COMMISSION OF INQUIRY

ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

MAY 13 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 .... Doctors Kara Laing et al

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

Pamela Taylor .... Members of the Breast Cancer
.... Testing Class Action

Mark Pike .... NL Medical Association
Jennifer Newbury ..... Canadian Cancer Society (NL Division)
David Eaton, Q.C. .... Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

THIS PAGE ONLY REVISED ON NOVEMBER 18, 2008

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LIST OF EXHIBITS

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1 COMMISSIONER:
2 Q. Mr. Browne
3 MR. GEORGE TILLEY, CROSS-EXAMINATION BY MR. PETER BROWNE
4 (CONTINUED)
5 MR. BROWNE:
6 Q. Thank you, Commissioner. Good morning. Good
7 morning, Mr. Tilley.
8 MR. TILLEY:
9 A. Good morning, sir.
10 MR. BROWNE:
11 Q. When we broke yesterday, I asked you about, I
12 guess, left off about the merger of the
13 various medical directors positions into the
14 VP of Medical Affairs under a new Health Care
15 Corporation, I think that's -
16 MR. TILLEY:
17 A. Yes.
18 MR. BROWNE:
19 Q. And I want to move now into the organizational
20 structure, for a moment, of the new Health
21 Care Corporation when it was created. And
22 under this new organizational structure the
23 laboratory medicine program for, I guess, for
24 St. John's hospitals at that time, the Grace,
25 Health Care Corporation, Janeway and St.

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1 Clare's all came under the auspices of the VP
2 Medical Affairs, is that -
3 MR. TILLEY:
4 A. Initially.
5 MR. BROWNE:
6 Q. Yes.
7 MR. TILLEY:
8 A. There was the General Hospital, St. Clare's,
9 Janeway and Waterford.
10 MR. BROWNE:
11 Q. Right.
12 MR. TILLEY:
13 A. You might have mentioned Health Sciences -
14 MR. BROWNE:
15 Q. That's right, yeah.
16 MR. TILLEY:
17 A. - Centre and Health Care Corporation is one
18 and the same. In the first instance I took
19 the responsibility for the lab.
20 MR. BROWNE:
21 Q. Okay.
22 MR. TILLEY:
23 A. The clinical chief of the lab, though, would
24 still report through to the VP Medical.
25 MR. BROWNE:

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1 Q. Okay, I'm going to ask you about that in a
2 moment. But you had mentioned yesterday, as
3 well, that, and I think probably even previous
4 to that, that you didn't entirely accept the
5 comments of Dr. Banerjee with regard to the
6 organizational structure, the matrix that
7 occurred between the clinical chief and the
8 program director. Is that a fair description?
9 MR. TILLEY:
10 A. Well, yes, in terms of his recommendation.
11 MR. BROWNE:
12 Q. Yes.
13 MR. TILLEY:
14 A. As I read it, he was implying that there was a
15 lack of a matrixed relationship. And I
16 interpreted his comment as being that the
17 director would report up to the vice president
18 and the VP would report up to the vice
19 president, but in fact, there is provision for
20 this leadership team, and that's where the
21 matrix relationship is intended to be pursued.
22 MR. BROWNE:
23 Q. Okay. If I could just for a moment have your
24 comment on, can the witness be shown P,
25 Exhibit P-0118, please? Thank you, Registrar.

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1 You'll see on the screen there, Mr. Tilley,
2 this is an organization chart of the
3 laboratory medicine program that was entered
4 as an exhibit, I believe, under Ms. Dawe. And
5 just as you mentioned there's the chief
6 executive officer position and then you'll see
7 the VP Medical Affairs. You'll notice that
8 the lines, and I'm presuming these are lines,
9 reporting lines of authority?
10 MR. TILLEY:
11 A. Authority.
12 MR. BROWNE:
13 Q. That there's not one between the laboratory
14 program director and the laboratory clinical
15 chief. You see that?
16 MR. TILLEY:
17 A. There's certainly not.
18 MR. BROWNE:
19 Q. Okay. And could that be what, in fact, Dr.
20 Banerjee may be alluding to in terms of that
21 there needs to be that line created?
22 MR. TILLEY:
23 A. Well -
24 MR. BROWNE:
25 Q. Or at least a position in between those two?

