, that's something Dr. Howell could
25 speak to?

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1 MS. JONES:
2 A. That, yeah.
3 CHAYTOR, Q.C.:
4 Q. Okay. Thank you, Commissioner.
5 THE COMMISSIONER:
6 Q. All right, then, why don't we meet again at
7 2:15?
8 (BREAK FOR LUNCH)
9 THE COMMISSIONER:
10 Q. Please be seated. Ms. Chaytor.
11 CHAYTOR, Q.C.:
12 Q. Thank you, Commissioner. P-0745 please, page
13 11. When we broke, Ms. Jones, we were looking
14 at this, the accreditation report of 2007.
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. This page deals with a response to previous
19 survey recommendations, and it notes that "the
20 organization is recognized for the work done
21 since 2005 in amalgamating seven separate
22 organizations to become a new entity, namely
23 the Eastern Health Authority. In 2006, the
24 organization submitted a report outlining its
25 progress with each recommendations from the

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1 seven legacy organizations. Those
2 recommendations had to do with ethics,
3 medication reconciliation, occurrence
4 reporting, communication of care planning,
5 complaints process, advocacy, quality and
6 clients' rights." So I take it there were
7 recommendations in all of those areas?
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. From prior accreditations?
12 MS. JONES:
13 A. In 2006, they would have been interim
14 accreditations to bring us to 2007. So at
15 least two of the organizations, two of our
16 previous boards had that.
17 CHAYTOR, Q.C.:
18 Q. So in 2006, an interim report went forward
19 regarding progress made on those eight
20 recommendations?
21 MS. JONES:
22 A. Yeah.
23 CHAYTOR, Q.C.:
24 Q. Okay, in those eight areas, and it's noted
25 here "there's been an excellent response to

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1 the recommendation related to address clinical
2 ethics issues and health clinical teams deal
3 with these issues," and I believe you told me
4 yesterday that that would have been other
5 organizations other than Health Care
6 Corporation?
7 MS. JONES:
8 A. That's right.
9 CHAYTOR, Q.C.:
10 Q. And it indicates that "an ethics policy
11 framework and plan have been developed and a
12 committee structure has been developed that
13 comprises an ethics advisory committee -
14 MS. JONES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. - an administrative ethics committee and four
18 clinical ethics committees in key areas. An
19 ethics lens is applied to policy development."
20 Were all of those things in existence in any
21 event at the Health Care Corporation?
22 MS. JONES:
23 A. The ethics advisory committee, the admin
24 ethics was. We had clinical ethics
25 committees. The ethics lens for policy

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1 development wouldn't have been as developed as
2 it is inside of Eastern Health.
3 CHAYTOR, Q.C.:
4 Q. Okay. So the improvements in those areas
5 pertained predominantly outside the St. John's
6 region?
7 MS. JONES:
8 A. Outside St. John's. Inside St. John's,
9 because we had community and long-term care as
10 well, but not the acute care hospital based.
11 CHAYTOR, Q.C.:
12 Q. Yes, okay, and we come down to this paragraph,
13 it says "attention has been paid to the
14 previous recommendation to develop a tracking
15 process to ensure incidents are followed up in
16 a timely manner and not delayed at any level
17 of the organization. There needs to be
18 documentation and tracking of the
19 communication with client and family to
20 prevent the feeling of their complaint being
21 lost in the system. In response, regional
22 policies have been developed on occurrence
23 reporting in management, disclosure and
24 responding to complaints, and funding has been
25 sought from Canada Health Info to support

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1 implementation of an electronic occurrence
2 reporting system. There is work still to do
3 to ensure that occurrences and complaints are
4 documented as having been consistently
5 followed up on."
6 MS. JONES:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. And are those issues, the attention that had
10 been paid to the previous recommendation of
11 developing a tracking process to ensure that
12 incidents are followed up on in a timely
13 manner, did that pertain to the Health Care
14 Corporation?
15 MS. JONES:
16 A. I'm not sure, but I would suspect that all of
17 the organizations would have had some tracking
18 system or occurrence reporting system, but I
19 can't speak to that particular, whether it was
20 Health Care Corp.
21 CHAYTOR, Q.C.:
22 Q. Okay, so this suggests that there had been a
23 recommendation, I would take it, in 2004.
24 MS. JONES:
25 A. 2004.

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1 CHAYTOR, Q.C.:
2 Q. 2004?
3 MS. JONES:
4 A. Yes.
5 CHAYTOR, Q.C.:
6 Q. And that there had been some attention paid
7 and that there still needs to be documentation
8 and tracking of communication with client and
9 families?
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. And if we come down to this paragraph, it says
14 "there has been a response to the
15 recommendation that Eastern Health Authority
16 provide an education process for staff and
17 managers at all levels of the organization to
18 ensure responsibility for the complaint
19 process are clearly understood and provide
20 information on how to advocate for client
21 families throughout the complaint process, and
22 the response is in the planning stages." So I
23 take it that is, again, in response to a prior
24 recommendation?
25 MS. JONES:

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1 A. Prior recommendation, and that one would be
2 more particularly related to the Carbonear
3 board because there was an actual complaint, a
4 family complaint that actually--families can
5 complain to Canadian Council on Health
6 Services Accreditation and there was an
7 investigation and follow up based upon that.
8 CHAYTOR, Q.C.:
9 Q. So do you understand that this is something
10 that did not pertain to the Health Care
11 Corporation?
12 MS. JONES:
13 A. No, I'm not saying that, but I'm saying in
14 particular, in relation to that, there was -
15 CHAYTOR, Q.C.:
16 Q. There was a particular incident in Carbonear?
17 MS. JONES:
18 A. There was a particular incident that they
19 would have probably been referencing there.
20 CHAYTOR, Q.C.:
21 Q. And this is still in the planning stages, I
22 take it, according to September 2007?
23 MS. JONES:
24 A. In September of 2007, yes.
25 CHAYTOR, Q.C.:

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1 Q. Has there been further progress made on that?
2 MS. JONES:
3 A. The complaints process, yes, there has and
4 there's--but it's more in relation to staff
5 education and that around the timeliness of
6 and the process that we had just put in place
7 around how to respond to complaints and the
8 time frame and where complaints are received
9 and how we forward them through the
10 organization.
11 CHAYTOR, Q.C.:
12 Q. And who would be in charge of that?
13 MS. JONES:
14 A. The quality department would be moving that
15 one forward.
16 CHAYTOR, Q.C.:
17 Q. "In response to the recommendation to
18 establish an advocacy role for client families
19 who are not satisfied with care delivery, the
20 Eastern Health Authority has appointed a
21 client satisfaction consultant and a client
22 relations consultant within the quality and
23 risk management division." Is that two
24 separate roles?
25 MS. JONES:

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1 A. That would be the Nancy Parsons kind of -
2 CHAYTOR, Q.C.:
3 Q. That's the patient -
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. Okay, so that's Nancy's role?
8 MS. JONES:
9 A. That would be Nancy's role, and that was there
10 in previous to Eastern Health.
11 CHAYTOR, Q.C.:
12 Q. Yes, that's nothing new.
13 MS. JONES:
14 A. That's nothing new, but as Eastern Health,
15 other parts of the organization, they receive
16 complaints through the entire organization.
17 So it's not just old Health Care Corporation.
18 CHAYTOR, Q.C.:
19 Q. So that's the patient relations officer?
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. Okay. The recommendation to establish quality
24 monitoring processes to ensure safe care is
25 delivered in all facilities has been addressed

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1 in that there is a detailed quality and risk
2 management framework in place. The
3 organization has completed the Health Care
4 Insurance Reciprocal of Canada, HIROC, self
5 assessment modules," and so there was a
6 recommendation, I take it, in 2004 to
7 establish quality monitoring processes and
8 it's indicated that has taken place, and I
9 will speak to you in a little while about the
10 quality and risk management framework.
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. What are the Health Insurance Reciprocal of
15 Canada self assessment modules?
16 MS. JONES:
17 A. That is a program that you go through which is
18 basically a set of questionnaires that you
19 will out and it has a lot of things in all of
20 the areas of the organization. Do you have
21 policies? Do you have processes in place? And
22 it is a risk assessment from the insurance's
23 perspective and then there's a grading of your
24 responses and there is a plan. The
25 organization makes a plan to move forward. So

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1 as part of completing the Health Insurance
2 Reciprocal of Canada, which is our insurers,
3 then you can look at potential rebates,
4 depending on the level of resources and the
5 work that you've done and the policy and those
6 kinds of things that would lead to potentially
7 decreasing claims, and that was done, it's a
8 fairly comprehensive assessment throughout all
9 parts of the organization, everything from
10 maintenance to the operating room.
11 CHAYTOR, Q.C.:
12 Q. So that's something that HIROC -
13 MS. JONES:
14 A. HIROC has.
15 CHAYTOR, Q.C.:
16 Q. - that you're obliged to carry out?
17 MS. JONES:
18 A. We're not obliged to carry out, but if we do
19 carry it out, then we do get an assessment and
20 then there's a rating from it.
21 CHAYTOR, Q.C.:
22 Q. And you can get a reduction in your premiums,
23 so to speak?
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. "An occurrence reporting system is in place,
3 though staff indicated that there remains
4 reluctance to report. Sentinel events and
5 near misses are investigated. Some failure
6 mode affects analysis have been done." So "an
7 occurrence reporting system is in place,
8 though staff indicated that there remains
9 reluctance to report." What's that about?
10 MS. JONES:
11 A. That's always an issue inside of an
12 organization with the completion of occurrence
13 reports. Sometimes it doesn't get to--
14 actually get to an occurrence report, but at
15 the end of the day becomes investigated and
16 the issue is resolved, and that really comes
17 back to the point earlier on around complaints
18 and that is educating staff and ensuring that
19 there's a comfort level with reporting
20 incidents and that that do occur.
21 CHAYTOR, Q.C.:
22 Q. And "sentinel events and near misses are
23 investigated."
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. And is that--what information would the
3 surveyors have to make that statement?
4 MS. JONES:
5 A. They would have had a policy around sentinel
6 events and they may very well have
7 documentation inside of the evidence binders,
8 as we would have called them at the time,
9 around the number of sentinel events or
10 investigations or the types. So that would
11 have been evidence to ensure them that this in
12 fact was going on, and there's also a part in
13 the leadership and partnership standards where
14 it would ask you to identify the number of
15 sentinel events that you have.
16 CHAYTOR, Q.C.:
17 Q. Okay. So would they actually--they would go
18 to see that there is a policy for
19 investigating a sentinel event or a near miss.
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And then would they actually look at the
24 documentation into the investigation?
25 MS. JONES:

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1 A. No, they wouldn't.
2 CHAYTOR, Q.C.:
3 Q. How would they satisfy themselves that an
4 investigation had taken place?
5 MS. JONES:
6 A. They would see the nature of the event in the
7 leadership and partnership and then they would
8 ask questions in an interview process around
9 particular incidents that would have been
10 reflected to ensure that there's a process.
11 CHAYTOR, Q.C.:
12 Q. So where would they get the information?
13 What's the leadership and partnership?
14 MS. JONES:
15 A. Leadership and partnership lists out what
16 sentinel events the organization has
17 experienced in the period of time.
18 CHAYTOR, Q.C.:
19 Q. So that's the documentation as -
20 MS. JONES:
21 A. That's the documentation -
22 CHAYTOR, Q.C.:
23 Q. - provided by leadership -
24 MS. JONES:
25 A. Provided by the Board and the executive.

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1 CHAYTOR, Q.C.:
2 Q. Okay.
3 MS. JONES:
4 A. Okay, so it would have been inside of the very
5 first interview that they had. They could
6 have explored it during that interview or in
7 subsequent interviews if in fact it was a
8 surgery area or in maintenance or whatever.
9 CHAYTOR, Q.C.:
10 Q. And what information were they provided
11 regarding this sentinel event, ER/PR?
12 MS. JONES:
13 A. They would have been provided that there was
14 an ER/PR issue and that there was a class
15 action law suit, I expect. So there would
16 have been a small documentation in that, and
17 they did have discussion during the interview
18 with the leadership and partnership around
19 that particular issue.
20 CHAYTOR, Q.C.:
21 Q. And were you present during that?
22 MS. JONES:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. And did you fill out--so I take it, it would

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1 be a form filled out on the -
2 MS. JONES:
3 A. No. It's inside of the documentation that we
4 sent in the self assessment.
5 CHAYTOR, Q.C.:
6 Q. And who filled out that?
7 MS. JONES:
8 A. The information would have come from all the
9 different areas, because you have everything
10 from community partnerships to needs
11 assessment. So that particular area probably
12 would have come from Pat Pilgrim's shop, in
13 terms of quality and filling in those quality
14 standards and that particular part of the
15 assessment.
16 CHAYTOR, Q.C.:
17 Q. So any information provided to the surveyors
18 on the ER/PR event would have come from Pat
19 Pilgrim?
20 MS. JONES:
21 A. Initially it would have come in that form of
22 the document.
23 CHAYTOR, Q.C.:
24 Q. And what was discussed with the surveyors
25 around the ER/PR incident?

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1 MS. JONES:
2 A. I'm not--can't recall. It would have been
3 whatever question line they would have wanted
4 to explore with the board. Probably we would
5 have indicated that we had external reviews
6 and that we had implemented the
7 recommendations from the external review and
8 that we were moving forward with it, but there
9 was no--surveyors don't go into the depth of
10 detail on a particular incident like that.
11 CHAYTOR, Q.C.:
12 Q. Okay, and I take it they would not have been
13 provided with copies of the external reviews?
14 MS. JONES:
15 A. No.
16 CHAYTOR, Q.C.:
17 Q. So you were present though when the issue was
18 discussed?
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. But they don't go into depth of what caused
23 the incident and what follow up is taking
24 place?
25 MS. JONES:

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1 A. It's more for them, what have you done and
2 what are you doing to ensure that it doesn't
3 happen again.
4 CHAYTOR, Q.C.:
5 Q. And so any comments that they have on the
6 issue is based on the information provided by
7 Eastern Health?
8 MS. JONES:
9 A. That's right.
10 THE COMMISSIONER:
11 Q. You turned the page, but I must ask, what's a
12 failure modes effects analysis?
13 MS. JONES:
14 A. It's a very in-depth analysis about a new
15 process. It's like a PDSA, plan to study and
16 act, and it is a way of ensuring that you've
17 looked at all of the process so that there
18 are--it's fail safe, and inside of
19 accreditation, you have to do at least one
20 FMEA every year, as part of either a new
21 process or a review of an existing process,
22 and this is a very, very in-depth review of an
23 issue or a new program that would be going in
24 place.
25 CHAYTOR, Q.C.:

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1 Q. Thank you, Commissioner. Yes, I did mean to
2 ask that. The next page then, page 12 of the
3 exhibit. The last paragraph states "there has
4 yet to be a response on the recommendation
5 that an appropriate process be developed to
6 ensure that client rights are in place and
7 upheld by implementing a client bill of rights
8 and an education and advocacy process for
9 clients on their rights" and I think that's
10 some thing we discussed earlier this morning.
11 Is that something, a client bill of rights, is
12 that something you think would have been
13 helpful to patients in dealing with the ER/PR
14 issue or could be useful in the future in
15 dealing with a similar incident?
16 MS. JONES:
17 A. It's hard to say, because this is really two
18 sides of the street. It is what we would
19 expect from patients and what patients would
20 expect from us. So when we talk about dealing
21 with ER/PR issue, a lot of what we talk about
22 is the disclosure piece and we have policy
23 around individual disclosure in that
24 particular area, so I'm not sure that this
25 would have furthered the way that we would

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1 have addressed it. The clients would clearly
2 have known that they have a right to ask
3 questions and I don't believe that that needs
4 to be inside of a bill of rights to have that
5 conversation with many of our clinicians that
6 are open to answering questions. So yes, in
7 terms of being in the forefront and having
8 something on a piece of paper, maybe, but in
9 the way that we work, I'm not so sure.
10 CHAYTOR, Q.C.:
11 Q. When I read this, I saw it as being broader
12 than just a piece of paper with their rights
13 stipulated. It talks about an education and
14 advocacy process for clients.
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. Is there some--is that something that's in the
19 works? Is Eastern Health now working on that?
20 MS. JONES:
21 A. The development of the bill of rights will
22 happen in a fashion that has a lot of input
23 into it based upon the values of the
24 organization and once that is in place, that's
25 at that point in time that you would move

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1 forward with public education about what that
2 is all about. We do have parts of the
3 organization that do have advisory committees
4 in them, and we do have parts of the
5 organization, like the Mental Health Advisory
6 Committee, we do have parts of the
7 organization that have family councils and
8 that particularly in long-term care, and
9 that's the kind of vehicles that you would use
10 to move some of that forward in those areas.
11 CHAYTOR, Q.C.:
12 Q. And if there was a clearly articulated policy
13 or process in place for advocacy for patients
14 confronted with a situation similar to the
15 ER/PR issue, would you see how that could have
16 been useful?
17 MS. JONES:
18 A. I think that there's--it's really hard to say
19 because advocacy happens in many different
20 ways and there are many--there's much movement
21 across the country about having advocacy or
22 people to work inside your organization on
23 advocacy. We would almost put that as our
24 patient relations officers where you would
25 call, you would have a complaint and that

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1 person would work on your behalf to move you
2 through the system. So depending on how an
3 advocacy role would want to play out, or
4 patient navigators is another expression
5 that's sometimes used on that, on an
6 individual patient basis, I'm not sure right
7 now.
8 CHAYTOR, Q.C.:
9 Q. I take it the surveyors were thinking of
10 something, though, more than your patient
11 relations because they have commented on the
12 fact that you have a patient relations officer
13 -
14 MS. JONES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. Or a client relations consultant, they call
18 it, and this is looking for something more
19 than that. It appears that there is some
20 other process that they have envisioned -
21 MS. JONES:
22 A. And that's what I, you know, the patient
23 navigators and patient advocates, inside of
24 the mental health program now, in the new
25 Mental Health Act particularly with certified

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1 patients there is an advocate established,
2 those kinds of things. So it's becoming more
3 and more prominent across the country in lots
4 of areas.
5 CHAYTOR, Q.C.:
6 Q. So I'm just thinking, though, in terms of the
7 issue that we're dealing with here and
8 patients who there was obviously confusion
9 about information that was out there and there
10 were patients trying to get information, there
11 were patients obviously calling "Open Line"
12 show -
13 MS. JONES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. So if you were to have an advocacy process in
17 place that they could channel their
18 information in through, whether or not that
19 may have been of assistance.
20 MS. JONES:
21 A. And I would still respond in the same way, we
22 did have telephone lines out there and the
23 individuals who would have taken their
24 complaint or their issue, whether it was
25 inside the cancer program or inside of the

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1 quality department, that is the role that I
2 see that that would play. There was not a
3 cancer advocate, there was not an ER advocate.
4 CHAYTOR, Q.C.:
5 Q. And I guess the Canadian Cancer Society was
6 fielding calls in that event too.
7 MS. JONES:
8 A. Yes, and they were sending them on to us as
9 well.
10 CHAYTOR, Q.C.:
11 Q. And this is the section dealing with response
12 to previous survey recommendations, so I take
13 it this was a recommendation that had come out
14 of the 2004?
15 MS. JONES:
16 A. The implementing the client Bill of Rights
17 would have been the other parts of that,
18 education and advocacy, I think you would have
19 to go back to see what was actually the
20 recommendation at the time.
21 CHAYTOR, Q.C.:
22 Q. Page 14 is the list of recommendations and do
23 you know what does rating D mean?
24 MS. JONES:
25 A. In development, D is development.

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1 CHAYTOR, Q.C.:
2 Q. Development. And what does N mean?
3 MS. JONES:
4 A. Non, I'm thinking.
5 CHAYTOR, Q.C.:
6 Q. So development and I take it there's a rating
7 higher than a D?
8 MS. JONES:
9 A. Yes, these are required organizational
10 practices, so, yeah, if I saw them, I -
11 CHAYTOR, Q.C.:
12 Q. So C would be completed?
13 MS. JONES:
14 A. C would be completed; D is in development and
15 then there's an N -
16 CHAYTOR, Q.C.:
17 Q. N meaning, I guess, not in development and not
18 completed.
19 MS. JONES:
20 A. I'd have to see the little key that's on top
21 of the page where we fill them out all the
22 time.
23 CHAYTOR, Q.C.:
24 Q. Yeah, I don't have the key, unfortunately.
25 MS. JONES:

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1 A. Unfortunately, I don't either.
2 CHAYTOR, Q.C.:
3 Q. Okay. So I take it what you want to see are
4 Cs?
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. Reporting of adverse events and this is under
9 goal area No. 1, Culture.
10 MS. JONES:
11 A. Yeah.
12 CHAYTOR, Q.C.:
13 Q. Recommendation: "It is recommended that the
14 organization fully implement support and
15 evaluate the occurrence reporting policy that
16 was approved on August 28th, 2007." So that's
17 in development?
18 MS. JONES:
19 A. In development, that's right.
20 CHAYTOR, Q.C.:
21 Q. Disclosure, the recommendation is, "It is
22 recommended that the organization roll out the
23 implementation of its disclosure policy with
24 attention to education of staff about the
25 process and the supports that are available

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1 for patients and staff alike." And again,
2 that's in development?
3 MS. JONES:
4 A. In development, yes.
5 CHAYTOR, Q.C.:
6 Q. Goal area number two, communications. "It is
7 recommended that the organization inform and
8 educate patients, clients and families about
9 their role in safety, using recently developed
10 written and verbal communication material."
11 Again in development?
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. And transfer of information, "It is
16 recommended that the organization employ and
17 communicate information about the
18 implementation of mechanisms for timely
19 transfer of information to all staff and
20 caregivers."
21 MS. JONES:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. And that's in development?
25 MS. JONES:

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1 A. Uh-hm.
2 CHAYTOR, Q.C.:
3 Q. Goal area number four, worklife/workforce
4 patient safety training. Recommendation: "It
5 is recommended that the organization develop
6 patient safety education and training material
7 and deliver at a minimum, annual sessions to
8 all staff and care service providers,
9 including targeting key areas in the
10 organization." And that received a "N"?
11 MS. JONES:
12 A. Yes, and there is patient safety education and
13 training that's going on inside of Eastern
14 Health, but this specifically talks about
15 every staff member having it, and so we could
16 not be compliant with that because we would
17 not answer that every staff member had had
18 that.
19 CHAYTOR, Q.C.:
20 Q. And that would be a national standard?
21 MS. JONES:
22 A. This is a new, what we call required
23 organizational practice and it is relatively
24 new.
25 CHAYTOR, Q.C.:

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1 Q. And is that something -
2 MS. JONES:
3 A. Since the last accreditation.
4 CHAYTOR, Q.C.:
5 Q. Since 2004.
6 MS. JONES:
7 A. Yes, since 2004.
8 CHAYTOR, Q.C.:
9 Q. And is that something that's now in progress?
10 MS. JONES:
11 A. Yes, and we have to report back on that in
12 June of this year. There are a number of
13 these required organizational practices, so
14 there is a report in June and a report in
15 December. So all of the safety related
16 education, we're in the process of collecting
17 all of the names and all of the actual staff
18 and the types of education as well for this
19 particular one.
20 CHAYTOR, Q.C.:
21 Q. And the patient safety plan, "It is
22 recommended that the organization develop and
23 implement a plan to assess patient safety
24 issues and carry out improvement activities."
25 MS. JONES:

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1 A. That was in progress.
2 CHAYTOR, Q.C.:
3 Q. That one is in development?
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. Roles and responsibilities, "It is recommended
8 that the organization provide communication
9 and education to staff and care service
10 providers to ensure that roles and
11 responsibilities for patient safety are well
12 understood." And that one also received a
13 "N".
14 MS. JONES:
15 A. And that, basically if you read down through
16 the criteria that goes along with that, it
17 says "every job description for all of the
18 staff inside of Eastern Health must reference
19 having a responsibility in safety." Okay, and
20 so we're in the process of developing all of
21 the re-developing of all of the job
22 descriptions, consistent across Eastern
23 Health, and that will be delineated as a role
24 inside of those job descriptions and then with
25 the new education and dispersing of that

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1 throughout the staff.
2 CHAYTOR, Q.C.:
3 Q. Okay, so that would not have been something
4 that would be going on before this?
5 MS. JONES:
6 A. No, no, you would have--in the redevelopment
7 of all of the job descriptions inside of
8 Eastern Health, it may not be inside of every
9 housekeeper, you know, the housekeeping job
10 description, it would have been inside the
11 nursing and maybe the physio or whatever, but
12 it talks about every staff member inside of an
13 organization having a responsibility for
14 safety. And so that is the process that we're
15 into, which is redeveloping all of our job
16 descriptions to ensure that that is an actual
17 accountability for all of the staff, even
18 though it may, in fact, be carried out and
19 then the education and the role out to staff
20 to make sure that they understand that.
21 CHAYTOR, Q.C.:
22 Q. Okay. And preventative maintenance, "It is
23 recommended that the preventative maintenance
24 program for medical devices, equipment and
25 technology be consistently implemented across

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1 all sites at the organization." And that
2 received a "D". Are you able to comment on
3 whether or not that involved the lab?
4 MS. JONES:
5 A. There is different processes in terms of
6 biomedical and preventative maintenance. I'm
7 not--it's not that it's not done, we have
8 biomedical services from Memorial who does the
9 work inside St. John's and we have individual
10 biomedical technicians who are hired by the
11 previous boards, so this is really a
12 consolidation around the preventative
13 maintenance, so yes, if you were to look at
14 the maintenance logs in the biomedical for the
15 medical equipment inside the lab, you would
16 see that that is complete.
17 CHAYTOR, Q.C.:
18 Q. Okay. And I asked you during the break, there
19 is two sections in here, there's laboratory
20 being blood banks and transfusion services,
21 and then there's also a biomedical laboratory
22 section.
23 MS. JONES:
24 A. Uh-hm.
25 CHAYTOR, Q.C.:

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1 Q. What's your understanding as to which section
2 the IHC lab would fall under?
3 MS. JONES:
4 A. It wouldn't be blood banks and transfusion
5 services.
6 CHAYTOR, Q.C.:
7 Q. Now you had understood that this wasn't done,
8 though, at this point in time?
9 MS. JONES:
10 A. The actual, the survey was a little later and
11 I'm not sure what report--whether you have the
12 complete report that would have inserted it
13 after the fact or not, because we did receive
14 recommendations from the blood bank and
15 transfusion services, so whether you have a
16 full report with that inserted, I can't answer
17 that question.
18 CHAYTOR, Q.C.:
19 Q. We appear to have the same, you know, the
20 pages are numbered consecutively.
21 MS. JONES:
22 A. They would have reissued a report.
23 CHAYTOR, Q.C.:
24 Q. Okay, and yet it would still be dated
25 September?

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1 MS. JONES:
2 A. It still would be dated September because as I
3 look, there was no date on your actual report,
4 other than reporting for the 23rd to the 28th,
5 right?
6 CHAYTOR, Q.C.:
7 Q. At the front, yes, that's right. Okay, and
8 I'll just take you through a couple of those
9 in any event, because I take it that the same
10 clinical team is responsible for all aspects
11 of the lab?
12 MS. JONES:
13 A. No, we had different teams, we had a team for
14 blood bank, okay, and we would have had a
15 different team for the other biomedical.
16 CHAYTOR, Q.C.:
17 Q. So the people who were responsible for the IHC
18 service -
19 MS. JONES:
20 A. Would not be in this team.
21 CHAYTOR, Q.C.:
22 Q. - would not be in this group, okay.
23 MS. JONES:
24 A. No.
25 CHAYTOR, Q.C.:

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1 Q. Because this recommendation dealt with the lab
2 having a planning process, including the
3 results of quality improvement activities and
4 lessons learned from adverse events?
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. And potential adverse event is "without
9 inclusion of the formal quality improvement
10 process, there is no objective means to ensure
11 the best possible result."
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. And the reason for urgency, "There is no
16 direct threat to patient care in a major
17 redesign, the lab planning process, including
18 quality improvement process is underway."
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. So that's not the IHC lab?
23 MS. JONES:
24 A. No.
25 CHAYTOR, Q.C.:

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1 Q. Under "Human Resources" the recommendation and
2 I believe we touched on this this morning, "It
3 is recommended that the processes to
4 credential appoint, reappoint and grant
5 medical staff privileges be standardized and
6 criteria be clearly defined."
7 MS. JONES:
8 A. Uh-hm.
9 CHAYTOR, Q.C.:
10 Q. And there's little consistency, it says, in
11 the content of the documentation on the
12 physician's files.
13 MS. JONES:
14 A. Content. And if you look at that, that
15 organization rating is four, which means it's
16 in progress, it's basic and they have rated it
17 as a three, so there's -
18 CHAYTOR, Q.C.:
19 Q. Right and the highest you can get is seven?
20 MS. JONES:
21 A. Highest you get is seven, there's no sevens
22 anywhere in this document and you wouldn't
23 find them really anywhere in the country
24 unless it's best practice in the country.
25 CHAYTOR, Q.C.:

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1 Q. But a three wouldn't even be a passing rate.
2 MS. JONES:
3 A. Three would mean that generally there is a
4 recommendation. Actually when you look at
5 this and as being accreditor, but I don't know
6 the lab accreditation, the three generally
7 would mean a recommendation, four would be a
8 recommendation, but lots of times here there's
9 five and five generally means that there--that
10 the standard is being met, but maybe we
11 haven't got the full cycle of the quality
12 improvement, meaning review done on a yearly
13 basis and the process hasn't been in place
14 long enough to have its annual review and
15 update and see if in fact it's still current.
16 CHAYTOR, Q.C.:
17 Q. So what you would want to see are fives?
18 MS. JONES:
19 A. Would want to see fives, fives and sixes
20 probably is where -
21 CHAYTOR, Q.C.:
22 Q. Fives or higher, six, sevens, sevens ideally.
23 MS. JONES:
24 A. Yeah, most of the organizations you would see
25 four, five and sixes.

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1 CHAYTOR, Q.C.:
2 Q. So the biomedical laboratory services is the
3 area that would include the IHC lab, I take
4 it?
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. And the first one we have here, what does the-
9 -I'm sorry, that's not the one I wanted to
10 look at, I think it's the next page. Here we
11 go. What does the descriptor safety mean?
12 MS. JONES:
13 A. There are eight quality descriptors that one
14 would be--that CCHSA uses and safety is one of
15 them, effectiveness, communication and the
16 list goes on. So whenever there--every one of
17 these criterion are tied to some aspect of
18 what they believe is in terms of their quality
19 framework, so you've got safety here, you've
20 got appropriateness, in your next one you've
21 got effectiveness, so that's how CCHSA looks
22 at and classifies its standards and every one
23 of their standards is tied to some kind of a
24 descriptor.
25 CHAYTOR, Q.C.:

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1 Q. Okay, and this first recommendation says, "It
2 is recommended that the laboratory have a
3 procedure for the transport of samples to and
4 from the laboratory, that it develop criteria
5 to accept or reject samples, such as the type
6 of two" and then it goes on with transport
7 delay, different issues, and that the process
8 for handling of leaking specimens be
9 documented.
10 MS. JONES:
11 A. Uh-hm.
12 CHAYTOR, Q.C.:
13 Q. The organization rated itself a four and the
14 survey also rated it a four.
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. "Potential adverse event could be incorrect
19 test results could lead to improper patient
20 diagnosis or treatment."
21 MS. JONES:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. "And because of the size of the area covered
25 by Eastern Health laboratories and thus the

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1 difficult of transport, the likelihood of
2 improper samples reaching test sites is high."
3 And do you know whether or not that had
4 anything to do with the IHC lab in terms of
5 the transportation of specimens between sites?
6 MS. JONES:
7 A. I can't speak to that specifically and this
8 would be much more generic around, including
9 lab, blood work coming from floors,
10 urinalysis, a whole variety of areas in terms
11 of the receiving of specimens.
12 CHAYTOR, Q.C.:
13 Q. And in terms of, at this point in time,
14 September of '07, what did you understand was
15 happening? Where was the specimens being
16 shipped? Were they being shipped--breast
17 specimens being shipped between the Health
18 Sciences if the surgery was done there, back
19 to St. Clare's or what did you understand the
20 process was?
21 MS. JONES:
22 A. The reverse of that.
23 CHAYTOR, Q.C.:
24 Q. So if surgery is taking place at St. Clare's -
25 MS. JONES:

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1 A. It would be going to the Health Sciences.
2 CHAYTOR, Q.C.:
3 Q. Were there any breast surgeries taking place
4 at the Health Sciences?
5 MS. JONES:
6 A. Yes, so they would be in that building itself.
7 CHAYTOR, Q.C.:
8 Q. And where did you understand the grossing of
9 the specimen would be taking place?
10 MS. JONES:
11 A. Well I can just say that I've seen the Health
12 Sciences lab and I do know that grossing does
13 take place there, so I'm not sure if there is
14 any that goes on at St. Clare's because I
15 haven't been physically in that lab.
16 CHAYTOR, Q.C.:
17 Q. So if there is a situation or have been a
18 situation where the grossing of the specimen,
19 surgery might take place at Health Science,
20 grossing takes place at St. Clare's and then
21 that the IHC testing is shipped -
22 MS. JONES:
23 A. It's too detailed for me.
24 CHAYTOR, Q.C.:
25 Q. You don't know.

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1 MS. JONES:
2 A. We don't go there.
3 CHAYTOR, Q.C.:
4 Q. We'll ask the lab people.
5 MS. JONES:
6 A. You'll ask the lab people, that's right.
7 CHAYTOR, Q.C.:
8 Q. Okay, the next one is, "It is recommended that
9 the laboratories develop and finalize their
10 SOPs for processing samples and specimens and
11 put in place a procedure for processing urgent
12 samples in a timely manner. It is also
13 recommended that laboratory staff responsible
14 for specific procedures have access to the
15 relevant SOPs." And the potential adverse
16 event--first of all, the organization rated
17 itself at four and so did the surveyors?
18 MS. JONES:
19 A. That's right, uh-hm.
20 CHAYTOR, Q.C.:
21 Q. And the potential adverse event, "improper
22 processing of samples will likely lead to
23 inaccurate results and undue delays in
24 providing results for urgent requests and the
25 practice is followed, but there is no

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1 documentation. Although current practices
2 seem adequate, these must be supported by
3 detailed procedures."
4 MS. JONES:
5 A. Uh-hm.
6 CHAYTOR, Q.C.:
7 Q. And again, I think this may have been a point
8 raised in the overall summary because I
9 mentioned to you this morning that one of the
10 issues identified clearly by Trish Wegrynowski
11 was documentation, SOPs being in place and
12 then documentation.
13 MS. JONES:
14 A. That's right and I said that to you as well,
15 so the particular IHC lab has worked very
16 diligently on that. This may be other parts
17 of the lab that need to continue their work to
18 get to that point where the IHC lab is now.
19 CHAYTOR, Q.C.:
20 Q. And is it your understanding that when QMPLS
21 came in, in December of '07 that there were
22 any issues regarding documentation that needed
23 to be followed up on?
24 MS. JONES:
25 A. I would have to refresh my memory on the

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1 actual report. There were some
2 recommendations inside of that report, but by
3 and far, the recommendations would not be to
4 this extent.
5 CHAYTOR, Q.C.:
6 Q. Okay, on this one, the middle page here,
7 there's a recommendation that "the laboratory
8 monitor overall results and analyze overall
9 trends and that it use the information as part
10 of its quality management system to make
11 improvements in future services."
12 Organization rated itself a three, as did the
13 surveyors. And it talks about "trends and
14 test results such as inaccuracies may remain
15 undetected, given lack of monitoring. Reason
16 for urgency monitoring on a long-term basis
17 would enable the organization to deliver more
18 accurate results." And cancer care, "It is
19 recommended that the team put in place a
20 process to assess the long-term effectiveness
21 of cancer services, including outcomes,
22 patient satisfaction and ongoing need for
23 care." Organization rating is a four, survey
24 rating at three. Potential adverse event
25 without such outcome data, "the team's

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1 planning might not be based on the best
2 assumptions, which also means that the patient
3 needs may go unmet and while there are no
4 immediate effects of not having such data, the
5 long-term implications could be significant."
6 What did you understand that to mean?
7 MS. JONES:
8 A. I think you might have to go back to the team
9 to get that and you would want to go back to
10 see what 15.3 actually referenced in terms of
11 what is underneath there. But if you look at
12 this, it's put in place processes for long-
13 term effectiveness of cancer services, that
14 may very well be related to databases and
15 whether in fact we were looking at outcome
16 data to see whether in fact the treatment
17 protocols or whatever that we were looking at,
18 were consistent with benchmarks and mortality
19 and those kinds of things across the country.
20 CHAYTOR, Q.C.:
21 Q. And these are the lab blood banks which don't
22 pertain to IHC, right?
23 MS. JONES:
24 A. That's right.
25 CHAYTOR, Q.C.:

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1 Q. The next one then, here we go. So this one is
2 biomedical laboratory services and it's a
3 recommendation that "the lab develop a
4 regional standardized report format that is
5 known to all users of the laboratory services
6 of Eastern Health and develop a regional
7 process to deal with results that fall within
8 alert and/or critical intervals." And it's
9 recommended that "the lab provide reports to
10 the appropriate individuals within timeframe
11 and lack of document procedure may result in
12 difficulties to identify and interpret test
13 results, inadequate delays for test reporting
14 and long delays in communicating critical
15 values might lead to improper patient
16 diagnosis or treatment. Inconsistency in
17 reporting critical values can impact safe
18 patient care." And the organization gave
19 itself a four and so did the surveyors. Do
20 you know was there any discussion around this
21 in the debriefing or do you know what this may
22 have involved?
23 MS. JONES:
24 A. There wouldn't have been discussion around the
25 debriefing, but if you look at 3.1, I expect

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1 that what it talks about is a standard format,
2 report format, and we are on multiple lab
3 information systems across the reason; so
4 therefore, the reporting and how it actually,
5 the results of lab tests get reported on a
6 particular form, as well as get sent out to
7 individual physicians who are ordering the
8 tests, may be different across the three
9 legacy lab systems that we would have had
10 inside of Eastern Health. So what you
11 actually see here is moving to a regional
12 standard format and then you've got the issue
13 of critical values. There is a process where
14 there's a flagging and usually something that
15 goes to the user if in fact a value is out of
16 range, that may not be consistent across
17 everything from St. John's to Carbonear to
18 Clarenville, so that is really that issue of
19 consolidating onto a single clinical database
20 and then having the processes consistent
21 across the region.
22 CHAYTOR, Q.C.:
23 Q. Okay. And cancer care--I take it the cancer
24 care program is all run out of here in St.
25 John's?