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1 MR. TILLEY:
2 A. Yeah, it's possible if he saw that, then he
3 might have made his recommendation from that.
4 MR. BROWNE:
5 Q. Okay.
6 MR. TILLEY:
7 A. I can tell you that in the program description
8 or in the description of the program-based
9 approach, the focus was on the leadership team
10 and the leadership team working
11 collaboratively to deal with issues within
12 their respective programs and from that
13 perspective the intent was certainly to have a
14 relationship between the clinical chief and
15 the program director.
16 MR. BROWNE:
17 Q. Okay. But you agree that that line is not
18 there in that organizational chart?
19 MR. TILLEY:
20 A. It's not in that chart.
21 MR. BROWNE:
22 Q. Okay.
23 COMMISSIONER:
24 Q. I'm sorry to interrupt, but I just want to
25 make sure. This particular chart was the--is

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1 the current operative chart or at least was
2 the operative chart in 2005?
3 MR. TILLEY:
4 A. I can't speak to that. Without seeing any
5 charts for any of the programs I would have
6 come here and said that there's a leadership
7 team for each of the programs.
8 COMMISSIONER:
9 Q. Um-hm.
10 MR. TILLEY:
11 A. With a program director, a clinical chief and
12 possibly a discipline chair, which would be
13 the university representative and that they
14 worked as a collaborative team in terms of
15 providing oversight and management to the
16 program.
17 COMMISSIONER:
18 Q. Um-hm.
19 MR. TILLEY:
20 A. What Dr. Cook shows here is for the most part,
21 he's not showing anything under the program
22 director. He seems to be only showing the
23 physician pieces underneath, underneath him.
24 MR. BROWNE:
25 Q. Perhaps if we can scroll through this a bit

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1 further, because there are other -
2 MR. TILLEY:
3 A. Okay. That would be helpful.
4 COMMISSIONER:
5 Q. Yes.
6 MR. BROWNE:
7 Q. And I don't know if--you'll see right here, as
8 well, this page 2 shows the reporting
9 mechanisms for the program director, as well.
10 MR. TILLEY:
11 A. Um-hm.
12 MR. BROWNE:
13 Q. And again, that line -
14 MR. TILLEY:
15 A. It's not there.
16 MR. BROWNE:
17 Q. Not there?
18 MR. TILLEY:
19 A. No.
20 MR. BROWNE:
21 Q. Okay.
22 MR. TILLEY:
23 A. No, you're right.
24 MR. BROWNE:
25 Q. And then page 3 I think is then you'll see the

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1 overall. And if you look at the top, you can
2 very--see it's in the left-hand corner there,
3 Mr. Tilley, you can see that this is revised
4 June, 2004?
5 MR. TILLEY:
6 A. That's correct.
7 MR. BROWNE:
8 Q. See that? So this is part of a, I guess,
9 organizational chart from your organization at
10 least I'm dating it presuming it's around
11 2004?
12 MR. TILLEY:
13 A. Yes, yeah.
14 MR. BROWNE:
15 Q. Okay.
16 MR. TILLEY:
17 A. All I can speak to on that matter is that the
18 charts were not reflective of the intent of
19 the program-based model.
20 MR. BROWNE:
21 Q. Now, just in terms of getting a picture of the
22 time frame for various persons, as you
23 mentioned, the personalities in play during, I
24 guess, let's focus on the time period that's
25 the terms of reference here, 1997, 2005. On

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1 the clinical chief position was it Dr.
2 Haegert, was he -
3 MR. TILLEY:
4 A. Dr. Haegert was the first clinical chief and
5 then moved to Dr. Cook.
6 MR. BROWNE:
7 Q. Right.
8 MR. TILLEY:
9 A. I'm sorry, I'm not able to tell you the dates
10 of transfer.
11 MR. BROWNE:
12 Q. But at least just using a time period of '97,
13 2005, that those two individuals would have
14 been in that role?
15 MR. TILLEY:
16 A. Yes, that's correct.
17 MR. BROWNE:
18 Q. And am I understanding, as well, that Dr.
19 Haegert also at some point held the position
20 of discipline chair?
21 MR. TILLEY:
22 A. He did.
23 MR. BROWNE:
24 Q. Okay. And do you recall if he was replaced by
25 Dr. Robb after that, is that -

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1 MR. TILLEY:
2 A. Dr. Robb was certainly there, but I stand to
3 be corrected if I had said one or the other.
4 MR. BROWNE:
5 Q. Okay. I think it was Dr. Haegert followed by
6 Dr. Robb. But without going back to that
7 diagram, as well, just on that point, there's
8 no, within that organization matrix, there's
9 no position in there for the discipline chair,
10 is there?
11 MR. TILLEY:
12 A. It's not written in the chart.
13 MR. BROWNE:
14 Q. Chart.
15 MR. TILLEY:
16 A. No.
17 MR. BROWNE:
18 Q. No?
19 MR. TILLEY:
20 A. No.
21 MR. BROWNE:
22 Q. Now, and on the program management side, would
23 the two individuals have been first Mr. Whalen
24 and then followed Mr. Gulliver?
25 MR. TILLEY:

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1 A. Yes.
2 MR. BROWNE:
3 Q. Okay. To go back to your comment to me just a
4 few questions ago, you had some role in, you
5 mentioned, overseeing the laboratory medicine
6 program when it first came under the auspices
7 of Health Care Corporation?
8 MR. TILLEY:
9 A. Yes.
10 MR. BROWNE:
11 Q. Okay. And did you have any role in--we talked
12 about the mergers in terms of there were
13 positions eliminated, the medical directors
14 positions were rolled into the vice president
15 of Medical Affairs. I think we talked about
16 yesterday, as well, that there were a number
17 of middle management positions that were
18 eliminated, as well. On top of this, as well,
19 was there some move to--and I know the Hay
20 report came later, but to identify other
21 efficiencies in the system and reductions,
22 budget reductions throughout the health care
23 system?
24 MR. TILLEY:
25 A. Very much so.

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1 MR. BROWNE:
2 Q. Okay. Did you have a role in that?
3 MR. TILLEY:
4 A. Well, as part of the leadership team, I
5 certainly would have been involved in that.
6 MR. BROWNE:
7 Q. And in particular in relation to lab medicine?
8 MR. TILLEY:
9 A. Likely, yes.
10 MR. BROWNE:
11 Q. Okay. Can I just refer you, for a minute, to
12 a document that has been provided by Ms.
13 Taylor and I'm taking the liberty of referring
14 to it before her? It was put into evidence
15 yesterday, and it's Exhibit 0697. And, Mr.
16 Tilley, my focus is on the--if we can just
17 scroll down? I can scroll down there. And
18 I'll let you take a moment. The topic
19 "Financial Issues", just take a moment and
20 read that.
21 MR. TILLEY:
22 A. Yes.
23 MR. BROWNE:
24 Q. In particular, the fourth paragraph. Okay, so
25 it was at that point in time, this is now, if

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1 you look at the top here, it's, I guess, March
2 4th, 1997, there was some discussion at the
3 executive team, and I'm sure it wasn't just
4 unique to the lab medicine program, but the
5 need for reductions and the lab medicine
6 program was identified to, I guess, save a
7 million dollars?
8 MR. TILLEY:
9 A. Yes.
10 MR. BROWNE:
11 Q. Do you recall this?
12 MR. TILLEY:
13 A. I do. The general recollection is that back
14 in '96, '97 when the organization was formed,
15 the expectation was that costs would be
16 reduced. On top of that, when the decision
17 was made to close sites, and you may recall
18 that the decision was to close the Children's
19 Rehabilitation Centre.
20 MR. BROWNE:
21 Q. Um-hm.
22 MR. TILLEY:
23 A. The Grace General Hospital and transfer the
24 Janeway to a new facility. The construction
25 costs of building the new Janeway and of

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1 renovating the Health Sciences Centre and St.
2 Clare's amounted to approximately 130-40
3 million dollars. And the expectation was is
4 that all of that would have to be paid from
5 operational savings as opposed to any capital
6 grants forthcoming from the province. There
7 was some experiences across the country with
8 site closures and what I remember is that a
9 group was invited in who had gone through a
10 process like this in British Columbia. And
11 they came in and met with a fairly large group
12 of managers within the organization and
13 started setting up some rules of thumb as to
14 what you could legitimately expect from all of
15 the different program areas in the way of
16 savings. So armed with that information the
17 executive team went to all of their respective
18 portfolios and started having discussions
19 about potential savings. And the million
20 dollar reference there, I'm not sure what the
21 lab program's total budget was -
22 MR. BROWNE:
23 Q. I was going to ask you that. Do you recall
24 what it was at that--now, if I -
25 MR. TILLEY:

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1 A. I'd be guessing if I did.
2 MR. BROWNE:
3 Q. The rule of thumb that has been mentioned to
4 me is about five percent of the total
5 operating budget. Is that something that
6 rings with you at all?
7 MR. TILLEY:
8 A. Actually, it doesn't ring that bell, but you
9 know, there was a percent that was felt of
10 laboratory programs operating over multiple
11 sites that other hospitals that had closed, it
12 found those savings by avoiding duplication
13 and taking advantage of the ability to process
14 a larger number of tests within one location
15 as opposed to spread over many. So at that
16 point in time the laboratory medicine as well
17 as a number of other programs were reporting
18 in to me and my task was to work with them and
19 say, "There's the figure that's been
20 identified for the lab. How realistic is it
21 to achieve that?" And the clinical chief and
22 the program director then would take it from
23 there.
24 MR. BROWNE:
25 Q. And if we go back to that exhibit and that

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1 paragraph, it seemed like both Dr. Haegert and
2 Mr. Whalen were consensus ad idem and that
3 they had some very--or they had some concerns
4 about that figure and how it would affect the
5 program?
6 MR. TILLEY:
7 A. Right.
8 MR. BROWNE:
9 Q. Is that a fair interpretation of what's
10 written here?
11 MR. TILLEY:
12 A. Yeah. I don't know if they ever did reach the
13 target that had been proposed.
14 MR. BROWNE:
15 Q. Okay. Do you recall what particular concerns
16 that were expressed or was it just a general
17 concern overall for the program?
18 MR. TILLEY:
19 A. My general sense is that they were talking
20 about just a general concern about the
21 program, per se, but I can't remember any
22 specific area being referenced.
23 MR. BROWNE:
24 Q. Okay. And in terms of the roles of the
25 clinical chief and program director and, I

Page 20

1 guess, the vice president of Medical Affairs,
2 what are their respective roles in planning
3 and priorizing budgets for the lab medicine?
4 MR. TILLEY:
5 A. Well, first of all, the budgeting process is
6 expected to be developed within the laboratory
7 medicine program, and that would be inclusive
8 of all of the medical input into it, as well.
9 If there was a new test that pathologists were
10 anticipating or wishing to incorporate, that
11 would have to all be built into the budget
12 submission. The budget submission then for
13 each program gets rolled up in terms of what
14 is likely to be needed, even if the status quo
15 is maintained and then another section is
16 added for those new items and all of that's
17 compiled for the organization as a whole and
18 submitted to government.
19 MR. BROWNE:
20 Q. Now, I may have misunderstood Ms. Jones when
21 she testified previous, but my understanding
22 was that, you know, in terms of preparing
23 this, the program manager would look at all
24 the technical aspects of the lab, the clinical
25 chief would look at the, I guess, the clinical

Page 21

1 or the medical side and then they would come
2 together and then make budget proposals, but
3 their focus was on their respective areas.
4 MR. TILLEY:
5 A. Right.
6 MR. BROWNE:
7 Q. Is that -
8 MR. TILLEY:
9 A. But having said that, the lab in particular is
10 a good example where there's a fair degree of
11 integration between the needs of both groups,
12 so it has to be brought forward in a united
13 way. I don't doubt in practical terms that
14 the program director would be focused in on
15 the technical pieces of the lab and the
16 unionized staff piece and the physician, his
17 portfolio -
18 MR. BROWNE:
19 Q. His portfolio -
20 MR. TILLEY:
21 A. - but at some point in time they got to be -
22 MR. BROWNE:
23 Q. Coming together, right. But I mean, their
24 respective, to use the term that's been used
25 here, the respective lenses are a bit

Page 22

1 different in terms of looking at their own
2 issues within their department?
3 MR. TILLEY:
4 A. Right. Typically the physician leaders are
5 not trained to do the budgeting process as
6 much as the program director -
7 MR. BROWNE:
8 Q. And that was where I was going to ask you,
9 that again, given the nature of the clinical
10 chief's position, which is, you know, I guess,
11 the percentage in some of the figures being
12 used is 30 percent, I would imagine it's
13 difficult for that person to be heavily
14 involved in the planning and budgeting process
15 if they're expected to carry out clinical
16 duties -
17 MR. TILLEY:
18 A. That is correct.
19 MR. BROWNE:
20 Q. To go back on Exhibit 0691 for a minute, do
21 you recall whether there was any particular
22 areas that were identified for reduction as
23 part of this figure, this million dollar
24 figure?
25 MR. TILLEY:

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1 A. The only thing that rings a bell with me is
2 centralization of some of the tests on a
3 single site.
4 MR. BROWNE:
5 Q. Okay.
6 MR. TILLEY:
7 A. Certainly there would likely be management
8 positions.
9 MR. BROWNE:
10 Q. Um-hm.
11 MR. TILLEY:
12 A. Because that seemed to be the flavour of the
13 day. And I don't doubt that there were
14 managers that took on larger roles through the
15 restructuring process.
16 MR. BROWNE:
17 Q. Right, okay.
18 COMMISSIONER:
19 Q. Sorry to interrupt, but I'm not sure I
20 understood the answer vis-a-vis the question.
21 I know you were being asked about the concerns
22 raised by Mr. Whalen and Dr. Haegert in
23 respect of that particular process, but when
24 you say that centralization on certain sites
25 was a concern, did you mean the fact of

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1 centralization or the budgetary impact of the
2 centralization?
3 MR. TILLEY:
4 A. It was the budgetary impact. The question
5 that I was intending to answer, and I
6 apologize, Mr. Browne, if I didn't get it
7 clear to you, was what types of things were
8 being considered in terms of potential cost
9 reductions and what in the end was pursued as
10 a cost reduction opportunity. The managers,
11 there's certainly less managers today than
12 there would have been then. But I was also
13 alluding to the fact that there was some
14 centralization of lab services, recognizing
15 you had labs at the Janeway, General, St.
16 Clare's, Waterford and Grace.
17 COMMISSIONER:
18 Q. Um-hm.
19 MR. TILLEY:
20 A. And by pulling some of those, not all, as you
21 know, we talked in a previous day about a
22 reluctance on some of the centralized
23 proposals that the Hay Group had made. But
24 some of that had, in fact, occurred, and when
25 that happens, it does allow you--for more

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1 efficiencies or economies of scale.
2 COMMISSIONER:
3 Q. All right. Thank you.
4 MR. BROWNE:
5 Q. Thank you, Commissioner. And again, just for
6 context of Commissioner's terms of reference,
7 it was around this time in 1997, I believe,
8 that the lab at the Health Sciences started
9 performing IHC, is that--do you recall when -
10 MR. TILLEY:
11 A. I'm really not informal (sic.) enough to give
12 you that answer, Mr. Browne, I'm sorry.
13 MR. BROWNE:
14 Q. And but just going on in sort of following the
15 line of questioning that the Commissioner just
16 raised. So you have this, I guess, need to
17 identify reductions within the system in 1997-
18 1998 and as you mentioned, looking forward
19 there was a plan for closures and then
20 construct--capital budget and you had to sort
21 of deal with this within your own budgetary
22 process, to come up with that amount of money,
23 as I understand it, and in the year 2000, the
24 Grace Hospital closed.
25 MR. TILLEY:

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1 A. Yes.
2 MR. BROWNE:
3 Q. And it's my understanding, those lab services
4 were then distributed between two sites, were
5 they not, between the Health Sciences and St.
6 Clare's?
7 MR. TILLEY:
8 A. Yes.
9 MR. BROWNE:
10 Q. And then in 2002, you had the Hay Report.
11 MR. TILLEY:
12 A. Yes.
13 MR. BROWNE:
14 Q. And were there cost efficiencies identified
15 for the lab program in that report as well?
16 MR. TILLEY:
17 A. That's my recollection. There were
18 suggestions made that there were savings to be
19 had. I remember the lab people, in
20 particular, being somewhat frustrated by the
21 Hay process because they felt that they were
22 running a very efficient service, but Hay kept
23 referencing that there were other comparators
24 out there suggested that they could do even
25 better. I think in the end, we may have

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1 discarded that point.
2 MR. BROWNE:
3 Q. And -
4 THE COMMISSIONER:
5 Q. Discarded the Hay's view?
6 MR. TILLEY:
7 A. Yes.
8 THE COMMISSIONER:
9 Q. Okay. So are you suggesting Hay had no impact
10 on lab functioning?
11 MR. TILLEY:
12 A. I can't say with assurances of that, because
13 Hay came in and made specific recommendations
14 throughout the organization, some of which
15 were clearly accepted and some of which were
16 outright rejected. But the mere fact that
17 they came into the organization and started
18 espousing the fact that there is thirty plus
19 million dollars available here, I suspect that
20 every person in the organization took that, to
21 one degree or another, and was constantly on
22 the lookout for cost efficiencies after that.
23 MR. BROWNE:
24 Q. So there was an environment of--continual
25 environment of looking for cost efficiencies