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1 MS. JONES:
2 A. Yes. This particular team was the NCTRF team.
3 And there may have been an individual or so
4 who was on that team because we do
5 chemotherapy outside of St. John's. We have
6 regional centres. So, it would reference at
7 least the aspects of cancer program that would
8 be inside a cancer clinic.
9 CHAYTOR, Q.C.:
10 Q. Okay. And the descriptor on this one on this
11 one is "Participation and partnership".
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. And the recommendation is that "the team
16 develop a process to include the voices of
17 patients and their families in the evaluation
18 and day-to-day planning of their services.
19 The team needs to look at the numerous
20 mechanisms available, including inviting
21 patients to participate in the team to include
22 expert patients in quality improvement
23 projects and to seek patient input via comment
24 cards or patient satisfaction surveys." And
25 my first question is, what's an expert

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1 patient?
2 MS. JONES:
3 A. In quality improvement project, I don't know.
4 CHAYTOR, Q.C.:
5 Q. Okay, and the organization rated itself a
6 four. The survey rating is a three.
7 Potential adverse event, "when there is no
8 direct patient involvement in the service,
9 patients might perceive that their needs and
10 preferences are not being priorized and the
11 reason for inurgency, the implications are not
12 immediate but could become quite important
13 over the long term. There is some involvement
14 of clients in the provincial cancer strategy
15 working group."
16 MS. JONES:
17 A. That's right.
18 CHAYTOR, Q.C.:
19 Q. And what is it that you understand this to be
20 talking about?
21 MS. JONES:
22 A. This is really about involvement in planning,
23 as well as feedback. We probably do have--I
24 can't speak specifically to, but we would have
25 patient satisfaction surveys. They may not

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1 have been current because there is ways that
2 we receive feedback, but in some other parts
3 of our organization, they would have heard of
4 like the mental health, client advocacy group
5 and those kinds of things and inside of cancer
6 care across the country, you are seeing
7 patient navigators and advocacy roles inside
8 of organizations. So, I'm sure at the team,
9 there would have been probably some discussion
10 around that and where were we as an
11 organization with those roles.
12 CHAYTOR, Q.C.:
13 Q. So, you don't have those roles?
14 MS. JONES:
15 A. We don't have those roles.
16 CHAYTOR, Q.C.:
17 Q. And is that something -
18 MS. JONES:
19 A. Cancer control strategy has, on a provincial
20 wide basis, has talked about patient navigator
21 roles and I'm not sure where that's going to
22 go, but that is a whole provincial control
23 strategy about where this province is going to
24 go as we move forward with cancer care.
25 CHAYTOR, Q.C.:

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1 Q. So, it's not something that's being considered
2 within Eastern Health itself.
3 MS. JONES:
4 A. Not right now.
5 CHAYTOR, Q.C.:
6 Q. Not right now. And in terms of getting the
7 information, where would the surveyors have
8 gotten this information? Would there have
9 been consultation with patients?
10 MS. JONES:
11 A. They would have had and I'm sure as part of
12 the cancer care, there would have been some
13 individual patient contact because there's
14 usually a couple of patients that the
15 surveyors would talk to during their tours and
16 interviews.
17 CHAYTOR, Q.C.:
18 Q. And is that a role, a patient navigator -
19 MS. JONES:
20 A. Patient navigator is one that usually the
21 cancer, not society, but it's generally called
22 a patient navigator in some of the other parts
23 of the country.
24 CHAYTOR, Q.C.:
25 Q. And is that a role that you think could have

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1 been useful in the ER/PR issue in terms of the
2 communications with patients?
3 MS. JONES:
4 A. I'm not too sure. I've seen some national
5 reporting on it in terms of talking about the
6 role and I've seen people talk about their
7 role and how they advocate, move people
8 through the system in accessing service or
9 appointments or, you know, informing them
10 about what's going on. So, I'm not sure
11 whether in this particular instance, it would
12 have worked in any way and not knowing very
13 much about the role, except what is reported
14 nationally and that. People in cancer care
15 and who have been working with the provincial
16 cancer control strategy would be very much
17 able to talk about that discussion has been
18 and what potentially that role could be inside
19 of this area.
20 CHAYTOR, Q.C.:
21 Q. And I take it the person filling that role
22 would have some expertise in dealing with
23 cancer patients and in communicating with
24 cancer patients.
25 MS. JONES:

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1 A. And I've only seen it as a nurse and that's
2 how I've seen it, in that, but that doesn't
3 mean that there are not advocates who are
4 individuals who have experienced it
5 themselves. So, it really it--I don't know
6 what the qualifications would be, but the only
7 person I've seen talk about it has been
8 somebody with a nursing background.
9 CHAYTOR, Q.C.:
10 Q. Um-hm. Okay, this one is under Human
11 Resources and the descriptor is "Learning
12 Environment". The recommendation is that the
13 "organization monitor compliance with the
14 performance evaluation process and develop
15 strategies to ensure appraisals are occuring
16 in a timely manner. Organization rated itself
17 a four, the survey gives a three. Potential
18 adverse event, lack of awareness of
19 performance expectations or recognition of
20 achievements may lead to low moral and weak
21 performance. There are few evaluations being
22 completed. Staff have requested that
23 performance evaluations be completed". Were
24 you aware of that prior to seeing this in the
25 accreditation?

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1 MS. JONES:
2 A. Every accreditation that I do across the
3 country, there's a similar recommendation.
4 CHAYTOR, Q.C.:
5 Q. But there are few evaluations being completed?
6 MS. JONES:
7 A. Yes. There are few--it is something that we
8 struggle with all of the time in terms of
9 regularly reviewing performance and
10 documenting it. It's not that individual
11 performance has not been--the comments here
12 came from the focus group of staff that we--we
13 brought together a focus group of staff and
14 that would be a standard question that you
15 would be asking. Who in this room has a
16 performance appraisal? Would it have been
17 beneficial to you? So, you know, 25 to 30
18 percent probably inside of the organization on
19 a yearly basis would have performance
20 appraisals. So, it's not unusual to see that.
21 And I would not have been surprised to see
22 that.
23 CHAYTOR, Q.C.:
24 Q. So, twenty five to thirty five percent of your
25 employees would have an annual performance

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1 evaluation?
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. So the vast majority do not.
6 MS. JONES:
7 A. And the thing about performance evaluations
8 is, is it in a yearly cycle; is it in every
9 two years or is it every three years. The
10 documentation of annual performance, it's the
11 documentation--there can be other ways of
12 doing performance appraisals other than
13 sitting. There's self evaluations that we do
14 in some of our areas that are then followed up
15 with much like what this is with a manager.
16 So, self plus the manager and move forward.
17 So, it's lots -
18 CHAYTOR, Q.C.:
19 Q. So, are you saying that there are other things
20 happening instead to evaluate your staff?
21 MS. JONES:
22 A. There is informal feedback all the time. And
23 this whole thing is around, people really need
24 to understand that they are doing a good job.
25 And when they're not doing a good job, that we

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1 provide them with the education or whatever
2 tools they might need to do a good job. So,
3 we do deal with the individual performer and
4 we deal with them in many different ways. But
5 to say that every staff member has an annual
6 performance evaluation would not be what any
7 health care organization in this country would
8 be able to say.
9 CHAYTOR, Q.C.:
10 Q. And this doesn't even say that it has to be
11 annual.
12 MS. JONES:
13 A. No.
14 CHAYTOR, Q.C.:
15 Q. But it says that in terms of it be regular -
16 MS. JONES:
17 A. Yes, most of us take that as being annual.
18 CHAYTOR, Q.C.:
19 Q. Yes, and so are you able to say, well, is it
20 happening every second year, every third year,
21 when, how often are your staff being formally
22 evaluated?
23 MS. JONES:
24 A. Well I can't--this is all part of the
25 development of the human resource information

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1 system and being able to log and know exactly
2 when performance appraisals are being
3 performed. They're in a paper-based process
4 right now, so really it is counting paper and
5 knowing how many performance appraisals are
6 actually being performed. I know in my old
7 role as COO I would, on a monthly basis, have
8 a reporting to me of how many performance
9 appraisals were being done inside of a
10 particular program every month as one of the
11 accountabilities to insure that we increased
12 the rate of appraisals for staff, so that was
13 my practice. But as an organization of 12,000
14 staff, three to four thousand every year would
15 have a documented on paper interview with
16 their manager at this point in time.
17 CHAYTOR, Q.C.:
18 Q. Is there a policy at Eastern Health for how
19 often performance evaluations are -
20 MS. JONES:
21 A. It doesn't say how often, it talks about
22 regular at this point in time. And we've been
23 redoing the tools because it always talks
24 about the tools and we say it's not the tools
25 that are important, it's the fact that staff

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1 have an interaction with their manager to talk
2 about their performance.
3 CHAYTOR, Q.C.:
4 Q. And this appears to suggest, though, that
5 staff are looking to have -
6 MS. JONES:
7 A. They would be looking forward to that.
8 CHAYTOR, Q.C.:
9 Q. - an evaluation completed?
10 MS. JONES:
11 A. That's right.
12 THE COMMISSIONER:
13 Q. What would be the largest number of employees
14 that any one manager would have to deal with?
15 MS. JONES:
16 A. Over 100.
17 THE COMMISSIONER:
18 Q. So you would have 100 persons reporting to one
19 person?
20 MS. JONES:
21 A. One, yes. Some departments have small, there
22 may be only eight or ten, but a lot of our
23 large clinical areas like your ICUs or even
24 your housekeepers or those kinds of things, it
25 would not be unusual to have in excess of 100,

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1 are probably average. And we do have stats on
2 that. When we look at just the number of
3 managers based upon the number of staff, it's
4 in the vicinity of probably around 30. So
5 each manager would have, you know, if you just
6 took the average, it would be about 30.
7 CHAYTOR, Q.C.:
8 Q. So is that why the evaluations aren't being
9 done, that there are too many staff per
10 manager?
11 MS. JONES:
12 A. There is not a correlation. We've looked at
13 it. Staff -
14 CHAYTOR, Q.C.:
15 Q. There's no correlation?
16 MS. JONES:
17 A. There's no correlation. We've actually looked
18 at that. Staff that have--a manager that has
19 a large staff, you know, have 75 to 100 staff
20 can have more performance appraisals done than
21 even somebody with a small staff of eight or
22 ten.
23 CHAYTOR, Q.C.:
24 Q. And I take -
25 MS. JONES:

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1 A. So it isn't a correlation.
2 CHAYTOR, Q.C.:
3 Q. No. So why aren't they being done?
4 MS. JONES:
5 A. Really I can't answer that. It's on an
6 individual, we've talked about and we've done
7 education for managers so that they have a
8 comfort level in terms of doing performance
9 appraisals and the objectives and what should
10 come out of them. But really it is a push
11 that has to happen all the time to insure that
12 staff do get feedback.
13 CHAYTOR, Q.C.:
14 Q. Um-hm.
15 MS. JONES:
16 A. And the only ones that we count are the
17 feedback that comes in the documented form.
18 There could be managers out there every single
19 day providing feedback to individual staff
20 about their performance and improving their
21 performance, but as long as it's not
22 documented, it's not considered done.
23 CHAYTOR, Q.C.:
24 Q. Right. And as a nurse, as long as it's not
25 documented, it's not done?

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1 MS. JONES:
2 A. That's right.
3 CHAYTOR, Q.C.:
4 Q. That's right. And so you have no evidence to
5 suggest to it is being done in any other way?
6 MS. JONES:
7 A. No.
8 CHAYTOR, Q.C.:
9 Q. Wouldn't human resources be able--if it's a
10 situation of making it easier for the process
11 to happen, for example, coming up with, human
12 resources coming up with checklists?
13 MS. JONES:
14 A. All done, Sandy.
15 CHAYTOR, Q.C.:
16 Q. That's all done?
17 MS. JONES:
18 A. Yeah.
19 CHAYTOR, Q.C.:
20 Q. So it's all in place, the system has been made
21 early for it to happen -
22 MS. JONES:
23 A. And there's been lots of discussion and
24 sometimes, you know, you bring a committee
25 together, this is what we've been doing on

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1 performance appraisals is bringing together
2 seven legacy organizations to identify and
3 there's probably two or three different sets
4 of forms that managers can use, depending on
5 what areas they are in. And in some areas
6 where you have program management where the
7 manager is not the manager of a discipline we
8 use self performance and peer review. So
9 there's many different ways that it's
10 happening, but do all 12,000 staff have
11 performance appraisals every year in a
12 documented fashion, the answer to that is
13 clearly here and we know that.
14 CHAYTOR, Q.C.:
15 Q. And in an era of emphasis on patient safety,
16 would you agree that it would be an important
17 thing to do?
18 MS. JONES:
19 A. I think that what you would be thinking is is
20 that the performance appraisal is actually
21 just a tool. If there are issues with respect
22 to quality, then they are dealt with and the
23 individual from a performance perspective is
24 dealt with. And some of those individuals who
25 may have performance issues may never even

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1 have the performance appraisal done on a
2 yearly basis, but would have had the
3 documentation around the performance issue and
4 what we need to do to move that issue forward
5 and that individual from either an education
6 or a qualifications perspective or whatever
7 the outcome on those performance issues are.
8 CHAYTOR, Q.C.:
9 Q. And if this something that your staff is
10 looking to have done and it's indicated in
11 this document that it would also be good for
12 morale of your staff -
13 MS. JONES:
14 A. That's right.
15 CHAYTOR, Q.C.:
16 Q. - and that is an issue that we've heard
17 Eastern Health has been struggling with, why
18 not just insist that it be done?
19 MS. JONES:
20 A. I think that you would need to understand what
21 a manager is doing every single day and what
22 priorities that they are doing. We've also
23 referenced the fact that some managers with
24 large spans of control or some managers with
25 small spans of control, so the most that we

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1 can do at this point in time, unless we are to
2 say "You absolutely have to do every one every
3 single year," you have to realize what the
4 workload is and what is going on. At the end
5 of the day we are saying that to managers and
6 then, and the program directors and that are
7 holding people accountable for, and those
8 numbers of performance appraisals are going
9 up.
10 CHAYTOR, Q.C.:
11 Q. So it's getting better?
12 MS. JONES:
13 A. It is getting better.
14 CHAYTOR, Q.C.:
15 Q. It's got a ways to go?
16 MS. JONES:
17 A. It's got a ways to go.
18 CHAYTOR, Q.C.:
19 Q. And it's not your intention to insist that it
20 be done?
21 MS. JONES:
22 A. We haven't--we will educate and we will
23 support. I think that as we go forward you
24 might actually see some discussion or we might
25 have some discussion around the under

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1 resourcing, particularly in the area of
2 support and administrative support. And if
3 some of that was in place, then it may free
4 managers to be able to do more of these kinds
5 of things.
6 CHAYTOR, Q.C.:
7 Q. So it's a timing issue?
8 MS. JONES:
9 A. Timing issue, workload issue.
10 CHAYTOR, Q.C.:
11 Q. The next recommendation is similar and it
12 involves the performance evaluation of
13 managers. So it's recommended that
14 performance evaluation involve managers,
15 include an evaluation of their promotion of
16 quality of work life for their staff."
17 Organization rated itself a four, survey gives
18 it a three. And talks about, "If managers
19 fail to promote quality of life, there is
20 potential for staff to be dissatisfied with
21 the work environment which might lead to
22 increased staff turnover. Quality of work
23 life initiatives can enhance recruitment and
24 retention of staff." So this is looking to
25 have the performance evaluation of managers

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1 include evaluation and promotion of quality of
2 life for staff. Were you aware that that was
3 an issue within the organization prior to
4 this?
5 MS. JONES:
6 A. This, if you look at this, this is suggesting
7 that as our management performance appraisals
8 are done, which are, in fact, higher than our
9 staff performance appraisals, that the person
10 who is doing the performance appraisal
11 actually specifically talk about what, in
12 fact, they are doing for quality of work life
13 for staff and is understanding and are they
14 moving that issue forward in their particular
15 part of the organization. So it is -
16 CHAYTOR, Q.C.:
17 Q. So managers are being -
18 MS. JONES:
19 A. - to put an emphasis on that.
20 CHAYTOR, Q.C.:
21 Q. Yes.
22 MS. JONES:
23 A. And from an accountability perspective ask
24 about that and what it is that managers are
25 doing to improve work life in their own areas.

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1 CHAYTOR, Q.C.:
2 Q. And managers are being evaluated -
3 MS. JONES:
4 A. More consistently than staff.
5 CHAYTOR, Q.C.:
6 Q. And so what's the percentage?
7 MS. JONES:
8 A. I can't speak to that. I can only speak to my
9 own managers and in my particular portfolio I
10 would say 80 to 85 percent of them would have
11 received an evaluation in the run of the year.
12 CHAYTOR, Q.C.:
13 Q. And only -
14 MS. JONES:
15 A. And because they have specific objectives that
16 they are reporting on on an annual basis and
17 that is one of the things that I did. Some
18 other areas it may be very different. But
19 there is definitely, because of the objectives
20 that we set, the strategic plan, the
21 operational plan that people have to deliver
22 on, that there is interaction and review of
23 that and where we are and where we're short,
24 shortfall is. And that's improving because we

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1 have more tools inside of the organization
2 that we're working with every day to try to
3 get more documentation around those kinds of
4 things.
5 CHAYTOR, Q.C.:
6 Q. So only 25 to 35 percent of the staff would be
7 being evaluated, but 80 to 85 of the managers?
8 MS. JONES:
9 A. In my old COO portfolio.
10 CHAYTOR, Q.C.:
11 Q. Okay.
12 MS. JONES:
13 A. But it would be definitely higher because all
14 of the program directors and that would have
15 underneath the chief operating officers or VPs
16 would be falling in line. Because we talk
17 about it a fair bit about having performance
18 appraisals done and then encouraging staff
19 once they have their performance appraisal
20 done, then that encourages them to work below
21 them all the time.
22 CHAYTOR, Q.C.:
23 Q. Okay. And the next one could perhaps tie into
24 this. "It's recommended that position
25 descriptions be reviewed and revised to

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1 reflect not only the creation of Eastern
2 Health Authority but to also reflect
3 responsibilities for client safety, potential
4 adverse events. Staff may be unclear about
5 duties, roles and responsibilities. Position
6 descriptions have neither been reviewed, nor
7 revised." And so this is looking to have the
8 job descriptions themselves reflect
9 responsibilities for client safety.
10 MS. JONES:
11 A. Yes. Which is what we've already talked
12 about.
13 CHAYTOR, Q.C.:
14 Q. And is your answer on that that it's positions
15 such as housekeeping that wouldn't have that
16 client safety emphasis in their job
17 description?
18 MS. JONES:
19 A. I wouldn't--as I said, I would--for nursing
20 that would be in there. But can I say all the
21 other clinical staff it would be in there, I
22 can't absolutely say. And with seven legacy
23 organizations there would be seven different
24 job descriptions for a particular
25 classification. And we're in the process of

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1 making sure that every employee has a role in
2 client safety as part of their job
3 description. So -
4 CHAYTOR, Q.C.:
5 Q. So there may be some clinical positions, as
6 well, that don't have client safety -
7 MS. JONES:
8 A. That it's not particularly articulated in.
9 CHAYTOR, Q.C.:
10 Q. Articulated. And this one is the--okay, page
11 48 talks about patient safety. "The
12 accreditation process evaluates the
13 organization's performance on key issues of
14 patient safety in two ways." And the first
15 is, "Patient safety goals and required
16 organizational practices" which are referred
17 to then throughout as ROPs. And secondly,
18 "Patient safety criteria." And under Section
19 1, "Patient safety goals and required
20 organizational practice. The table below
21 displays the organization's performance. And
22 there's 21 ROPs, so that's the required -
23 MS. JONES:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. - organizational practices. According to the
2 five patient safety goal areas which are
3 identified as culture and communication,
4 medication use, work life, workforce and
5 infection control." And it goes on to say,
6 "The table indicates that the organization has
7 five of the ROPs not in place. Twelve are in
8 development and four are fully implemented."
9 MS. JONES:
10 A. "Implemented."
11 CHAYTOR, Q.C.:
12 Q. So out of the 21 there are 17 that are either
13 not in place or are in progress and four are
14 fully implemented?
15 MS. JONES:
16 A. Um, yes.
17 CHAYTOR, Q.C.:
18 Q. And I take it has this been identified as an
19 area, then, that needs further work?
20 MS. JONES:
21 A. Most of this would have been, these are new, a
22 lot of these are new required organizational
23 practices in the last year or so. There are
24 parts of our organization that have them in
25 place, but they are not consistent throughout

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1 all parts of the organization. So when you
2 look at in development, a lot of that is in
3 development in that the program has been
4 identified but hasn't been rolled out through
5 all parts of the organization. And if you go
6 back with issues such as the patient safety
7 plan and the disclosure and those kinds of
8 things which would come in underneath some of
9 these areas.
10 CHAYTOR, Q.C.:
11 Q. Okay. And this then talks about some of the
12 required organizational practices.
13 MS. JONES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. The first goal area being culture?
17 MS. JONES:
18 A. Um.
19 CHAYTOR, Q.C.:
20 Q. And what do these ratings mean?
21 MS. JONES:
22 A. Oh, that's in development.
23 CHAYTOR, Q.C.:
24 Q. Is that in development?
25 MS. JONES:

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1 A. The I is in development and the D is
2 developed. There you go.
3 CHAYTOR, Q.C.:
4 Q. D is developed?
5 MS. JONES:
6 A. Well, I'm just--we really need the key on the
7 top.
8 CHAYTOR, Q.C.:
9 Q. Okay, the key, all right. So those that we
10 took you through before -
11 MS. JONES:
12 A. It's incomplete or -
13 CHAYTOR, Q.C.:
14 Q. - probably meant developed?
15 MS. JONES:
16 A. Yeah. You don't use it that often and you
17 don't see it and it's not a -
18 CHAYTOR, Q.C.:
19 Q. Okay, fair enough.
20 MS. JONES:
21 A. - natural key -
22 CHAYTOR, Q.C.:
23 Q. Fair enough.
24 MS. JONES:
25 A. It's not a natural key.

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1 MR. SIMMONS:
2 Q. Those letters are defined on the bottom -
3 CHAYTOR, Q.C.:
4 Q. Good. Tell us what they are.
5 MR. SIMMONS:
6 Q. - of the page underneath the table.
7 MS. JONES:
8 A. Yes, keep going, tell us -
9 MR. SIMMONS:
10 Q. - (unintelligible) previous page, scroll up a
11 little bit.
12 MS. JONES:
13 A. Up.
14 MR. SIMMONS:
15 Q. Up, yeah, right there.
16 UNKNOWN SPEAKER:
17 Q. Small print.
18 MS. JONES:
19 A. Where?
20 CHAYTOR, Q.C.:
21 Q. Where?
22 MR. SIMMONS:
23 Q. In the (unintelligible).
24 CHAYTOR, Q.C.:
25 Q. Oh, up here, okay.

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1 MS. JONES:
2 A. Oh, look. Implemented, I is implemented.
3 Look.
4 CHAYTOR, Q.C.:
5 Q. D is in development -
6 MS. JONES:
7 A. In development. So we were right.
8 CHAYTOR, Q.C.:
9 Q. We were right, it is in development.
10 MS. JONES:
11 A. We were, we were right.
12 CHAYTOR, Q.C.:
13 Q. And I is fully implemented.
14 MS. JONES:
15 A. Yeah. And N is not in place.
16 CHAYTOR, Q.C.:
17 Q. Not, or not -
18 MS. JONES:
19 A. They're not natural what you would think,
20 right.
21 CHAYTOR, Q.C.:
22 Q. No, that's right. Okay. So N is not -
23 THE COMMISSIONER:
24 Q. That would be communicating clearly. We
25 wouldn't want that.

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1 CHAYTOR, Q.C.:
2 Q. Thank. Thank you, others, thank you.
3 MS. JONES:
4 A. We'll have to keep that one on top, Sandy.
5 CHAYTOR, Q.C.:
6 Q. That's right. We're good now.
7 MS. JONES:
8 A. No, we're not. I'll have to write them down.
9 CHAYTOR, Q.C.:
10 Q. Okay. All we need to know here is that fully
11 implemented, I.
12 MS. JONES:
13 A. Yeah.
14 CHAYTOR, Q.C.:
15 Q. In development is D, not in place is N?
16 MS. JONES:
17 A. Yeah.
18 CHAYTOR, Q.C.:
19 Q. And leading practice is L?
20 MS. JONES:
21 A. Yeah.
22 CHAYTOR, Q.C.:
23 Q. Okay. So adopting patient safety is a written
24 strategic priority goal that's implemented?
25 MS. JONES:

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1 A. Yeah.
2 CHAYTOR, Q.C.:
3 Q. Providing quarterly reports to the board on
4 the issues is implemented?
5 MS. JONES:
6 A. Yeah.
7 CHAYTOR, Q.C.:
8 Q. Establishing a reporting system for actual and
9 potential adverse events, including
10 appropriate follow-up. "This should be in
11 compliance with applicable legislation within
12 any protection afforded by the legislation."
13 MS. JONES:
14 A. Yeah.
15 CHAYTOR, Q.C.:
16 Q. And that's in development?
17 MS. JONES:
18 A. Um.
19 CHAYTOR, Q.C.:
20 Q. And it says, "It is recommended the
21 organization fully implement" -
22 MS. JONES:
23 A. "Fully implement."
24 CHAYTOR, Q.C.:
25 Q. - "support and evaluate the occurrence

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1 reporting policy that was approved." And we
2 heard of that before.
3 MS. JONES:
4 A. Yeah.
5 CHAYTOR, Q.C.:
6 Q. And, "Quality risk management and peer review
7 committees are protected under the Evidence
8 Act."
9 MS. JONES:
10 A. Um.
11 CHAYTOR, Q.C.:
12 Q. "Some staff indicate reluctance to report
13 adverse events because they perceive they will
14 be blamed. Education and modelling work will
15 be necessary to change to a trusting culture."
16 MS. JONES:
17 A. Um-hm.
18 CHAYTOR, Q.C.:
19 Q. So what's that about?
20 MS. JONES:
21 A. That is exactly what it says. We have a new
22 occurrence reporting, we talked about this
23 earlier on, and it needs a lot of education
24 for staff so that they have a comfort level in
25 reporting occurrences through the official

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1 channels. And health and the health care
2 environment, a trusting culture is the word or
3 just and trusting culture is the words that we
4 used. And I'm sure you probably heard that
5 last week in terms of reporting and in terms
6 of improving and quality improving, then this
7 absolutely has to be here to insure that we
8 are aware of every single occurrence that
9 comes in in play and whether there's anything
10 that needs to be done or could it have been
11 prevented and what redundances do we need to
12 put in the system to make sure it doesn't
13 happen again.
14 CHAYTOR, Q.C.:
15 Q. And I guess, and maybe you could speak to this
16 in terms of your background, but the
17 perception, particularly when you're dealing
18 with patient safety and the health of people,
19 the concept of not reporting issues which may
20 be pertinent to that out of fear that you may
21 receive some sort of personal blame, there's a
22 bit of a disconnect in my mind on that. If
23 there's an issue out there or an incident that
24 has happened which can affect a patient's
25 safety or a patient's health, surely

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1 professionals who are trained in helping
2 people and in trying to preserve and promote
3 health would not be reluctant to report?
4 MS. JONES:
5 A. I think every person is out there on the front
6 line who is dealing with patients, okay,
7 whether they be near misses or an incident,
8 deals with the issue. The question here is
9 reporting the issue and through an official
10 occurrence reporting process. So the--any
11 person who is involved with an issue will deal
12 with the issue. It is the investigation and
13 making sure that it doesn't happen again that
14 becomes more like a--if, in fact, the patient
15 missed a medication at 2:00 and you never got
16 it until 2:30, do you actually write that out
17 as an occurrence or do you, you know, correct
18 yourself and make sure that in the future, so
19 there's those kinds of things. So that is an
20 occurrence according to our definition of
21 occurrence. Are all of those occurrences
22 reported? Probably not.
23 CHAYTOR, Q.C.:
24 Q. But the idea of having an occurrence that the
25 nurse working next to you or the professional

1 working next to you could learn from and
2 reporting that, there wouldn't be reluctance -
3 MS. JONES:
4 A. No.
5 CHAYTOR, Q.C.:
6 Q. - report something like that?
7 MS. JONES:
8 A. There's not, no, no. And we have a policy on
9 near misses in terms of, you know, an almost,
10 and we have redundancy in and all of those
11 kinds of things, you know, second checks in
12 the operating room to make sure that you're
13 operating on the proper side or those kinds of
14 things, and those are the things that you
15 build in place so that you don't make a
16 mistake. And so we capture near misses and we
17 try to learn from those. And by the
18 redundancy systems that we have in place, the
19 double checking and those kinds of things,
20 that's the kind of system that you would
21 ultimately want to have.
22 CHAYTOR, Q.C.:
23 Q. So the reluctance to report because of fear of
24 blame isn't, we're not talking about issues
25 where people are actually at risk, we're

1 talking about things that could be innocuous
2 such as a half hour delay in giving
3 medication?
4 MS. JONES:
5 A. Some of it would be that, right. The actual
6 occurrence reporting and what institutes, what
7 is identified as an occurrence in some areas
8 may not be an occurrence in other areas, so
9 there is inconsistency. If, in fact, there's
10 things going on in the ICU where it is
11 inappropriate to give the patient the med at
12 2:00, then usually that's documented in.
13 Literally because it should have been given at
14 2:00 and you didn't give it until 2:30, that
15 is an occurrence. And that's the kind of
16 thing. And this just and trusting culture is
17 another. Lots of times there may very well be
18 system issues where it's not your individual
19 issue, but it's a cumulation because issues
20 haven't been picked up along the way that at
21 the end of the day, you've talked about the
22 Swiss cheese model that the redundancy has not
23 picked up an issue and there may be an error.
24 And in that kind of incidence--and if there is
25 an issue and that is where you actually do the

1 investigation and try to find the root cause
2 analysis.
3 CHAYTOR, Q.C.:
4 Q. And that's how others learn, from -
5 MS. JONES:
6 A. And that's how others learn.
7 CHAYTOR, Q.C.:
8 Q. So that the incident is not repeated over and
9 over again.
10 MS. JONES:
11 A. Absolutely, and what do we need to put in
12 place so that we create enough redundancies
13 back in the system so that if there is a human
14 error or an issue that it is picked up and the
15 system is--it'll never be foolproof, but that
16 there is enough checks and balances in the
17 system so that it doesn't happen.
18 CHAYTOR, Q.C.:
19 Q. Yes, and I guess just in my mind, in thinking
20 about it, that people who dedicate their
21 lives, as I said, to promoting health and
22 protecting people would not be reluctant to
23 report in any incident where there could be a
24 learning for the next patient or for the next
25 health professional.

1 MS. JONES:
2 A. That would be my -
3 CHAYTOR, Q.C.:
4 Q. That would be your professional expectation?
5 MS. JONES:
6 A. That's right.
7 CHAYTOR, Q.C.:
8 Q. "Implement a formal transparent policy and
9 process of disclosure of adverse events to
10 patients, families, including support
11 mechanisms for patients, family and care
12 service providers" and D is in development.
13 MS. JONES:
14 A. Development. I had to look.
15 CHAYTOR, Q.C.:
16 Q. D is in development, okay, so this is a formal
17 transparent policy and process of disclosure
18 of adverse events, so to implement that,
19 including support mechanisms for patients,
20 family and care service providers. What do
21 you understand is being asked of Eastern
22 Health in this recommendation?
23 MS. JONES:
24 A. It is--we have a policy and there would have
25 been a policy at that time. We were waiting

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1 for the Canadian Patient Safety Institute
2 because we knew that they were revising their
3 guidelines as we were going through Eastern
4 Health. They should have been done in the
5 spring of 2007. They actually didn't come out
6 until the fall. So we were holding back on
7 re-developing the Eastern Health. We had a
8 policy in the old Health Care Corporation and
9 some of the areas had it, but we wanted to
10 make sure that we were consistent with best
11 practice. Even since then, we've had a look
12 at that policy. It is consistent with the
13 Canadian Patient Safety guidelines, but that
14 policy, from our perspective, is not complete
15 or full because public disclosure is not
16 addressed in it and multiple casualty or
17 multiple patient is not. The whole policy
18 that we have is around individual patient
19 issues around disclosure. It's very clear how
20 that is handled, but where there is multiple
21 patients, the individual patient aspect is
22 identified, but the public disclosure is not,
23 and I think that that has been something that,
24 even as the Canadian Patient Safety Guidelines
25 were being addressed, we were asking in their

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1 consultation what about public disclosure. So
2 we have to have that discussion and the Task
3 Force on Adverse Events in the province also
4 put that forward and said "this really needs
5 to be discussed about where is the public in
6 this and how, and what mechanism." So we do
7 have the individual patient disclosure, but
8 the other points -
9 CHAYTOR, Q.C.:
10 Q. This is what this appears to be addressing.
11 MS. JONES:
12 A. Absolutely.
13 CHAYTOR, Q.C.:
14 Q. The individual. So there's a suggestion that
15 you implement a formal, transparent policy,
16 and transparent is in brackets.
17 MS. JONES:
18 A. Yeah.
19 CHAYTOR, Q.C.:
20 Q. And process of disclosure. Would the
21 surveyors have been provided with the -
22 MS. JONES:
23 A. Yes.
24 CHAYTOR, Q.C.:
25 Q. - disclosure policy that you had?

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1 MS. JONES:
2 A. Absolutely, yeah.
3 CHAYTOR, Q.C.:
4 Q. And so what is it that -
5 MS. JONES:
6 A. In the evidence binders.
7 CHAYTOR, Q.C.:
8 Q. Yes, so what is it that would have been
9 lacking in that? Why do they have formal,
10 transparent policy?
11 MS. JONES:
12 A. I have no idea what value or judgment they
13 made on our individual policy that we had that
14 was in draft at the time.
15 MR. SIMMONS:
16 Q. The comments section, the first line -
17 MS. JONES:
18 A. Takes it.
19 MR. SIMMONS:
20 Q. - the sentence says "the organization has
21 recently approved a policy on disclosure."
22 MS. JONES:
23 A. Yes.
24 MR. SIMMONS:
25 Q. So it appears that they were aware of the

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1 approval of a policy.
2 MS. JONES:
3 A. That were aware of the content.
4 CHAYTOR, Q.C.:
5 Q. Yes, so they're aware of it, and it says "to
6 include support mechanisms for patients,
7 family and care service providers."
8 MS. JONES:
9 A. And that's all in the policy.
10 CHAYTOR, Q.C.:
11 Q. Yes, and they say "it is recommended the
12 organization roll out the implementation of
13 its disclosure policy."
14 MS. JONES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. "With attention to education and staff about
18 the process and the supports that are
19 available for patients and staff alike." So
20 is it that they were of the understanding that
21 while the policy is there, that it's not being
22 implemented?
23 MS. JONES:
24 A. The policy, I think if you look at it, is
25 similar to the August of 2007, would have been

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1 very close to the time that they had come on.
2 They came in September. So it probably has a
3 date of approval somewhere through the summer
4 of 2007. So there would not have been an
5 opportunity to roll it out through the
6 organization in its compliance.
7 CHAYTOR, Q.C.:
8 Q. But you were operating under your Health Care
9 Corporation policy which was very similar in
10 terms of -
11 MS. JONES:
12 A. Inside of -
13 CHAYTOR, Q.C.:
14 Q. If not identical.
15 MS. JONES:
16 A. Yeah.
17 CHAYTOR, Q.C.:
18 Q. Inside of Health Care.
19 MS. JONES:
20 A. Inside of the Health Care Corporation, and
21 remember that these are regional, okay. So if
22 there was not a disclosure policy or a policy,
23 written policy in the area of the old
24 Peninsulas Board or the Avalon Board, but
25 these are all regional policies.

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1 THE COMMISSIONER:
2 Q. I just want to clarify a point because I heard
3 two things and then I heard one. The
4 deficiency in the policy which you have
5 developed -
6 MS. JONES:
7 A. Yes.
8 THE COMMISSIONER:
9 Q. - one deficiency was it doesn't address public
10 disclosure?
11 MS. JONES:
12 A. That's right.
13 THE COMMISSIONER:
14 Q. Did you say it was a deficiency that it didn't
15 address multiple disclosures or did you say
16 yours didn't address multiple disclosure?
17 MS. JONES:
18 A. Ours doesn't address it. The policy, if you
19 read it, actually talks about really
20 individual disclosure and it doesn't talk
21 about multiple patients being affected,
22 although at the end of the day, the disclosing
23 to the individual patient would be contained
24 inside of that, but it does not have any
25 reference to public disclosure.

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1 THE COMMISSIONER:
2 Q. And you weren't talking about the Canadian
3 Patient Safety Institute's suggestions
4 regarding disclosure. You were talking about
5 your own?
6 MS. JONES:
7 A. Our own.
8 THE COMMISSIONER:
9 Q. Okay, thank you.
10 CHAYTOR, Q.C.:
11 Q. And Ms. Jones, this goes on to say that the
12 organization, as Mr. Simmons points out, has
13 recently approved a policy.
14 MS. JONES:
15 A. Approved it, yeah.,
16 CHAYTOR, Q.C.:
17 Q. So it seems to be the issue of implementing
18 it.
19 MS. JONES:
20 A. That's right.
21 CHAYTOR, Q.C.:
22 Q. Although we understand that the organization
23 within St. John's acute care anyhow was still
24 operating under the Health Care Corporation
25 policy.

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1 MS. JONES:
2 A. That's right, that had been developed in the
3 latter part of '04/05.
4 CHAYTOR, Q.C.:
5 Q. '04, which is really pretty much identical to
6 the new policy that's approved.
7 MS. JONES:
8 A. That's right.
9 CHAYTOR, Q.C.:
10 Q. "Staff indicate that disclosure takes place
11 when harm occurs to a patient or client and
12 that quality and risk management personnel
13 have a prominent role."
14 MS. JONES:
15 A. That's right.
16 CHAYTOR, Q.C.:
17 Q. There is, however, inconsistent awareness.
18 Does that mean amongst your staff,
19 inconsistent awareness?
20 MS. JONES:
21 A. The inconsistent awareness, and I would say
22 throughout the region, because it would be
23 parts of the region who had the disclosure
24 policy and were probably very well familiar
25 with it, old Health Care Corporation St.

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1 John's, but if talk to staff in Health and
2 Community Services or Burin, they may not have
3 been aware of. So that's the inconsistent--
4 that's this whole issue of this being a
5 regional accreditation and the redevelopment
6 of policy and procedure work that is regional
7 in nature.
8 CHAYTOR, Q.C.:
9 Q. And this has now gone out, in any event,
10 throughout your whole region?
11 MS. JONES:
12 A. In a region.
13 CHAYTOR, Q.C.:
14 Q. And everybody is aware of the disclosure
15 policy?
16 MS. JONES:
17 A. There's been education done around it.
18 CHAYTOR, Q.C.:
19 Q. And this goes on to say "based on interviews
20 with the cancer care team, disclosure to
21 individual patients whose breast cancer
22 receptor status was in question did occur.
23 This was done as soon as new information was
24 available to the team and the patient had been
25 traced. Disclosure was conducted in an

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1 ethical and appropriate manner." So where
2 would that information have come from?
3 MS. JONES:
4 A. I would suggest that what that--there was
5 discussion inside the interview that they
6 would have had with the cancer team and
7 explored the issue of ER/PR. You had asked
8 earlier on where would they have gotten
9 information around ER/PR, the sentinel event
10 would have been in the leadership and
11 partnership and they would, as they had gone
12 through the organization, asked teams that
13 were--had some role to play in that about this
14 particular issue and in this instance, it does
15 say that they did talk to the cancer team
16 about it.
17 CHAYTOR, Q.C.:
18 Q. Yes, and who would the cancer team be?
19 MS. JONES:
20 A. It would have been the members, mostly the
21 NCTRF and I can't tell you who sat on the
22 team, but there would have been the program
23 leader, Sharon Smith. There would have likely
24 been the clinical chief. There may have been
25 other physicians in radiation, oncology,

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1 surgeons with respect to cancer surgeries.
2 There would have been staff on that team as
3 well, radiation therapists, whatever.
4 CHAYTOR, Q.C.:
5 Q. Would Mrs. Pilgrim be on the team?
6 MS. JONES:
7 A. No.
8 CHAYTOR, Q.C.:
9 Q. And who would the clinical chief be?
10 MS. JONES:
11 A. That would have been Kara Laing, but I'm
12 saying I'm not sure for the actual interview.
13 There would have been a team, a quality team
14 in cancer and that would have been the team
15 that they would have interviewed.
16 CHAYTOR, Q.C.:
17 Q. And that's how they would have received their
18 information in terms of what disclosures had
19 taken place?
20 MS. JONES:
21 A. Absolutely.
22 CHAYTOR, Q.C.:
23 Q. And do we know who is the author of this
24 statement? Do we know who, which one of the
25 surveyors actually wrote this?

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1 MS. JONES:
2 A. No, we would never know that.
3 CHAYTOR, Q.C.:
4 Q. You would never know?
5 MS. JONES:
6 A. You would have had--what you generally have is
7 a team that comes together. They talk about
8 recommendations. If there are recommendations
9 specifically to--this one doesn't say to the
10 cancer team, okay, in terms of in development.
11 I'm still having to look. So the ROPs are
12 reviewed by the entire team about the evidence
13 that they've seen across the entire
14 organization. So in this instance, there
15 would have been at least ten of the surveyors
16 who would have had a discussion about what
17 they saw across the entire organization, and
18 even though one set of surveyors may have
19 found that it was complete or their interviews
20 and their documentation would have led them to
21 say that it was in place, a team that had
22 another part of the organization and felt that
23 it wasn't in place. So when there was any
24 question at all, it becomes either not
25 applicable or in development.

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1 CHAYTOR, Q.C.:
2 Q. And whether or not any of those--so it could
3 have been one of any ten people who write
4 this?
5 MS. JONES:
6 A. One of any ten people who would have been
7 contributing to writing that recommendation.
8 CHAYTOR, Q.C.:
9 Q. And whether or not that person has any
10 expertise in ethics or appropriate disclosure
11 processes, we wouldn't know?
12 MS. JONES:
13 A. We wouldn't know. You would have to go back
14 to the backgrounds of the individuals that
15 made up the team.
16 THE COMMISSIONER:
17 Q. Ms. Chaytor, wherever you can find a
18 convenient place, we'll take the afternoon
19 break.
20 CHAYTOR, Q.C.:
21 Q. Okay. I was hoping that I'd be finished, but
22 I do have two or three more questions on this
23 document, so perhaps we'll stop now.
24 THE COMMISSIONER:
25 Q. Okay, we'll take 15.