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1 throughout this time? Would that be a fair
2 description?
3 MR. TILLEY:
4 A. That would be a fair description.
5 MR. BROWNE:
6 Q. And in terms of the--and just to go back on
7 the Commissioner's point, is there somebody
8 else within your organization during this time
9 who would be better in a position to sort of
10 address those points? Would Dr. Williams or
11 someone else, for instance, or -
12 MR. TILLEY:
13 A. I'm just thinking of the executive level. It
14 might be somebody in the financial piece, if
15 Dr. Williams is not able to--now we have had a
16 number of changes in the financial side as
17 well, so -
18 MR. BROWNE:
19 Q. But it would be the financial piece that they
20 would probably be able to sort of talk about
21 the numbers and how they were handled?
22 MR. TILLEY:
23 A. Right, or the program director for the lab
24 itself.
25 MR. BROWNE:

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1 Q. Sure, thank you, and again, would there be a
2 number of levels within the organization, from
3 an executive team down, who were charged with
4 the responsibility of identifying these cost
5 efficiencies?
6 MR. TILLEY:
7 A. Certainly. From my benefit, the team, the
8 executive team would be tasked to go out and
9 talk to the appropriate leadership teams
10 throughout the whole organization and talk
11 about what our year-to-date financial status
12 is, what our projection is for year end, talk
13 to the leadership teams about whether they are
14 on target, as far as their budget is
15 concerned, and if not, why not. There was an
16 expectation that all program areas contribute
17 to a variance report that explained their
18 financial situation and that would be rolled
19 up to the Board of Trustees. In the end, each
20 particular area, being as large as it was, was
21 then asked to identify what other potential
22 opportunities there might be.
23 MR. BROWNE:
24 Q. Now I believe you testified, I think the
25 previous occasion you were here, that the

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1 reorganization, and I'm hoping I'm capturing
2 your phraseology correct, was a challenging
3 process?
4 MR. TILLEY:
5 A. Yes, it was.
6 MR. BROWNE:
7 Q. And I think you used that in relation to both
8 the Health Care Corporation reorganization and
9 the subsequent Eastern Health reorganization?
10 MR. TILLEY:
11 A. Um-hm.
12 MR. BROWNE:
13 Q. And again, if I captured your reasons for
14 that, you identified two challenges. The first
15 was the way the organization was structured
16 and then, two, the imposition of financial
17 constraints. Can I ask you what you meant by
18 the first, the way the organization was
19 structured?
20 MR. TILLEY:
21 A. Well, in relation to Eastern Health, there
22 were--unlike the Health Care Corporation,
23 where we brought together a number of very
24 like entities, they were acute care hospitals
25 that provided both primary, secondary and

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1 tertiary care. The Eastern Health
2 organization brought in rural areas and it
3 also brought in issues like child welfare,
4 child protection and those were services that,
5 for those of us that had been in the system
6 for some time, would have typically fallen
7 under the social sector. So all of a sudden
8 we were dealing with the approval of daycare
9 centres and the like, so we had a greater mix
10 of responsibilities in the Eastern Health
11 organization.
12 MR. BROWNE:
13 Q. And I guess, focusing a bit more appropriately
14 on the lab medicine program, at the same time,
15 are you aware that, I guess, there were a
16 number of--there was high turnover rate among
17 pathologists, that there were shortages of
18 staff, I think both on the technical and on
19 the pathology side?
20 MR. TILLEY:
21 A. Well, I'm certainly aware on the pathology
22 side. I don't have it -
23 MR. BROWNE:
24 Q. And I could be mistaken, but at least on the
25 pathology side there were staff shortages?

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1 MR. TILLEY:
2 A. Yes.
3 MR. BROWNE:
4 Q. Would these also be additional challenges for
5 at least within that subset of the
6 organization, in this framework?
7 MR. TILLEY:
8 A. Well, yes. I mean, to the same degree that
9 our managers were working with less peers and
10 taking on extra responsibility, when the
11 turnover of pathologists occurred, then
12 obviously you're taking the remaining workload
13 and trying to find a way of appropriately
14 distributing it over others, but as a point in
15 time, there's no doubt that everybody's
16 working more than your normal expectation.
17 MR. BROWNE:
18 Q. And I think just on, to sort of close that
19 loop, Ms. Jones testified that, again, as the
20 evolution moved through of the reorganization
21 from the Health Care Corporation into Eastern
22 Health and so on, that a lot of the focus was
23 on identifying efficiencies within the system,
24 but more recently, and I think using the
25 creation of the Regional Health Authorities