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1 (RECESS)
2 THE COMMISSIONER:
3 Q. Please be seated. Ms. Chaytor.
4 CHAYTOR, Q.C.:
5 Q. Thank you, Commissioner. Ms. Jones, if we
6 could continue on then, please, with the
7 accreditation document, and page 52 refers to
8 goal area number four, work life, work force,
9 "deliver at least annual education training on
10 patient safety to all staff, including
11 targeted patient safety focus areas within the
12 organization," and that's given an N meaning
13 not being done. Is this a new recommendation
14 as well?
15 MS. JONES:
16 A. This is new, in terms of annual education and
17 training, and if you remember my earlier
18 comments, this indicates that every staff
19 member inside the organization, all 12,000.
20 So this is--you know, there's lots of staff
21 who had annual patient safety, but not all
22 12,000.
23 CHAYTOR, Q.C.:
24 Q. So in order to be able to ultimately get an I
25 in this, you have to show that all 12,000

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1 staff -
2 MS. JONES:
3 A. 12,000 have had and what those sessions have
4 been.
5 CHAYTOR, Q.C.:
6 Q. And it says that "it's recommended the
7 organization develop patient safety education
8 and training material and develop, at a
9 minimum, annual sessions to all staff."
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. Is this being done for any staff?
14 MS. JONES:
15 A. Yes, absolutely, and -
16 CHAYTOR, Q.C.:
17 Q. And in the past three years leading up to this
18 accreditation, had it been done?
19 MS. JONES:
20 A. Yes, it has.
21 CHAYTOR, Q.C.:
22 Q. And had it been done for the staff in the
23 acute health care?
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. Number three, "delineate clearly the roles,
3 responsibilities and accountabilities of staff
4 and other providers for patient client care
5 and safety" and that also is an N, and "it's
6 recommended the organization provide
7 communication and education to staff and care
8 service providers to ensure that roles and
9 responsibilities for patient safety are well
10 understood."
11 MS. JONES:
12 A. Well understood.
13 CHAYTOR, Q.C.:
14 Q. I take it that's the same issue that we
15 discussed before?
16 MS. JONES:
17 A. Yes, and it says here the physician
18 descriptions as well. It's not that patient--
19 not that staff are not talked about or that we
20 haven't had patient safety and that they
21 understand it, but it is does 12,000 staff
22 inside of Eastern Health understand their
23 role.
24 CHAYTOR, Q.C.:
25 Q. And if we could move ahead then, please,

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1 Registrar, to page 244? And this--in fact, if
2 we just go back a page here in key findings,
3 it follows, and I'm not sure because it
4 follows right on the biomedical lab services,
5 then runs into -
6 MS. JONES:
7 A. Blood bank.
8 CHAYTOR, Q.C.:
9 Q. So this looks like it's key findings for the
10 laboratory blood bank only?
11 MS. JONES:
12 A. That's right.
13 CHAYTOR, Q.C.:
14 Q. That follows immediately after.
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. So those findings, while it says the
19 laboratory -
20 MS. JONES:
21 A. It would be -
22 CHAYTOR, Q.C.:
23 Q. - would be relating back to the -
24 MS. JONES:
25 A. Whatever was ahead of it.

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1 CHAYTOR, Q.C.:
2 Q. Immediately before, okay.
3 MS. JONES:
4 A. Okay.
5 CHAYTOR, Q.C.:
6 Q. So we can skip -
7 MS. JONES:
8 A. Those are summary ratings based upon each one
9 of the--you would see standard number one
10 listed here.
11 CHAYTOR, Q.C.:
12 Q. So this would be the laboratory, for example,
13 when we have--I think number three here talks
14 about the laboratory staff are qualified and
15 competent -
16 MS. JONES:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. - then the organization's rating and the
20 surveyor ratings.
21 MS. JONES:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. Okay, but those would relate only to the blood
25 banks and transfusion services?

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1 MS. JONES:
2 A. Yes. Ultimately, what they--what I
3 understand, if all three--if the survey had
4 been completed, there would have been a
5 consolidation of all of these because a lot of
6 the recommendations--if you just go to the
7 next page
8 CHAYTOR, Q.C.:
9 Q. Sure.
10 MS. JONES:
11 A. 42, the laboratory plan and design services to
12 meet the needs of clients and service
13 providers, that would have been in the two or
14 three teams. So there would have been an
15 overall rating. They would have pulled it
16 together, but because part of the lab was not
17 accredited until after, because there was a
18 member that was sick, so you may in fact see,
19 in the future, a full laboratory rating versus
20 the individual rating for the actual team.
21 CHAYTOR, Q.C.:
22 Q. I guess I didn't find though similar criteria
23 for the other section, the biomedical lab.
24 MS. JONES:
25 A. And so that's why I'm saying that this may

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1 very well be a full--because the whole idea -
2 CHAYTOR, Q.C.:
3 Q. It might be all of the lab?
4 MS. JONES:
5 A. Yeah. The whole idea was, with the lab, is
6 that there would be a consolidated lab report.
7 CHAYTOR, Q.C.:
8 Q. Right.
9 MS. JONES:
10 A. But there was part of the lab that couldn't be
11 accredited at the time that the original
12 report, and if this is, in fact, a
13 consolidated report, this may very well be the
14 total rating of all parts of the lab.
15 CHAYTOR, Q.C.:
16 Q. So this might be all parts of the lab?
17 MS. JONES:
18 A. All parts of the lab.
19 CHAYTOR, Q.C.:
20 Q. Now the only thing I found following from the
21 biomedical, they did have a list. The only
22 key findings--unless--yeah, the only key
23 findings, if we go back to page 165, these
24 were the three key findings that follow
25 immediately after the biomedical lab services.

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1 MS. JONES:
2 A. Yes, and so these would be the ones that--
3 yeah.
4 CHAYTOR, Q.C.:
5 Q. All right, and then if we can go back, please,
6 to 242, I think it was, these key findings
7 follow immediately after -
8 MS. JONES:
9 A. The blood bank.
10 CHAYTOR, Q.C.:
11 Q. - the blood bank.
12 MS. JONES:
13 A. That's right.
14 CHAYTOR, Q.C.:
15 Q. But they are different. So they talk about
16 the lab plans. They talk about services being
17 integrated, the lab staff, qualification and
18 competence.
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. So would these--are you saying these might
23 very well pertain to the entire lab service?
24 MS. JONES:
25 A. No, not that you showed me the earlier one.

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1 CHAYTOR, Q.C.:
2 Q. Okay. So these would be the blood bank?
3 MS. JONES:
4 A. This would be the blood bank and I'm thinking
5 that this is more towards the end of the
6 document, is it now? It may have been added
7 in after.
8 CHAYTOR, Q.C.:
9 Q. Yes, we're up to page 705.
10 MS. JONES:
11 A. Yeah.
12 CHAYTOR, Q.C.:
13 Q. Okay. So all of these would pertain to the
14 blood bank. So I'll just skip through that
15 then. If I could have then, please, 0732?
16 And this is a letter from Mr. Thompson dated
17 October 14th 2007 to yourself.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. And Mr. Thompson writes re: notification of
22 patients whose samples are sent for retesting,
23 and it's clearly related to the ER/PR testing.
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. He indicates that "one result of the research
3 that has been undertaken by NLCHI has been the
4 identification of a further three patients
5 with negative results who have recently been
6 sent for retesting at Mount Sinai. A further
7 14 patient samples were just sent from the
8 Carbonear area for ER/PR retesting, and I
9 understand an additional 16 patient samples
10 from this area are now to be sent for ER/PR
11 retesting. While you may be aware of all
12 these cases from Eastern Health personnel, I
13 am conveying this information to you to
14 reemphasize the need to communicate with these
15 patients in a timely and appropriate manner
16 that their tissue samples are being retested.
17 Thank you for your attention to this matter."
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. First of all, why is the word "reemphasize"
22 used? Had you already had discussions with
23 Mr. Thompson around the issue of timeliness
24 and appropriate communication with patients?
25 MS. JONES:

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1 A. Not necessarily related to this, but just as
2 we move forward with this, if there are
3 individuals that have been identified that, in
4 fact, that there is communication with those
5 individuals.
6 CHAYTOR, Q.C.:
7 Q. What did you understand to be the
8 circumstances regarding those patients? Who,
9 in October 2007, were only being sent for the
10 first time for retesting?
11 MS. JONES:
12 A. The Carbonear ones. What I understood was
13 that the--even though there had been a review
14 done in 2005 to identify clients based upon
15 the pathology reports that were in Carbonear
16 at the time, the ER/PR, there were patients'
17 charts who were identified and samples that
18 were sent and there was a further review of
19 those by the--whether it was by the
20 pathologist or the pathologist asked to go and
21 have a look at all of those again, these were
22 additional patients that they had identified
23 through the summer or well, obviously before
24 the 19th of October, that were identified that
25 were not identified in 2005.

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1 CHAYTOR, Q.C.:
2 Q. And your understanding is they were identified
3 in the summer of 2007?
4 MS. JONES:
5 A. Sometime before this letter, so it would have
6 been certainly in September because 14 were
7 already gone and there was pulling of blocks
8 and that for additional samples that were
9 going to be sent and they were all from
10 Carbonear.
11 CHAYTOR, Q.C.:
12 Q. And were you able to ascertain why these
13 people had not been identified two years prior
14 when the others had been?
15 MS. JONES:
16 A. Only that there had been a review of the files
17 at that particular time and they had sent the
18 samples that they believed met the criteria,
19 and then upon a review again, in--either
20 through the summer or into September, they had
21 identified these additional patients.
22 CHAYTOR, Q.C.:
23 Q. When was it brought to your attention that not
24 all patients had been identified?
25 MS. JONES:

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1 A. It would have been after the first 14, okay,
2 had gone off. I wouldn't be -
3 CHAYTOR, Q.C.:
4 Q. So when was that?
5 MS. JONES:
6 A. More towards the latter part of September. On
7 a daily basis, if they had received samples in
8 from Carbonear to say these need to go for
9 retesting, that would not have been
10 information that would have come up to the
11 CEO. They would have been dealing with that
12 at the level of the lab, of getting the
13 samples, of sending them on and then working
14 with quality to sort of say we have additional
15 patients that need to be retested.
16 CHAYTOR, Q.C.:
17 Q. So by the time you learned about it in,
18 towards the end of September, it would have
19 already been in process for some time?
20 MS. JONES:
21 A. It would have already been in process, that's
22 right.
23 CHAYTOR, Q.C.:
24 Q. And at this point in time, who is tasked with
25 the handling of the ER/PR issue, in terms of

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1 identifying patients and making sure everybody
2 has been identified?
3 MS. JONES:
4 A. At this point in time, we had NLCHI who was
5 developing the database and so we did not do
6 any continuing of checking of if there was any
7 other patients in the province. What had been
8 happening is that as patients have self
9 disclosed to us, we were going back either
10 inside of our own data to see what it was or
11 asking the other regions to check in fact to
12 see if there was an ER/PR on a particular
13 patient. So we were dealing with it on an
14 individual basis. I'm not sure where the
15 further three with negative results, I think
16 that they may have been identified by NLCHI
17 themselves, but NLCHI would absolutely be able
18 to talk to that and more than likely Pat
19 Pilgrim, because she was dealing with that
20 file on an daily basis.
21 CHAYTOR, Q.C.:
22 Q. So when you learned about this sometime in
23 late September, who told you?
24 MS. JONES:
25 A. It would have been Pat Pilgrim that told me

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1 that there were additional patients in
2 Carbonear that had been identified, that
3 weren't identified in the first--when they
4 sent their samples in, in the fall of 2005.
5 CHAYTOR, Q.C.:
6 Q. And how that came to be or the cause for them
7 not to be identified at the time -
8 MS. JONES:
9 A. Identified at that time -
10 CHAYTOR, Q.C.:
11 Q. You didn't ask.
12 MS. JONES:
13 A. Well I asked and it was a process that they
14 used to review the files and they had
15 identified a certain number of patients. I
16 suspect that it was that in September they
17 wanted to make sure and it wasn't a prompting
18 by us, it was a prompting by Carbonear itself.
19 Now whether it was a pathologist in Carbonear,
20 I would expect, who then went and personally
21 reviewed the files and identified more -
22 CHAYTOR, Q.C.:
23 Q. Or whether it was a patient that came forward,
24 you don't know.
25 MS. JONES:

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1 A. Don't know. But in this instance, as you see
2 here, a significant number of patients that
3 were not identified in 2005.
4 CHAYTOR, Q.C.:
5 Q. And so when you learned about this then, did
6 you question whether or not there could be
7 other people and if so, was there any process
8 put in place to go back and check to make sure
9 everybody had been identified?
10 MS. JONES:
11 A. We had, at that point in time, already had
12 NLCHI who was reviewing all of the ER/PR to
13 identify all of the clients that potentially
14 should have been sent for retesting. So we
15 just -
16 CHAYTOR, Q.C.:
17 Q. Okay, just let me stop there, did you
18 understand NLCHI was reviewing all -
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. So 2700 ER/PRs?
23 MS. JONES:
24 A. That was my understanding, if you remember my
25 conversation earlier on was we were in a

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1 process or wanting to develop, start to
2 develop a database ourselves to see if there
3 was another way of identifying individuals and
4 the people that we would have put on that
5 database were the same ones that NLCHI would
6 have needed to develop their database. And
7 there was a document, a scoping document, so
8 in discussions with Robert, it was really the
9 discussion around NLCHI will develop that
10 database and see if there's anybody we missed.
11 CHAYTOR, Q.C.:
12 Q. Okay, so your understanding was that there was
13 no need then to put anything in place at
14 Eastern Health to ensure there hadn't been
15 further patients, because NLCHI was looking
16 after that?
17 MS. JONES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. They were reviewing all 27 and some odd
21 patients who had ever had an ER/PR test in the
22 timeframe and they would be able to identify
23 any patients that weren't already in the
24 database?
25 MS. JONES:

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1 A. That was one of the things because people had
2 kept coming forward, self-identifying in prior
3 to the summer of 2007, we had small numbers
4 that would come forward. And so at the end of
5 the day, it was my understanding that they
6 were going to redo this work to make sure
7 everybody was captured.
8 CHAYTOR, Q.C.:
9 Q. So based on your discussion with Robert,
10 there's no need for Eastern Health to be doing
11 that because his team -
12 MS. JONES:
13 A. His team were doing it, the information that
14 they would produce would be passed over to
15 Eastern Health at the point in time when it
16 was completed and then we would be able to
17 utilize it for our purposes.
18 CHAYTOR, Q.C.:
19 Q. And the patients that we've recently heard
20 about in this past year, who've been
21 identified, how were they identified?
22 MS. JONES:
23 A. Some of them through the NLCHI process, but
24 others continue to be self-identified, not
25 identified in the NLCHI process.

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1 CHAYTOR, Q.C.:
2 Q. And has there been any explanation as to how
3 that could be, how people could have been
4 missed through Eastern Health's original
5 process and now through NLCHI's process?
6 MS. JONES:
7 A. No, only that there isn't a database, there is
8 no single source to go through. We were
9 using--the database was not inside of St.
10 John's and that we were relying on other
11 regions and individuals to check their manual
12 pathology reports to look for ER/PR results
13 and identify the negative ones based upon the
14 criteria that were set in 2005 around the 10
15 percent and the 30 percent.
16 CHAYTOR, Q.C.:
17 Q. And, Ms. Pilgrim you say is responsible within
18 Eastern Health now for managing the ER/PR
19 issue.
20 MS. JONES:
21 A. For managing the file, yes.
22 CHAYTOR, Q.C.:
23 Q. And what does that involve? What is it that
24 she's been tasked with?
25 MS. JONES:

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1 A. Any of the correspondence and the work that is
2 done between Robert and--Robert doesn't
3 necessarily talk to me unless there is a
4 bigger issue, but on the day-to-day
5 communications around the database, what's in
6 the database, what do we need to follow up on,
7 the communications, where are we, the lists
8 that have come from NLCHI to verify those
9 kinds of things, those are all the things that
10 Pat would co-ordinate for Eastern Health.
11 CHAYTOR, Q.C.:
12 Q. Okay, and do you have then regular meetings
13 with her to get updates on where the issue is?
14 MS. JONES:
15 A. Yes, we do. We have regular monthly meetings,
16 but in between times, she would also call and
17 say what actually has been going on, or if
18 there's an issue like this one, which samples
19 from Carbonear that were identified by
20 Carbonear themselves, she would have notified
21 me. Maybe not the day that she was aware of
22 it, but, you know, it a very short period of
23 time after that.
24 CHAYTOR, Q.C.:
25 Q. Okay. And if we could have P-0733 please? So

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1 I take it overall, though, Ms. Jones then you
2 can't be confident that everyone has now been
3 retested?
4 MS. JONES:
5 A. I would say that and I think the board chair
6 had said that. Even with the amount of work
7 that NLCHI has put in on this database, I
8 would not say that we're a hundred percent
9 confident that everybody has been identified.
10 There is just no way in the way that this
11 information is inside of organizations,
12 databases, that it's able to be extracted.
13 CHAYTOR, Q.C.:
14 Q. And I guess the information that NLCHI is
15 relying on is information that has been
16 provided to it by Eastern Health and the other
17 authorities?
18 MS. JONES:
19 A. And the other regional health authorities,
20 yes.
21 CHAYTOR, Q.C.:
22 Q. So in terms of then NLCHI being able to
23 identify any further patients that may have
24 been missed, if that information hasn't been
25 provided to them, if they don't even have the

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1 patient in the original identified documents,
2 they're not going to pick that up?
3 MS. JONES:
4 A. They have picked up patients by reviewing,
5 identifying individuals, so you really need to
6 talk to them about their methodology and their
7 process. They did use Meditec to do that and
8 extract as much as they can, but they're best
9 able to speak to how they develop the database
10 because at the end of the day, we know from
11 the database that we had that we were
12 originally working from, we know that there
13 were people who were not identified early on
14 and we had instances where St. Anthony had
15 sent their samples late and we had close to 30
16 here in September of 2007. But they were
17 because those organizations had, for whatever
18 reason, reviewed or identified samples on
19 subsequent reviews. So, but that only
20 accounts for 739, which is what we had in our
21 original database, potentially close to 40,
22 that's only 779, but NLCHI has identified many
23 more than that. And they were utilizing the
24 same kinds of information inside the various
25 health authorities, as we had asked the health

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1 authorities and ourselves to look at.
2 CHAYTOR, Q.C.:
3 Q. And if there's recently though an incident
4 where there was somebody who hadn't been
5 picked up by NLCHI -
6 MS. JONES:
7 A. That's right.
8 CHAYTOR, Q.C.:
9 Q. - did that prompt Eastern Health, are you now
10 reviewing your own records to figure out how
11 that could have happened and whether there are
12 others who would fit in that category?
13 MS. JONES:
14 A. We have on, well in this instance there is the
15 pathology reports, there is over 300,000 pages
16 of text. It's an impossible task to do that
17 on a manual basis. And so for us and in terms
18 of the way ER/PR was reported throughout the
19 various years, it wasn't in a single format,
20 in a particular area in the text and in a
21 particular way to be reported, so from our
22 perspective that particular issue, I don't
23 know if we had ever had any assurance or is
24 there another way of doing this.
25 CHAYTOR, Q.C.:

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1 Q. So over 300,000 pathology reports pertaining
2 to breast cancer?
3 MS. JONES:
4 A. 300,000 pages of reports because of
5 pathologists -
6 CHAYTOR, Q.C.:
7 Q. Pertaining to breast cancer patients.
8 MS. JONES:
9 A. Pertaining to breast because you can't define
10 it even less than that, so you have to start
11 with that figure.
12 CHAYTOR, Q.C.:
13 Q. But has there been anything done to go back
14 and try other means of identifying whether it
15 is to key in other words or has there been any
16 further attempt?
17 MS. JONES:
18 A. There's been discussion around that, but we
19 were waiting for NLCHI to complete its
20 database because we felt that it was to be
21 their effort, they'd have expertise in
22 database management and even in releases that
23 the minister did. On the individual release
24 in November, I would acknowledge that and
25 we've only received that database ourselves in

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1 its complete entirety only in the last couple
2 of weeks.
3 CHAYTOR, Q.C.:
4 Q. So if we look here at 0733, this appears to be
5 draft minutes from a meeting of October 27th,
6 2007?
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And it's a meeting regarding outstanding ER/PR
11 data retests and communication issues.
12 MS. JONES:
13 A. Yes.
14 CHAYTOR, Q.C.:
15 Q. Takes place at the department. You attend,
16 along with Terry Gulliver, Pat Pilgrim,
17 Heather Predham, Reza and Robert Thompson.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. And what was the purpose of this meeting?
22 MS. JONES:
23 A. This was Robert--this was a Saturday morning
24 meeting and there had been a lot of work been
25 done on the various lists that they had, they

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1 kept talking about lists and Robert wanted
2 this group to come together to look at where
3 they were, where the outstanding issues were
4 and how we were going to move forward. He was
5 also tempting to try and finalize all of the
6 information that they had inside of NLCHI and
7 validate it, verify it because he was getting
8 prepared to release some numbers to the
9 Commission, as well as the minister wanted to
10 move forward with having some communication to
11 the public about what they had found.
12 CHAYTOR, Q.C.:
13 Q. Okay, so it says here that the objective was
14 to discuss continuing activity directed at
15 identifying patients that had not been
16 retested.
17 MS. JONES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. Or if retested, had not been contacted.
21 MS. JONES:
22 A. Been contacted, uh-hm. And the thrust of the
23 meeting was more around identifying that
24 patients were retested not the contact,
25 because the actual work on the contact list

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1 and whether in fact all of those patients had
2 been contacted, you had to have the list first
3 before you would then go and do the second
4 piece of the work, was to make sure everybody
5 had been contacted.
6 CHAYTOR, Q.C.:
7 Q. Okay. And if we could go, please, to 0735?
8 I'm sorry, before we leave that, if we could
9 go back, please, 0733? And this is a section
10 under "Communications".
11 MS. JONES:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. See that on, I believe that's page 3?
15 MS. JONES:
16 A. Page 3, yes.
17 CHAYTOR, Q.C.:
18 Q. And "Eastern Health also noted that the panel
19 process is no longer in place. This means
20 that results for patients who have an
21 oncologist still practising in the province
22 will be straight forward because a
23 doctor/patient relationship exists. Eastern
24 Health may have to contract with an additional
25 oncologist to see patients for whom there is

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1 no existing oncologist/patient relationship
2 still existing within the province. For both
3 groups, Eastern Health will write letters to
4 their GPs."
5 MS. JONES:
6 A. Uh-hm.
7 CHAYTOR, Q.C.:
8 Q. And so why is it that those without an
9 existing doctor/patient relationship could not
10 be referred to other oncologists?
11 MS. JONES:
12 A. They wouldn't have had a relationship with the
13 oncologist, they would have been discharged,
14 as we would say, have had their five-year
15 follow up.
16 CHAYTOR, Q.C.:
17 Q. I understand that.
18 MS. JONES:
19 A. And so therefore, we had to re-institute a
20 panel to be able to look at the results that
21 were coming back, if there were changes. And
22 in fact, that's what ended up happening.
23 CHAYTOR, Q.C.:
24 Q. Yes, what happened?
25 MS. JONES:

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1 A. We ended up panelling, okay, this was a
2 discussion at the time saying we don't have a
3 panel right now. If we do have change results
4 and they, there is an existing relationship,
5 then the oncologist can deal with it, but at
6 the end of the day what we did do, is anything
7 that came back with a change in results was
8 panelled. We pulled the panel together on an
9 ad hoc basis to deal with the issues as they
10 were coming back.
11 CHAYTOR, Q.C.
12 Q. So they were put through the same process?
13 MS. JONES:
14 A. They were put through the same process.
15 CHAYTOR, Q.C.:
16 Q. And was it the same individuals involved, the
17 same oncologists, pathologists, risk manager?
18 MS. JONES:
19 A. Yeah.
20 CHAYTOR, Q.C.:
21 Q. The same group?
22 MS. JONES:
23 A. The same group would have come together when
24 they had a number of individuals or changes
25 that they had to deal with.

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1 CHAYTOR, Q.C.:
2 Q. So it was Dr. Laing and others.
3 MS. JONES:
4 A. And others, yes.
5 CHAYTOR, Q.C.:
6 Q. 0735 please? And this appears to be a follow
7 up e-mail exchange following the meeting with
8 Robert and I believe it starts actually on the
9 next page.
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. E-mail from Robert Thompson to yourself, sent
14 Sunday, October 28th, 2007. And he sends
15 along attached draft notes, which I assume is
16 what we just looked at.
17 MS. JONES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. And if you have any variances with your own
21 notes, let him know and he sets out some key
22 next steps.
23 MS. JONES:
24 A. Uh-hm.
25 CHAYTOR, Q.C.:

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1 Q. And this included the department was to
2 contact the other regional health authorities
3 regarding cases which may not have been
4 retested.
5 MS. JONES:
6 A. That's right.
7 CHAYTOR, Q.C.:
8 Q. So I take it there was suspicion that this was
9 happening in other regions as well?
10 MS. JONES:
11 A. That's right and as soon as the database or
12 NLCHI was involved, we only were able to see
13 the parts of the database that related to
14 Eastern Health clients, so then NLCHI dealt
15 with the Central and the Western Regional
16 Health Authority around their own issues with
17 respect to retesting.
18 CHAYTOR, Q.C.:
19 Q. Okay.
20 MS. JONES:
21 A. Now we did have some basic information that we
22 would have put into the database, but the
23 discussion was really between the other
24 regional health authorities then.
25 CHAYTOR, Q.C.:

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1 Q. Okay, the third was that Eastern was to
2 establish--or Eastern to establish
3 communication protocol for patients who are
4 currently being retested or who will be
5 retested, advise the department of the
6 protocol and begin making contact.
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And "Eastern, fourthly, to develop a
11 communication's plan for making the public
12 aware of the new group of retests and possibly
13 the test for which communications were not
14 undertaken and will consult the department on
15 this plan. And Eastern and NLCHI officials
16 will consult directly on a number of cases to
17 verify the reasons why they were not
18 retested."
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. And that communication will occur will Reza
23 returns. So this issue of Eastern
24 establishing a communication protocol and
25 developing a communication plan, and in doing

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1 so, consulting with the department, did that
2 happen?
3 MS. JONES:
4 A. Yes, and I think there's some e-mails as well
5 to talk about some discussion between the
6 communication specialist and there is
7 actually, I note that this is the 28th of
8 October, there's actually some e-mail
9 discussion that happens later on around the
10 process for follow up from Pat Pilgrim to each
11 one of the regional health authorities. So
12 there was ongoing discussion around what was
13 going to happen and how we were going to
14 follow up and the notification when the
15 testing had come back. There was some
16 discussion and there's also some e-mail
17 correspondence to say is this what we thought
18 came out of the meeting, because develop a
19 communication plan for making the public aware
20 was not something that we had--I had thought,
21 I had flagged it and so did Pat Pilgrim, so we
22 didn't understand that as we came out of that.
23 But in terms of the public communication plan
24 and the public awareness, the minister himself
25 went out on the 2nd of November and made those

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1 issues known in terms of public communication.
2 CHAYTOR, Q.C.:
3 Q. So in terms of Eastern developing a
4 communication's plan to the public, that in
5 fact got taken on by the department.
6 MS. JONES:
7 A. The department did, there was a press
8 conference on the 2nd of November.
9 CHAYTOR, Q.C.:
10 Q. November 2nd, that's right.
11 MS. JONES:
12 A. Coming out of this particular -
13 CHAYTOR, Q.C.:
14 Q. You didn't understand that to be your -
15 MS. JONES:
16 A. We didn't understand that to be our role; we
17 understood that we would develop a
18 communication protocol about this retesting
19 and all of that, how we were, and that was
20 worked through with the regional health
21 authorities and in discussions through the
22 period of time after this.
23 CHAYTOR, Q.C.:
24 Q. And what communication's protocol would have
25 to be developed by Eastern for patients who

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1 are being retested in 2007? Didn't Eastern
2 Health follow the same protocol that had been
3 in place in 2005, 2006?
4 MS. JONES:
5 A. If you look at what actually happened, it did,
6 it was notifying them that their sample had
7 been sent, they had been identified that their
8 sample had been sent for retesting and then
9 when the results come back that in fact there
10 would be follow up from that.
11 CHAYTOR, Q.C.:
12 Q. So I guess my only question is why would a key
13 point or a key step coming out of the meeting
14 be for Eastern to develop a communication
15 protocol for patient contact if Eastern
16 already had such a plan in place?
17 MS. JONES:
18 A. We had a practice in which we were in, I'm
19 sure Robert would speak to this, it wanted to
20 make sure that we knew exactly how we were
21 going to move forward on that communication.
22 CHAYTOR, Q.C.:
23 Q. And how did you move forward on it? What
24 happened?
25 MS. JONES:

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1 A. Well depending on what aspect or where they
2 were in their retesting, the September stuff,
3 the Carbonear stuff had already gone forward,
4 so those would have been phone calls that
5 would have been made to say, you know, you've
6 been identified and we will call you when we
7 have the results.
8 CHAYTOR, Q.C.:
9 Q. So the patients were contacted to be told that
10 they were in the process of being retested.
11 MS. JONES:
12 A. That's right.
13 CHAYTOR, Q.C.:
14 Q. And then they were panelled?
15 MS. JONES:
16 A. If need be, right.
17 CHAYTOR, Q.C.:
18 Q. If there were a change in the results, they
19 were panelled.
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And then letters went to the physicians?
24 MS. JONES:
25 A. Yes, it was the same process and the November

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1 30th letter, because when you send off the
2 stuff to Mount Sinai, it takes awhile to get
3 back, so at the end of the day there was that,
4 you know, we will follow the same process. We
5 will send you information if it's, if there's
6 no change, then this is the expectation.
7 CHAYTOR, Q.C.:
8 Q. So there was no knew communication protocol
9 developed for those patients?
10 MS. JONES:
11 A. No, it was just establish a communication
12 protocol.
13 CHAYTOR, Q.C.:
14 Q. And the last tier, to consult directly on a
15 number of cases, to verify the reasons why
16 they were not retested. So Eastern and NLCHI
17 officials were going to consult directly to
18 verify the reasons they were not retested.
19 MS. JONES:
20 A. Uh-hm.
21 CHAYTOR, Q.C.:
22 Q. And I asked you that a few minutes ago.
23 MS. JONES:
24 A. And there was many, many lists and somebody
25 who would be able to just go down through the

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1 lists, there was lots of, there were patients
2 who were sent away for consults who didn't
3 have an ER, an original ER/PR, but NLCHI had a
4 Mount Sinai ER/PR, so originally would not
5 have been done and particularly in the period
6 of time from July to maybe September, when we
7 stopped testing and there were consults to
8 Mount Sinai all through this period of time
9 for HER2/neu testing and that, so there was
10 lots of individual pieces where what NLCHI had
11 been putting together in their individual
12 database was incomplete, so they needed the
13 discussion with the staff inside of Eastern
14 Health who had the information. And as we
15 went through, even as we were into January and
16 February, around contact lists and lists that
17 were coming forward and when were these--it
18 was information that we had had, but was not
19 at that point in time into the NLCHI database.
20 CHAYTOR, Q.C.:
21 Q. Okay. And my question was going to be whether
22 or not in, fact, you're able to verify the
23 reasons why these people had not been
24 originally retested.
25 MS. JONES:

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1 A. Yes.
2 CHAYTOR, Q.C.:
3 Q. And if you don't know why or have not been
4 told, then who would be able to tell us?
5 MS. JONES:
6 A. Pat would be because she was managing it. So,
7 there's lots of correspondence that goes
8 forward. Like, in the Saturday meeting and I
9 looked at Robert at the end and I said, why
10 would you need the CEO in this. It was a very
11 technical meeting; there was lists; there was
12 patient names; there was lots of blanks on the
13 end of the list. And I just sat there at the
14 end of the day while the individuals who know
15 the information, whether it was a lab
16 individual or Heather Predham or Reza who had
17 been working through this. Pat was very
18 familiar with it because she was dealing with
19 it on a daily basis, but Robert and I weren't.
20 But obviously, he had a need to bring people
21 together to see how close we were because he
22 was trying to move this particular issue
23 forward so that they could complete that
24 database for the Commission and for himself.
25 CHAYTOR, Q.C.:

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1 Q. So, you felt you didn't have much to really
2 give to the Saturday meeting in terms of -
3 MS. JONES:
4 A. No, but we spent a couple of hours there and,
5 you know, I could see the process. I could
6 see the discussion that was happening, even on
7 an individual name place where there was
8 nothing in the database. Individuals would
9 even know the names and say, I've talked to
10 that individual, that kind of thing. So, they
11 knew because they had been working the file
12 for a couple of years, they knew the
13 individual pieces of the file.
14 CHAYTOR, Q.C.:
15 Q. And you had had minimal involvement in -
16 MS. JONES:
17 A. I had no involvement with that file per se.
18 CHAYTOR, Q.C.:
19 Q. And this is an e-mail communication. This is
20 the same -
21 MS. JONES:
22 A. In the same sequence, yeah.
23 CHAYTOR, Q.C.:
24 Q. The first page and this is--I guess if we
25 start from the bottom and work our way up.

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1 MS. JONES:
2 A. Yeah.
3 CHAYTOR, Q.C.:
4 Q. And then Pat, the other e-mail--you forward on
5 Robert's e-mail to Pat on October 29.
6 MS. JONES:
7 A. Yeah.
8 CHAYTOR, Q.C.:
9 Q. And then Pat e-mails back to you Monday,
10 October 29, "re: Notes from the meeting.
11 Louise, first of all, hope you're hanging in
12 there. I know how close you were to this
13 whole situation and how difficult this must be
14 for you". What's she referring to?
15 MS. JONES:
16 A. It's just the whole ER/PR as well as we had
17 just been through the Burin radiology. So,
18 that's just a personal note to hang in there.
19 CHAYTOR, Q.C.:
20 Q. But "I know how close you were to this whole
21 situation and how difficult this must be for
22 you". Now were you close to the situation? I
23 understood that you had -
24 MS. JONES:
25 A. Not in that, but you'll have to ask Pat what

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1 she actually meant by it. It didn't even
2 register in relation to the ER/PR. It
3 registered to me in terms of the issues that
4 were going on and hang in there as a CEO.
5 CHAYTOR, Q.C.:
6 Q. Yes, I understand the "hang in there" part.
7 The part that I'm not understanding is why she
8 would say you were close to the whole
9 situation.
10 MS. JONES:
11 A. Yeah, but I wasn't.
12 CHAYTOR, Q.C.:
13 Q. You don't--you weren't close to this
14 situation?
15 MS. JONES:
16 A. No, not on an individual daily basis, the work
17 that was going forward. You're going to have
18 to ask Pat why she would have used those
19 words.
20 CHAYTOR, Q.C.:
21 Q. And "how difficult this must be for you", why
22 is this particular exchange difficult? What's
23 difficult about the situation at this point in
24 time?
25 MS. JONES:

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1 A. I can't answer that. Pat will have, you know,
2 that's how she perceived it.
3 CHAYTOR, Q.C.:
4 Q. So, what did you think when you read it? Were
5 you puzzled?
6 MS. JONES:
7 A. I was more interested in the second part
8 because I had the same issue as Pat did which
9 was where is the communication, the public
10 communication that was not part of--so, yes, I
11 read it, didn't really mean anything to me,
12 except on a personal note.
13 CHAYTOR, Q.C.:
14 Q. You weren't puzzled by what she must mean, why
15 am I close to this situation and this being
16 difficult?
17 MS. JONES:
18 A. No.
19 CHAYTOR, Q.C.:
20 Q. That didn't puzzle you?
21 MS. JONES:
22 A. No.
23 CHAYTOR, Q.C.:
24 Q. All right. And then you go and you write back
25 to her and you don't address that issue.

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1 MS. JONES:
2 A. No.
3 CHAYTOR, Q.C.:
4 Q. If we could have 0488 please and I believe
5 it's page 75. Okay. And this is--actually we
6 should go up to the top and see what date--
7 this is back a bit. It's October 3, 2007 and
8 I missed this one in going through. So, I
9 think I had a question on this. Yes, page 75,
10 it refers to "The Wall Street Journal" has
11 requested an interview. Did Eastern Health do
12 that interview?
13 MS. JONES:
14 A. I can't recall, but I do believe that Pat
15 Pilgrim did do something for "The Wall Street
16 Journal".
17 CHAYTOR, Q.C.:
18 Q. Okay. And then it goes on to say, "Pat
19 Pilgrim and Louise Jones to discuss outside
20 this forum, the request for information re
21 ER/PR from the Department of Health and
22 Community Services". And this is the
23 beginning of October '07.
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. What information was, in fact, was being
3 requested from the Department of Health on the
4 issue at that point in time?
5 MS. JONES:
6 A. Can't recall what that would have been, but
7 any--we didn't talk numbers or whatever. It
8 may have been that at the end of the day, all
9 of the lists that were coming forward that Pat
10 was dealing with and she may have wanted to
11 have some discussion about that.
12 CHAYTOR, Q.C.:
13 Q. So, you don't recall what they were looking
14 for -
15 MS. JONES:
16 A. No.
17 CHAYTOR, Q.C.:
18 Q. - back in October, a few months ago?
19 MS. JONES:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. Okay. If we could look at then, 0728, please.
23 And this is your correspondence, September 11,
24 2007 and it's the 2008/2009--I'm sorry, this
25 is Robert Thompson writing to you regarding

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1 the budget submission for the year of 2002
2 (sic.), 2008.
3 MS. JONES:
4 A. That's right. And what they expected in and
5 the time lines.
6 CHAYTOR, Q.C.:
7 Q. That's right.
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. Is there anything in particular that
12 ultimately is included in your submission
13 which was intended to address the concerns
14 raised by the ER/PR issue?
15 MS. JONES:
16 A. I think if you look at the letter that is a
17 transmission letter on the 24th of October to
18 Mr. Thompson, that there is some commentary in
19 there that talks about a need to look at
20 reinvestment in support systems and
21 infrastructure, particularly in administrative
22 capacity and supports. And there's references
23 to information systems and references to
24 administration and support. So, in a high
25 level, there is a discussion around where

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1 Eastern Health with respect to its
2 infrastructure and the supports for the entire
3 system and there is reference there. And in
4 the individual submission where we're asked to
5 priorize issues with respect to the top 100
6 which was the way we were asked to. We ended
7 putting things such as information technology
8 investment as our number two item and decision
9 support as our number three item and
10 administrative and clinical support throughout
11 the organization as number four. And then you
12 move on with staff education and that. So, if
13 you look in the way that we priorize our
14 budget submission, that it was very clearly on
15 what our deficiencies were inside the
16 organization and what we absolutely needed to
17 do to move the organization forward. And that
18 is having a robust administrative and clinical
19 support structure to having an information
20 management system that would allow us to move
21 forward. And this particular budget
22 submission that you're looking at now is only
23 the operating budget.
24 CHAYTOR, Q.C.:
25 Q. Yes.

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1 MS. JONES:
2 A. The budget letter also references the capital
3 budget that they need to look at because a lot
4 of the information technology pieces are in
5 the capital budget submission and not
6 necessarily in the operational budget. So,
7 that is the highlights of that with respect to
8 decision support as well as information
9 technology and our ability to be able to work
10 through an issue if it came up, such as this
11 in the future and be able to get at
12 information that we needed to do and have
13 supports around us to be able to do this in a
14 much more effective manner.
15 CHAYTOR, Q.C.:
16 Q. Okay. So, it was mainly around your
17 information management structure?
18 MS. JONES:
19 A. Information management structure as well as
20 around supports for managers to be able to--
21 supports for managers. There's many parts--
22 for instance in many parts of the organization
23 managers do not have secretarial support or
24 other kinds of supports that will allow them
25 to be able to do the things that we were

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1 talking about earlier on today. For example,
2 spend time with staff in terms of performance
3 appraisals. So, it was allowing managers the
4 time to be able to do the things that we would
5 absolutely need them to be doing in a highly
6 functioning organization.
7 CHAYTOR, Q.C.:
8 Q. So, there was--this is October 24th, 2007 that
9 you write back to -
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. - Mr. Thompson with your proposal.
14 MS. JONES:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. So, what you're telling us is, is that it was
18 supports in terms of administrative supports
19 to your manager.
20 MS. JONES:
21 A. That's right.
22 CHAYTOR, Q.C.:
23 Q. And information management.
24 MS. JONES:
25 A. Information management.

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1 CHAYTOR, Q.C.:
2 Q. Those would have been the things -
3 MS. JONES:
4 A. And then inside of here you will also see
5 things such as education, okay. So, there -
6 CHAYTOR, Q.C.:
7 Q. So, education for the lab personnel?
8 MS. JONES:
9 A. It's rolled up here in staff education in a
10 generic perspective. Further on down in that
11 same line, you will see risk managers. So,
12 that would be quality people. One of those
13 would have been for the lab and later on there
14 would have been some other lab related issues.
15 What you would need to know is, is that most
16 of the actual resources that we needed inside
17 of the immunohistochemistry lab, like the
18 pathology assistants and those kinds of things
19 that came out of the 2 external review
20 reports, we had put them in the year before.
21 CHAYTOR, Q.C.:
22 Q. Yes.
23 MS. JONES:
24 A. So, most of this was around all of the other
25 things that would allow us to function and to

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1 work our way through this so that we would
2 have the structures around us so that we
3 wouldn't be in the situation we are today.
4 CHAYTOR, Q.C.:
5 Q. In November then, November 16, 2007 you make
6 another submission specifically on information
7 management.
8 MS. JONES:
9 A. Yes.
10 CHAYTOR, Q.C.:
11 Q. So, is that--it was included, you're telling
12 us, in your budget submission.
13 MS. JONES:
14 A. Yes.
15 CHAYTOR, Q.C.:
16 Q. Just a couple of weeks before.
17 MS. JONES:
18 A. Yes.
19 CHAYTOR, Q.C.:
20 Q. So, were you then requested to make a more
21 detailed submission on information management?
22 MS. JONES:
23 A. No, what had happened was there was a--the
24 minister had gone out with a press release on
25 the 2nd of November where he updated the

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1 public with respect to the database and what
2 the NLCHI finding was inside of the database
3 and did make comments inside of that about
4 inadequate data management systems inside of
5 Eastern Health and the Premier then after that
6 says whatever Eastern Health needs to address
7 this issue, they will have it.
8 So we had heard that in the commentary
9 and so following that, we said "okay, here we
10 have the Premier saying whatever they need
11 inside of, to do their work and to do it
12 appropriately, then they can have it." So
13 what we did then, so it was very clear what we
14 needed was take our original budget submission
15 and package it in a way that actually says
16 these are the critical components inside of
17 the 16 million dollar request that we had in
18 here and the components that we had identified
19 were listed in terms of consolidating on a
20 single database, looking at data management
21 systems, and then decision support, all of
22 which were inside of the bigger request of 50
23 million dollars on the operating and then we
24 had a capital equipment request that had part
25 of this in it as well. So it was pulling it

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1 together so it was very clear what it was from
2 a perspective that we absolutely needed to
3 move forward.
4 CHAYTOR, Q.C.:
5 Q. So you extracted your numbers that were put
6 forward in October?
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And put it into your -
11 MS. JONES:
12 A. In a package, that's right.
13 CHAYTOR, Q.C.:
14 Q. - presentation on November 16th dealing
15 specifically with the issue of information
16 management.
17 MS. JONES:
18 A. We had had--our Board chair had called the
19 minister to say "we've heard this. We want to
20 come in and have a discussion with you. We
21 will do a presentation. The Premier has
22 offered us saying whatever we need. We will
23 come in and show you exactly what we need."
24 So what you see in the correspondence that
25 goes there is the fact that we were not able

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1 to--even though the meeting had--the minister
2 and the Board chair had--we weren't able to
3 confirm a time for that, so rather than let it
4 go, continue to let it go, we sent the actual
5 presentation that we had put together on that
6 aspect alone, as a separate--just as a
7 reenforcement of what was inside the budget.
8 CHAYTOR, Q.C.:
9 Q. And did that then actually get dealt with
10 through the regular budget submission or is
11 that -
12 MS. JONES:
13 A. I don't know. The budget's out today.
14 CHAYTOR, Q.C.:
15 Q. Right, okay. So but your funding -
16 MS. JONES:
17 A. There was part -
18 CHAYTOR, Q.C.:
19 Q. - your funding though, your funding came
20 through, I understood, back in November, did
21 it not?
22 MS. JONES:
23 A. No.
24 CHAYTOR, Q.C.:
25 Q. No, okay. So that hasn't -

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1 MS. JONES:
2 A. There was -
3 CHAYTOR, Q.C.:
4 Q. - even though you're -
5 MS. JONES:
6 A. There was, on the 22nd of February, when the
7 minister went out with another press
8 conference updating, particularly around the
9 communication piece -
10 CHAYTOR, Q.C.:
11 Q. There was an announcement that you'd be
12 getting that funding.
13 MS. JONES:
14 A. There was an announcement that we would be
15 getting--that the province would be getting
16 this. There were parts of it that were
17 consistent with what we had identified and
18 sent in on the 16th of November, but it wasn't
19 the entire package.
20 CHAYTOR, Q.C.:
21 Q. Maybe not your whole wish list, but -
22 MS. JONES:
23 A. Not my whole wish list, but parts of the
24 package.
25 CHAYTOR, Q.C.:

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1 Q. - but the announcement that was made in
2 February -
3 MS. JONES:
4 A. Was a pre-budget--it wasn't--we didn't get any
5 official correspondence from the government at
6 that time and it was said that there were pre-
7 budget announcements. So I expect today that
8 we will actually see or when we actually get
9 the budget letters to say what's actually
10 inside the budget for this particular piece.
11 CHAYTOR, Q.C.:
12 Q. And back in February as well, there was e-mail
13 correspondences identifying, I think it's
14 around 180,000 -
15 MS. JONES:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. - or 178,000 dollars as being identified as
19 monies or linked to the ER/PR issue.
20 MS. JONES:
21 A. Linked to the ER/PR.
22 CHAYTOR, Q.C.:
23 Q. And what about that funding, what happened
24 with that?
25 MS. JONES:

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1 A. I expect that we will see that in the budget
2 because it was a pre-commitment to the budget.
3 The request at that time, and if you track the
4 e-mail correspondence, was what is it of the
5 recommendations for inside of the two external
6 reviews have not been actioned or do you need
7 money to action? We had in fact actioned all
8 of them and we had done the continuing
9 education and all of that, but to be able to
10 do it on an ongoing basis, then this was
11 funding for that. We had asked for funding
12 for an additional quality person, which was
13 inside the budget request, and then there was-
14 -because of the nature of being a small
15 province that we would want visiting people to
16 come into the province to do education and
17 that with that particular lab area and there
18 was a provision in there for that as well.
19 CHAYTOR, Q.C.:
20 Q. So were all of those items identified in the
21 submission that went forward in October?
22 MS. JONES:
23 A. It would have been rolled up in other--in
24 terms of staff education and those kinds of
25 things, there's a fair amount of money that

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1 was asked for in staff education and
2 resources, a million dollars there. So part
3 of the funding that was rolled up there would
4 have been to address some of those issues.
5 CHAYTOR, Q.C.:
6 Q. And that's a million dollars, 12,000
7 employees.
8 MS. JONES:
9 A. Yeah, it's 1.2 million dollars there.
10 CHAYTOR, Q.C.:
11 Q. Could we look at P-0753, please? And I'm out
12 of chronological order here, but -
13 MS. JONES:
14 A. That's okay.
15 CHAYTOR, Q.C.:
16 Q. These are the series--since we're on the
17 topic, these are the series of e-mails, I
18 believe, which dealt -
19 MS. JONES:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. - with looking for the numbers.
23 MS. JONES:
24 A. The numbers, that's right.
25 CHAYTOR, Q.C.:

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1 Q. So this is an e-mail here from yourself--we'll
2 start at the bottom, I guess. E-mail from Pat
3 to Dr. Howell and yourself regarding the
4 budget.
5 MS. JONES:
6 A. Yeah.
7 CHAYTOR, Q.C.:
8 Q. And it's the gist of that, "we would respond
9 to Robert re: the lab," and there's issues of-
10 -"many of these relate to written policies and
11 procedures." She indicates there's
12 recommendations relating to standardizing
13 policies and recommendations relating to
14 trimming and tracking information, and "out of
15 the QMPLS review of the lab, most of the
16 recommendations relate to policy and procedure
17 development and practices. The education
18 recommendations do have monetary
19 implications," and she talks about the peer
20 review recommendations, and response to "all
21 are in process and some are complete. The
22 information system components are the major
23 area that will require additional funding and
24 additional staff." She indicates have been
25 put in place, which was a monetary item, and

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1 that happened in the year prior?
2 MS. JONES:
3 A. That happened in the year prior.
4 CHAYTOR, Q.C.:
5 Q. Right, okay, and then from yourself back to
6 Pat and Oscar, "is there any cost that we can
7 put in for continuing education
8 recommendations? I heard from Ford Elms that
9 when I did the lab tour, 2,000 per year was
10 not enough. So even from the pathologists'
11 side ensuring they get out once a year, it
12 would seem we need $75,000 for a pathologist
13 with a small amount for technicians." So the
14 figure of 100,000 or 75 to 100,000 is being
15 forward.
16 MS. JONES:
17 A. Yes.
18 CHAYTOR, Q.C.:
19 Q. And then Oscar to yourself and Pat, and he
20 copies Dr. Denic. "The proposed additional
21 support for the quality, there's an increase
22 from the current 2,000 to 5,000 for CMEs for
23 the pathologists, for a total of 66,000 and
24 expert pathologists come in," is that three
25 times per year?

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1 MS. JONES:
2 A. Three times a year, about 7,000 per trip.
3 CHAYTOR, Q.C.:
4 Q. Okay, and that's to do reviews of the lab?
5 MS. JONES:
6 A. No, that's to come in and work with our
7 pathologists and do education while they're
8 there.
9 CHAYTOR, Q.C.:
10 Q. Okay.
11 MS. JONES:
12 A. Okay, so that is to bring expertise in, so
13 that we can keep up the expertise, plus the
14 other one above it would be sending them out
15 to conferences in their particular areas and
16 to maintain their competence.
17 CHAYTOR, Q.C.:
18 Q. And to bring an expert pathologist in three
19 times a year for continuing education
20 purposes?
21 MS. JONES:
22 A. Yeah.
23 CHAYTOR, Q.C.:
24 Q. Annual education for technologists, 11,000,
25 and an additional QA manager at 80,000 -

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1 MS. JONES:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. - for a total, that's the 178 figure.
5 MS. JONES:
6 A. Yeah.
7 CHAYTOR, Q.C.:
8 Q. So if this is approved in the budget, then--
9 and this is what you put forward?
10 MS. JONES:
11 A. Yes.
12 CHAYTOR, Q.C.:
13 Q. And as you said, there has been already some
14 acknowledgement that this money would be
15 forthcoming?
16 MS. JONES:
17 A. That's right.
18 CHAYTOR, Q.C.:
19 Q. This would mean that the plan is for
20 pathologists to have $5,000 per year?
21 MS. JONES:
22 A. Yes.
23 CHAYTOR, Q.C.:
24 Q. To attend continuing medical education
25 seminars?

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1 MS. JONES:
2 A. Yes.
3 CHAYTOR, Q.C.:
4 Q. And that an expert pathologist would be
5 brought in three times a year to continue with
6 educational exercises?
7 MS. JONES:
8 A. Yes.
9 CHAYTOR, Q.C.:
10 Q. And as well, there would be funding for
11 technologists to the tune of 11,000?
12 MS. JONES:
13 A. That's right.
14 CHAYTOR, Q.C.:
15 Q. And an additional QA manager.
16 MS. JONES:
17 A. And the reason for the additional QA manager
18 is that we do have a person now, safety and
19 quality leader, and for the lab, but the whole
20 time that she's been in place, she's been
21 working with the IHC lab and in order to be
22 able to do the entire lab, then--and allow her
23 to get on, then this would be a manager
24 specifically around that area.
25 CHAYTOR, Q.C.:

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1 Q. For the whole lab, not just IHC?
2 MS. JONES:
3 A. There would be two, right.
4 CHAYTOR, Q.C.:
5 Q. So the person for IHC would still maintain her
6 position and this would be someone for the
7 rest of the lab?
8 MS. JONES:
9 A. Yes, either way, however it works out.
10 CHAYTOR, Q.C.:
11 Q. If we could have P-0488, please, page 83?
12 MS. JONES:
13 A. November, okay.
14 CHAYTOR, Q.C.:
15 Q. October 31st, 2007.
16 MS. JONES:
17 A. Yeah, okay.
18 CHAYTOR, Q.C.:
19 Q. And this is executive management, and it just
20 says that "in preparation for the Commission
21 of Inquiry, the Department of Health
22 contracted NLCHI to build the database.
23 Discrepancies in the ER/PR data have been
24 identified. Both organizations are
25 endeavouring to develop an accurate list,

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1 however it is problematic. The validation
2 process is ongoing, and with respect to the
3 deceased files, the organization is starting
4 to send the deceased data to Mount Sinai to be
5 reread. The process is slower than
6 anticipated. There is resistance amongst the
7 oncologists with respect to meeting with the
8 families of the deceased. The organization
9 will be writing the families to advise that a
10 retest will be done, and offer an opportunity
11 to meet for discussion," I guess that should
12 be. "It has yet to be determined who will be
13 meeting with the families that request to
14 meet." And on a related note, Dr. Howell
15 raised the issue of a unique patient
16 identifier.
17 What was the issue? Why was there
18 resistance amongst the oncologists to meet
19 with families of the deceased?
20 MS. JONES:
21 A. All through this particular period of time,
22 even though that there had been blocks sent
23 away when we didn't know that the patient had
24 been deceased, it was the question of if in
25 fact the family had called forward and the

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1 oncologists knew the family, then they didn't
2 have a problem with sitting, but the question
3 was what were they going to say. Where was
4 it? Would it have made a difference? Those
5 kinds of things. So the real question for
6 them was if they hadn't had any relationship
7 with some of these families. This was over a
8 ten-year period of time. We had lots of
9 oncologists who had come and gone in that
10 particular period of time, so what were they
11 going to be saying to families who they had no
12 relationship with, and couldn't really make
13 any determination of what might have been or
14 could have been said. And the way that this
15 is written, this is early in the process. The
16 way that this is written here about us
17 notifying families and that, we did not go
18 that way, at the end, and you'll see that.
19 CHAYTOR, Q.C.:
20 Q. So what ultimately happened?
21 MS. JONES:
22 A. What ultimately happened was, with the blocks,
23 because there isn't a client, there is a next
24 of kin, we would have had to try to identify
25 the next of kin. We did send the blocks for

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1 retesting to Mount Sinai and that was a
2 commitment that Mr. Tilley had made in May of
3 '07, conference that if in fact the public
4 wished or the families wished that the blocks
5 would be sent away, then they would. So we
6 were in the process then in the fall of '07 of
7 getting all of the blocks from all across the
8 province and sending them. There was some
9 discussion whether the individual boards would
10 send them. At the end of the day, they did
11 come into Eastern Health in the same way that
12 the blocks for the living patients did come
13 in. We sent them to Mount Sinai for
14 processing and then they came back through us.
15 We also had a lot of discussion about,
16 from an ethics perspective, we did not believe
17 that--if in fact a family would come forward
18 and want to have some discussion, we wanted to
19 provide and have a vehicle to provide support
20 to that family to try to answer whatever
21 questions we could or they could, but at this
22 point in time, the oncologists were saying on
23 individual patient basis, "my own clients I'm
24 dealing with them now. Families have called
25 in and we've sent blocks away." So they were

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1 dealing with those, but as an organization, we
2 made the decision to send all of the blocks to
3 Eastern Health. They wouldn't be there to be
4 able to support us. Their workload was
5 excessive at the time and they hadn't had a
6 relationship with, as this talks about in some
7 ways and you'll see it in others, they didn't
8 have a relationship with the individual
9 family.
10 CHAYTOR, Q.C.:
11 Q. So they were prepared to meet with the
12 families of anybody who had been their
13 personal patient?
14 MS. JONES:
15 A. That's right, because they would have had a
16 personal contact. They would have been able
17 to talk to them around that particular -
18 CHAYTOR, Q.C.:
19 Q. And what's happening with respect to the
20 others?
21 MS. JONES:
22 A. What we ultimately did, we had talked around
23 trying to contract with, as this says, an
24 oncologist or whatever. We were not really--
25 we were not successful in kind of identifying

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1 somebody who might be willing to do that for
2 us, so at the end of the day, we did make the
3 announcement that all of the testing for the
4 dead, the patients who had died, their ER
5 results were back. We did that inside of a
6 press conference that the minister had on the
7 22nd of February, and we would deal with the
8 requests on an individual basis, and our
9 ethics consult that happened in June of '06
10 really was about letting the public know that
11 if they wanted the information, they could
12 come forward.
13 So I think I referenced that either
14 yesterday or the day--yesterday or this
15 morning that we made a public announcement
16 inside the 22nd of February press conference.
17 We actually did paper, newspaper ads
18 throughout the entire province around the fact
19 that any family member who wished to have the
20 results of their next--of their family member
21 to come forward and be able to identify for
22 themselves. We followed that up with radio
23 ads throughout the province and we also did a
24 Globe and Mail ad as well because not all
25 patients--not all families live in the

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1 province. So those were the initiatives we've
2 taken since all of the results have been back
3 and looked at.
4 THE COMMISSIONER:
5 Q. So did anybody come?
6 MS. JONES:
7 A. Yes, we've had close to maybe 80.
8 THE COMMISSIONER:
9 Q. Who did they meet with? Who did they--the
10 response is just a telephone response or did
11 they meet with somebody?
12 MS. JONES:
13 A. It depends on the--there's been 60 to 80,
14 somewhere in that vicinity, who have called in
15 to the hotline that we have had asking for
16 results. Some of them have been referred on
17 to the oncologist. Some of them only wanted
18 the results. Sometimes we would be able to
19 say these are the results, they have not
20 changed, or they have changed, and then
21 individually, if there was a patient who
22 wanted more information and wasn't already
23 associated with an oncologist, we've gone back
24 on an individual basis to Dr. Laing and said
25 "will you discuss this?" or "can you discuss

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1 this with individual family member, even
2 though there is not a referring oncologist
3 here in the province?"
4 CHAYTOR, Q.C.:
5 Q. And has she done that?
6 MS. JONES:
7 A. Yes, we haven't entered into a point where
8 anybody who has requested additional follow up
9 or discussion hasn't been afforded that
10 opportunity. Now that doesn't -
11 CHAYTOR, Q.C.:
12 Q. So to date, no--to date, that hasn't happened?
13 MS. JONES:
14 A. To date, that hasn't happened. Will it happen
15 as we move forward? I'm not sure.
16 CHAYTOR, Q.C.:
17 Q. Have people requested it?
18 MS. JONES:
19 A. Yes. Most of these families that would have
20 been looking for their results, they were
21 dealing with them all through the last two
22 years. So the 60 to 80 that have called as a
23 result of the public notification that all of
24 the results are back, a lot of them were just
25 looking for results, did they change.

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1 CHAYTOR, Q.C.:
2 Q. So there are people, though, that have
3 requested further -
4 MS. JONES:
5 A. Yes.
6 CHAYTOR, Q.C.:
7 Q. - follow up or to meet with a physician?
8 MS. JONES:
9 A. And we facilitate that from our quality
10 department talking to the cancer program and
11 then talking to Kara Laing and the
12 oncologists.
13 CHAYTOR, Q.C.:
14 Q. But those meetings haven't happened yet?
15 MS. JONES:
16 A. Some of them may very well have happened
17 because that's since the 22nd, we're almost
18 two months out.
19 CHAYTOR, Q.C.:
20 Q. Yes.
21 MS. JONES:
22 A. And I would anticipate that that anybody who's
23 requested that to date, that's already been
24 actioned.
25 THE COMMISSIONER:

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1 Q. Are you ready to break for the day?
2 CHAYTOR, Q.C.:
3 Q. We can keep going if everyone else is okay to
4 keep going and get -
5 THE COMMISSIONER:
6 Q. I'm prepared to go for another ten. The
7 witness had been on the stand all day, let's
8 not be too cruel to her.
9 MS. JONES:
10 A. No. I have a board meeting tomorrow at 2:00,
11 I'd like to -
12 CHAYTOR, Q.C.:
13 Q. Few more questions then.
14 MS. JONES:
15 A. Few more questions. Keep going, Sandy.
16 CHAYTOR, Q.C.:
17 Q. Thank you, okay. P-0737, please? And this is
18 an e-mail exchange from your assistant sent on
19 your behalf, so from you to Dr. Howell?
20 MS. JONES:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. And it's dated November 1st, 2007. The
24 importance is high. And for--you're
25 indicating that you've met with the Commission

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1 lawyers as well as Robert Thompson, Rolf
2 Pritchard?
3 MS. JONES:
4 A. Um.
5 CHAYTOR, Q.C.:
6 Q. Should be, "this afternoon with respect to the
7 ER/PR database and the numbers." And "One of
8 the questions that Bernie Coffey raised for
9 Robert Thompson potentially that will not be
10 the focus of the Commission of Inquiry is IHC
11 testing for other than breast specimens.
12 Bernie Coffey expects that it will be a focus
13 for the task force on adverse health events
14 and gave Robert Thompson the heads up that he
15 should consider the answer to that question.
16 So that having been said, what other types of
17 specimens have been done that are questionable
18 in the IHC lab that we should be aware of??
19 The question to be asked is why haven't we not
20 retested if we believed that we had problems
21 in the lab? I have heard some discussion
22 around that in the past and maybe we need to
23 have a discussion as I expect Robert Thompson
24 will be asking questions in the future now
25 that he is full-time on the task force and

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1 adverse health events."
2 MS. JONES:
3 A. Yes.
4 CHAYTOR, Q.C.:
5 Q. And, Ms. Jones, you indicate here that you had
6 heard some discussion around this issue that
7 Mr. Coffey raised, that you'd heard some
8 discussion about it in the past. What had you
9 heard and when in the past?
10 MS. JONES:
11 A. I can't relate back to actual time frame, but
12 there had been, like if there was this issue
13 with ER/PR, what about other tests. And I
14 know that they had been multiple discussions
15 about the nature of the other tests and they
16 were different than the ER/PR tests. So the
17 out cue of this in talking to Oscar was that
18 if, in fact, Robert Thompson needs any
19 information, then the best person to talk to
20 would have been Nash Denic or Don Cook and
21 that, in fact, if that needed to happen for
22 Robert to understand what it had--what this
23 discussion had been over the years, then that
24 would have happened.
25 CHAYTOR, Q.C.:

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1 Q. So the discussion that you've heard in the
2 past on it -
3 MS. JONES:
4 A. Was are there other areas in the IHC lab that
5 would have had similar -
6 CHAYTOR, Q.C.:
7 Q. And when were you hearing that and who were
8 you hearing that from? So when Mr. Coffey
9 raised it, it wasn't the first time you'd
10 heard this issue discussed?
11 MS. JONES:
12 A. Probably since I took over in the CEO role,
13 right, as we were preparing for what other
14 things might have been going on in the IHC
15 lab, right. And this was really around ER/PR.
16 You also by that time had had the Ejeckam memo
17 that was in the house, so there was a question
18 mark there about, and it wasn't tests, it was
19 markers or whatever at that particular time.
20 CHAYTOR, Q.C.:
21 Q. So this is now in November, this exchange it
22 taking place. So sometime after you took over
23 as CEO, so July 9th onwards up to November?
24 MS. JONES:
25 A. Yes.

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1 CHAYTOR, Q.C.:
2 Q. There had been discussions in Eastern Health
3 about those other stains?
4 MS. JONES:
5 A. There would have been discussions early along
6 in the game that I wouldn't have known about,
7 but this here raised it. Oscar said to me,
8 "Yes, they have been. I asked those
9 questions. I got assurances. If Mr. Thompson
10 needs assurances about what those--what else
11 is going on in the IHC lab and why this is
12 different, then Robert needs to talk to our
13 pathologists."
14 CHAYTOR, Q.C.:
15 Q. And did that happen?
16 MS. JONES:
17 A. I never heard back any more from Robert about
18 that so--and I know that Oscar would have made
19 that phone call to say "If, in fact, you need
20 anything from Nash or Don Cook, please let us
21 know. We are available to have any discussion
22 that you need to have."
23 CHAYTOR, Q.C.:
24 Q. So in saying that you had heard some
25 discussion around that in the past, you mean

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1 in the past couple of months?
2 MS. JONES:
3 A. In the--from the Ejeckam letter, yes.
4 CHAYTOR, Q.C.:
5 Q. May of '07?
6 MS. JONES:
7 A. Yes.
8 CHAYTOR, Q.C.:
9 Q. And anything else that's been done in terms of
10 follow-up on this, do you know what has
11 happened?
12 MS. JONES:
13 A. Not inside of Eastern Health, only to the
14 discussion that if Robert needs more
15 information, then have--let's have that
16 discussion with him.
17 CHAYTOR, Q.C.:
18 Q. So has Eastern Health done anything to
19 investigate whether or not there should be any
20 further retesting?
21 MS. JONES:
22 A. Basically from the discussion that I had with
23 Oscar and with Nash Denic and saying more
24 recently what does this all mean, particularly
25 around Robert's request of QMPLS, around in

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1 March or so, what does it all mean. This is
2 the same information we would have been
3 provided, we would provide him with if he had
4 asked the question, and I don't know if he had
5 asked that question. But, you know, that was
6 around the individual pieces. The testing in
7 terms of ER/PR testing is very, very specific
8 and it is very sensitive and it's used to
9 develop treatment options. The other pieces
10 of the IHC testing is really profiles that the
11 pathologists would ask for in helping them to
12 pin down the type of cancer, not the fact that
13 cancer is there. So in having that discussion
14 with Nash and having had that discussion
15 earlier on with Oscar, my sense is and from
16 what they're saying is is that there is no
17 need to look at any other area of the IHC lab
18 because it's not the same as ER/PR.
19 CHAYTOR, Q.C.:
20 Q. Okay. So from what I understand is what
21 you've done in follow-up is had discussions
22 with Dr. Denic and with Dr. Howell?
23 MS. JONES:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. And they both have given assurances that there
2 would be no need to look at any -
3 MS. JONES:
4 A. Anything else because this is very different
5 testing than the other things that go on in
6 the IHC lab.
7 CHAYTOR, Q.C.:
8 Q. And has Eastern Health received any opinion
9 from any pathologist or other expert external
10 to Eastern Health?
11 MS. JONES:
12 A. Not that I am aware of. And just the QMPLS
13 that came in to look at what we're doing now,
14 but not from a retrospective and -
15 CHAYTOR, Q.C.:
16 Q. They didn't look at those other stains -
17 MS. JONES:
18 A. - I don't know whether, in fact, Don Cook or
19 Nash Denic would have had discussions earlier
20 on in that. I was asking in that respect.
21 CHAYTOR, Q.C.:
22 Q. And the department receiving an opinion on
23 that issue from QMPLS -
24 MS. JONES:
25 A. PLS.

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1 CHAYTOR, Q.C.:
2 Q. - has that been shared with you?
3 MS. JONES:
4 A. Only in the exhibits notifications that's -
5 CHAYTOR, Q.C.:
6 Q. Only through this process?
7 MS. JONES:
8 A. Only through this process.
9 CHAYTOR, Q.C.:
10 Q. And were you aware that that was going to take
11 place?
12 MS. JONES:
13 A. No.
14 CHAYTOR, Q.C.:
15 Q. P-0738 please? And this is an e-mail from you
16 to the Board of Trustees, it's a memorandum
17 and it's being forwarded on by e-mail.
18 MS. JONES:
19 A. Yes.
20 CHAYTOR, Q.C.:
21 Q. And the date on the e-mail is the same date as
22 we've just referred to, November 1st.
23 MS. JONES:
24 A. Yes.
25 CHAYTOR, Q.C.:

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1 Q. And you're writing to the board, "You may
2 recall that Eastern Health had identified that
3 its database had 939 clients since July. The
4 NLCHI has been building the database and has
5 identified an additional number of patients.
6 All of the regional health authorities have
7 been asked to validate the data in the NLCHI
8 database. Through this validation process and
9 at a meeting today, November 1, 2007, it has
10 been determined the database continues to need
11 refinement and therefore, the exact number of
12 patients, as of 15:30 today is still not
13 clarified. Eastern Health has confirmed a
14 number of patients that are now on the
15 database that require retesting. We are
16 currently in the process of talking to the
17 patient physicians for background and then
18 we'll look to contact the patient themselves.
19 This cannot happen within the next day and
20 this has been communicated to the department.
21 The minister will be making a press release
22 tomorrow and we understand the message to be
23 that the department has been working with
24 NLCHI to confirm the database and although the
25 database has not been finalized, there are

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1 additional clients who require retesting."
2 And then you indicate, "I have talked with the
3 chair regarding our concern of the department
4 being out in the media before we are able to
5 contact all clients affected by this
6 announcement" and the chair has attempted to
7 call the minister and is followed up with the
8 deputy minister.
9 MS. JONES:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. So what's that issue about, Ms. Jones?
13 MS. JONES:
14 A. There was, we had that meeting that day, the
15 database was still not locked down. We knew
16 that there were other patients and that in
17 fact, as this memo goes on to say, that there
18 were identified patients through the NLCHI
19 building of the database, that we would have
20 to call and -
21 CHAYTOR, Q.C.:
22 Q. Sorry, this memo goes on where, sorry?
23 MS. JONES:
24 A. Here, right.
25 CHAYTOR, Q.C.:

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1 Q. Okay. Part of what I just read out?
2 MS. JONES:
3 A. Yes, part of what you just read out. So that
4 at this point in time, now that there were
5 identified patients that would have to be sent
6 for retesting, that we would have wanted to
7 call the patients individually to say you have
8 now been identified inside of the database
9 that has been created, you were not sent for
10 testing in 2005 and now your sample is going
11 off. So that was really what we had wanted to
12 do, and there was an understanding that the
13 minister had wanted to move forward with the
14 release of the information without the contact
15 for the individual patients. So that was a
16 concern -
17 CHAYTOR, Q.C.:
18 Q. The minister was going to make a public
19 announcement.
20 MS. JONES:
21 A. A public announcement.
22 CHAYTOR, Q.C.:
23 Q. And Eastern Health was asking the department
24 to hold off until you had an opportunity to
25 contact the patients?

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1 MS. JONES:
2 A. To contact the individual patients because
3 what we would have out there is another story
4 that says there's still patients who don't
5 know that they're part of this retesting and
6 we wanted to make sure that the patient was
7 the first to be notified and that had been our
8 protocol all through this process. So in this
9 instance where we had now identified patients,
10 we were wanting to be in the process of
11 contacting them and the numbers that were
12 identified, and I don't remember the exact
13 numbers, but between the period of time
14 because remember we had been working since
15 Saturday, the 27th of October, we had been in
16 with many lists and tried to validate and
17 clarify and where are they and have you
18 contacted them, so we'd been working
19 diligently through the week, but here on the
20 Thursday it was the minister believes he needs
21 to go out tomorrow. So we had had that
22 discussion, I had called the chair to say our
23 concern is is that now we're putting a story
24 out there and we have not had an opportunity
25 to talk to patients. So that is the impetus

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1 behind that.
2 CHAYTOR, Q.C.:
3 Q. And the chair communicated that concern, she
4 tried to reach the minister.
5 MS. JONES:
6 A. Yes.
7 CHAYTOR, Q.C.:
8 Q. And did follow up with the deputy.
9 MS. JONES:
10 A. With the deputy minister.
11 CHAYTOR, Q.C.:
12 Q. So that concern was conveyed to the department
13 and what happened?
14 MS. JONES:
15 A. And about 5:00 that day, because this goes out
16 at 7:10, but at 5:00 that day and I had left
17 the department at around 3:30, at the end of
18 the day I get a call from Robert to ask me to
19 be available in the night because there would
20 be a press release he wanted me to have a look
21 at and I said to him, "have you confirmed the
22 numbers?" and he said, "we will have it
23 confirmed, you know, as we work through the
24 night." So that was fine, so I was watching
25 my BlackBerry and about 8:35, the draft press

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1 release came in just for us to look at. I
2 clearly understood that if the minister was
3 going to go out with their press release the
4 next day, the most that I could have input
5 into was what was inside of the press release.
6 So we seen a press release at 8:35, I went
7 into the office and the press release had also
8 gone to Susan Bonnell, who was the
9 communication director at the time. Susan
10 called looking for me, found me in the office
11 and she came into the office, but by that
12 time, I had been reviewing the press release
13 and had talked to Robert and I said, "your
14 press release says 990", because earlier on in
15 the day we didn't have a number of patients.
16 So it started out being 990, I said "are you
17 sure of that number?" and they said, "well we
18 will work through that." So here we were with
19 a press release at 8:30 that had 990, there
20 was parts of the press release that had
21 referenced other regional health authorities
22 as well and in the--in some track changes you
23 have here in terms of the original press
24 release, we sent them back some information
25 around 10:30 suggesting and clarifying because

1 some of the information, from a wording
2 perspective, was not quite right. So we sent
3 that back around 10:35 and had asked them not
4 to include the reference to Western Regional
5 Health Authority because at the end of the
6 day, Eastern Health was the one that was seen
7 to be in the media around this. We were co-
8 ordinating a lot of the work, but we were
9 expecting, we were relying on other regional
10 health authorities, so I had clearly said,
11 "Robert, why do you want to put another
12 regional health authority in here in terms of
13 name, Eastern Health. This issue is known in
14 the public as Eastern Health, so why confuse
15 the public?" So the e-mail that went back to
16 him says, "Look, you know, don't use--Eastern
17 Health, Eastern Health is out there, they know
18 that this issue and the public associates it
19 with Eastern Health, so let's leave it clean
20 at Eastern Health." We had offered some
21 comments at about 11:30 or 12:00 we had a
22 press release, now we were gone home by that
23 time, so the next morning there was a draft
24 press release with many of the changes that we
25 had suggested in it, but now the number was at

1 1000, so it had gone from 990 to 1000 in terms
2 of the database there, so it had said around
3 1000 and we were expecting the minister to go
4 out with a press release at 11:00 in the
5 morning. So when I saw that, you know, we had
6 incorporated as many of the changes, some of
7 them had been accepted, some of them had not
8 been accepted.
9 CHAYTOR, Q.C.:
10 Q. And did the press release then go ahead that
11 day, November 2nd?
12 MS. JONES:
13 A. The press release went ahead that day. The
14 press conference was supposed to be at 11:00.
15 You will also have some e-mail correspondence
16 in here that says we were waiting--this was a
17 draft press release that had to be approved
18 and I'm not sure what process they have inside
19 of the department for that, that had to be
20 approved, so we were waiting in the morning,
21 understanding that there would be a press
22 conference at 11:00. So we were waiting and
23 waiting and that was on a Friday and we had a
24 strategic planning board meeting in
25 Clarenville that day, so we were waiting for

1 the press release to come out. And in the
2 meantime, my individuals who were working in
3 quality and were working diligently to try to
4 contact every person who had now been
5 identified that their samples were going
6 forward. So there is an e-mail--I'm in Susan
7 Bonnell's office and it's around five to
8 eleven and we get this call about one of the
9 clients that were on the original list not
10 being a person that should be categorized.
11 And so we e-mailed because we know that
12 they're going into a press conference saying
13 your numbers are not right and we'll all
14 concerned about numbers because Eastern Health
15 has taken a hit on numbers significantly about
16 not being able to do a database. So we e-
17 mailed and say one of those numbers is not
18 correct and, you know, if you had waited, the
19 implication was that if you waited, we would
20 have been able to confirm because we had been
21 working with these lists that you have had for
22 a number of--for a long time. The press
23 conference did go ahead. The press release
24 that was actually issued was very different
25 than the one that we had seen at 12:30 that

1 night. And the press release in that morning
2 also had reference to poor data management
3 practices inside of Eastern Health as being
4 one of the contributing factors, that we had
5 not seen in any of the others. And that was a
6 concern for the board because when we talk
7 about working in partnership and for the
8 betterment of the organization, it was yes, we
9 understood that the data management and the
10 ability to be able to extract and identify all
11 of the clients was a problem, but we would
12 work together on moving that issue forward.
13 CHAYTOR, Q.C.:
14 Q. What was the urgency? Why did -
15 MS. JONES:
16 A. I have no idea what the urgency was.
17 CHAYTOR, Q.C.:
18 Q. Did you ask?
19 MS. JONES:
20 A. It wasn't--we had already indicated earlier on
21 in the day that we wanted to talk to clients,
22 make sure that they were aware of that they
23 were a part of now the retesting. And I fully
24 respected that the minister would--we don't
25 direct. We had the board chair bring forward

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1 our concerns. We inputted into their press
2 release, you know, late in the evening on
3 Thursday evening and we were waiting for that,
4 understanding and if you read the press
5 releases, there was nothing to talk about data
6 management. Although we had been having
7 discussion, we knew that our database was
8 problematic. We knew that the numbers were in
9 the vicinity of 990 versus the 939, but we
10 really wanted the opportunity to be able to
11 contact patients. And to be able to say,
12 inside of that, all of the people that have
13 been identified for retesting have been
14 contacted. That was our, really only issue.
15 CHAYTOR, Q.C.:
16 Q. And you weren't afforded an opportunity to do
17 that?
18 MS. JONES:
19 A. We weren't afforded the opportunity to
20 complete that. Now, you also have to
21 understand that NLCHI had been working with us
22 since July, August, September, October and
23 every time we were trying to get to an end
24 point, there was another set of issues that
25 were not able to be addressed inside of the

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1 database. We'd have to go back, find more
2 information. Yes, this person is contacted.
3 This one wasn't a retest. So, all of those
4 lists were happening on a daily basis
5 throughout this entire process and continued
6 to happen right up until March of this year.
7 CHAYTOR, Q.C.:
8 Q. So, are you saying even if you had contacted
9 the people who had been identified by November
10 1, there still would have been others?
11 MS. JONES:
12 A. The actual release said approximately a
13 thousand and it clearly said in the press
14 release "and this may grow" because the
15 database wasn't completed at the time.
16 CHAYTOR, Q.C.:
17 Q. And so your question as to why the urgency,
18 you didn't get an answer?
19 MS. JONES:
20 A. We didn't get an answer.
21 CHAYTOR, Q.C.:
22 Q. And just because we need to finish for the
23 day, but before we leave that point, on the
24 point about western and you not wanting
25 Western Health Authority, ultimately was

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1 Western Health Authority mentioned?
2 MS. JONES:
3 A. It wasn't.
4 CHAYTOR, Q.C.:
5 Q. Okay. And just so I understand your concern
6 around that, I take it that the reference to
7 western was going to be that some of the
8 patients, in fact, were patients of Western
9 Health?
10 MS. JONES:
11 A. I think if you read it, I think it did mention
12 and so that was, in some ways -
13 CHAYTOR, Q.C.:
14 Q. I'm just wondering from your point of view,
15 how that would cause more confusion as opposed
16 to perhaps that might be clarity because
17 somebody might be hearing all this as an
18 Eastern Health problem and not a Western
19 Health problem. Would the patients even know
20 that the testing was actually taking place at
21 eastern?
22 MS. JONES:
23 A. No, but at the end of the day, the whole issue
24 is that as you read through the original draft
25 press release, it was putting a lot of types

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1 of things in there that really wasn't adding
2 to the fact that we had now identified 990,
3 that the database was incomplete, that there
4 was still work that needed to be done. So,
5 adding whether it's eastern, western or
6 central or Labrador really didn't add to that.
7 There was information in there that said at
8 the end of the day that there were 15 patients
9 and, you know, some of them had not had their
10 test rechanged, those kinds of things.
11 CHAYTOR, Q.C.:
12 Q. Yes, but you're concerned about having western
13 there, you indicated was that there--might add
14 to the confusion. And so that's -
15 MS. JONES:
16 A. Eastern Health was the one, who, in the public
17 had been carrying that file and there really
18 hadn't been--even though we had been working
19 with the other regional health authorities and
20 getting information from them, that wasn't
21 really well identified in the public. And
22 even today I would suggest to you that most
23 people will believe that this is an eastern
24 issue. Even though the clients are from all
25 across the province, but when we developed the

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1 database, when we identified the individual
2 patients, because we didn't read ER/PR
3 results, that the slides were sent back to the
4 individual regions, there was none of that
5 knowledge known in the public at the time,
6 that it was pathologists in those areas that
7 were reading slides that we had produced.
8 CHAYTOR, Q.C.:
9 Q. Okay. Thank you, Commissioner, I apologize.
10 THE COMMISSIONER:
11 Q. Not at all. The witness has indicated she
12 wants to get to her meeting tomorrow. So, why
13 don't we do the rounds of the room, starting
14 with you, Ms. Chaytor. And try to get an
15 assessment of what kind of time frame we'll
16 need tomorrow.
17 CHAYTOR, Q.C.:
18 Q. I will need less than an our.
19 THE COMMISSIONER:
20 Q. Okay. Mr. Pritchard?
21 MR. PRITCHARD:
22 Q. Ten minutes, Commissioner.
23 THE COMMISSIONER:
24 Q. Okay. Mr. Browne?
25 MR. BROWNE:

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1 Q. About 15, 20 minutes.
2 MS. NEWBURY:
3 Q. Twenty minutes or so.
4 THE COMMISSIONER:
5 Q. No?
6 MR. PIKE:
7 Q. Ten minutes for me, Commissioner.
8 THE COMMISSIONER:
9 Q. Do you want to weigh in here, Mr. Simmons on
10 what the rest of them say?
11 MR. SIMMONS:
12 Q. The time -
13 THE COMMISSIONER:
14 Q. I understand it is an estimate. I'm not
15 putting a stop watch on anybody.
16 MR. SIMMONS:
17 Q. It's either been growing or shrinking and
18 every half hour it changes depending on what's
19 covered. Right now, I don't anticipate
20 needing very much time, but that of course,
21 depends on what everyone else has.
22 THE COMMISSIONER:
23 Q. Okay then. Well, it does look hopeful for
24 your meeting.
25 MS. JONES:

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1 A. It's a board meeting. That's the only reason
2 why I would be saying that.
3 THE COMMISSIONER:
4 Q. All right. We'll adjourn for the day; 9:30
5 tomorrow.
6 Upon conclusion at 5:15 p.m.

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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 29th day of March, 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 29th day of March, A.D., 2008
13 Judy Moss

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