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1 and the strategic plans that have been
2 developed, there's now been a focus towards
3 quality assurance, because that seemed to have
4 been supplanted to these cost efficiencies
5 approach. Is that a fair--again, a fair
6 description, in terms of identifying the sort
7 of priorities and so on?
8 MR. TILLEY:
9 A. Well, within the organization, quality always
10 was an important issue. The Health Care
11 Corporation, when it was organized in 1995,
12 established a quality initiatives department
13 and those staff were also accountable to me,
14 and we were really building it from scratch.
15 We were developing a program for the whole
16 organization. That was continued on into
17 Eastern Health. Now that's an issue that we
18 took upon ourselves and made it an important
19 issue.
20 In terms of drivers, like what were the
21 external drivers on it, it certainly wasn't
22 one to say, you know, quality has got to be
23 the priority over all else. What we were
24 looking at were drivers that said
25 restructuring and financial control. So

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1 anything on a quality side would have been
2 really our own doing.
3 MR. BROWNE:
4 Q. Now you mentioned a moment ago about the
5 centralization of lab services. Do you ever
6 recall any discussions with Dr. Cook or Dr.
7 Williams about the concerns Dr. Cook had about
8 centralization, and I think in relation to the
9 St. Clare's and Health Sciences centres?
10 MR. TILLEY:
11 A. Yes. I know that there was resistance from
12 the St. Clare's pathologists in particular to
13 removing the--or centralizing part of the
14 service that was located both at the General
15 site and at the St. Clare's site.
16 MR. BROWNE:
17 Q. Do you recall whether Dr. Cook expressed
18 concern that he felt he wasn't in opposition
19 to the notion of centralization, but he felt
20 that there needed to be a strategic plan
21 developed before that occurred?
22 MR. TILLEY:
23 A. Well, not specifically, though if it was, then
24 the Laboratory Medicine program would
25 certainly be the group that I would expect to

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1 put together that plan.
2 MR. BROWNE:
3 Q. Now Mr. Coffey also asked you about Dr.
4 Ejeckam's memo, and Registrar, please, if we
5 need to refer to it, it's P-0891. Oh, no,
6 sorry that's--no, my apologies, 0890. Now
7 this is a fax transmission from Dr. Howell to
8 Mr. Abbott, but nevertheless, it is the copy
9 of -
10 MR. TILLEY:
11 A. Yes.
12 MR. BROWNE:
13 Q. - Dr. Ejeckam's July 19th memo--June, sorry,
14 June 19th, 2003 memo. Did you ever inquire of
15 Mr. Gulliver if he brought this memo to the
16 attention of anybody in the executive in 2003?
17 MR. TILLEY:
18 A. I didn't personally, no.
19 MR. BROWNE:
20 Q. Okay, and if you need to, just take a moment
21 and review, I guess, the items that are
22 identified in that document. You may be
23 familiar with it enough, but if you wish to
24 take a moment, and you can -
25 THE COMMISSIONER:

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1 Q. You can have the mouse -
2 MR. BROWNE:
3 Q. - your mouse is there, just to scroll down
4 through it.
5 THE COMMISSIONER:
6 Q. - if you want to -
7 MR. TILLEY:
8 A. Yes.
9 MR. BROWNE:
10 Q. Okay?
11 MR. TILLEY:
12 A. Okay.
13 MR. BROWNE:
14 Q. Would you agree, Mr. Tilley, that the topics,
15 in terms of the suggestions that he's making
16 recommendations for are primarily technical in
17 nature?
18 MR. TILLEY:
19 A. Yes.
20 MR. BROWNE:
21 Q. Okay, and I think in answer to one of Mr.
22 Coffey's questions earlier about these memos,
23 you indicated that Dr. Ejeckam was in the
24 position of overseeing IHC. Do you know if,
25 in 2003, your institution--we saw the

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1 organizational charts a moment ago.
2 MR. TILLEY:
3 A. Yes.
4 MR. BROWNE:
5 Q. Was there a director position? Was there a
6 formal position within Eastern Health, or I
7 guess then it would be Health Care Corporation
8 of St. John's, for an oversight position by a
9 pathologist?
10 MR. TILLEY:
11 A. Not aware of one.
12 MR. BROWNE:
13 Q. Do you know if there is one--there has been
14 one subsequent to all of this created?
15 MR. TILLEY:
16 A. For quality purposes?
17 MR. BROWNE:
18 Q. Or just for, again if you want to talk that
19 matrix that you talked about.
20 MR. TILLEY:
21 A. Okay.
22 MR. BROWNE:
23 Q. Do you know if there's actually a formal
24 position that's been created since 2005?
25 MR. TILLEY:

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1 A. I know of a quality position that's been
2 created. I'm not sure if that's the one that
3 you may be thinking of.
4 MR. BROWNE:
5 Q. And I think there may be others who -
6 MR. TILLEY:
7 A. Okay, I really can't speak to it.
8 MR. BROWNE:
9 Q. - can best answer it. No, that's fine. So
10 are you of the understanding though that he
11 was sort of formally charged with taking this
12 responsibility?
13 MR. TILLEY:
14 A. Dr. Ejeckam?
15 MR. BROWNE:
16 Q. Yes.
17 MR. TILLEY:
18 A. The fact that he was able to shut it down, I
19 made some conclusions from that that he was in
20 a position of authority.
21 MR. BROWNE:
22 Q. Now you had mentioned as well, I guess, in
23 response to some questions from both Mr.
24 Coffey and the Commissioner yesterday, about
25 your reflections upon all of this and one of

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1 the notions that you--or one of the
2 observations you made, sort of looking back
3 with hindsight, is the ability or the benefit
4 of potentially having a swat team to sort of
5 focus in on the situation and deal with it and
6 run with it. Can the witness be shown Exhibit
7 P-0069?
8 This is--I think you were shown this
9 previously. It's a letter from Dr. Carter to
10 Dr. Cook in July of 2005.
11 MR. TILLEY:
12 A. Yes.
13 MR. BROWNE:
14 Q. And I think you're generally familiar with the
15 contents of it?
16 MR. TILLEY:
17 A. I am.
18 MR. BROWNE:
19 Q. Dr. Carter is sort of proposing sort of a
20 strategic plan in some respects here. I guess
21 my question is this, again looking forward
22 with the benefit of hindsight. What sort of
23 individuals would you think should be on that
24 type of swat team? Would an individual such
25 as Dr. Carter, a breast pathologist, have been

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1 a good pick for that?
2 MR. TILLEY:
3 A. Certainly Dr. Carter would have been able to
4 provide a major role, but when I mentioned the
5 swat team -
6 MR. BROWNE:
7 Q. Yes.
8 MR. TILLEY:
9 A. - I was thinking about it more in the context
10 of the data management process.
11 MR. BROWNE:
12 Q. Okay.
13 MR. TILLEY:
14 A. Because I think the admirable efforts of the
15 people that made the patient contacts could
16 have been significantly enhanced if a lot of
17 that had been automated and there was somebody
18 there who could sort of close the loop when
19 patients had been contacted.
20 MR. BROWNE:
21 Q. Okay. So, and I'm still--when you say a--I
22 guess when I think of a team, I think of
23 others there as well, besides--I agree IT.
24 MR. TILLEY:
25 A. My specific reference was around the data

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1 management piece.
2 MR. BROWNE:
3 Q. Okay.
4 MR. TILLEY:
5 A. You know, in terms of what went on in the lab,
6 I would have expected everybody who had
7 expertise in that area to be working together
8 to find the common solutions here.
9 MR. BROWNE:
10 Q. Now you were asked as well about the evolution
11 of the disclosure, both to patients and to the
12 public, and quite a bit of time has been spent
13 on that. I just want to focus in on the
14 oncologists' position, and in the summer of
15 2005, I think Mr. Coffey asked you about the
16 oncologists' role and did I understand that
17 initially the oncologists were concerned when
18 this first sort of came forward, the issue
19 came forward, there was some question
20 surrounding probably the under calling of the
21 DAKO and the possible over calling of the
22 Ventana. Do you recall those discussions
23 around that, that concern?
24 MR. TILLEY:
25 A. Yes, I do.

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1 MR. BROWNE:
2 Q. And was there concern expressed by the
3 oncologists, "we need to sort--before we
4 disclose anything, we need to sort out whether
5 or not--this issue, because if we're wrong, we
6 may be giving people the wrong information"?
7 MR. TILLEY:
8 A. Right.
9 MR. BROWNE:
10 Q. And I think it was expressed, like we may be
11 going around in circles here.
12 MR. TILLEY:
13 A. Yes.
14 MR. BROWNE:
15 Q. Was that the initial position that was
16 expressed?
17 MR. TILLEY:
18 A. Well that was one of the positions and I
19 recall that there were a number of cases that
20 we had run on the new Ventana system and
21 patients were contacted about that, but there
22 were others that were still outstanding and
23 then the issue of the Ventana and its
24 reliability came up.
25 MR. BROWNE:

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1 Q. Right.
2 MR. TILLEY:
3 A. And I remember and somewhere in my written
4 notes, I think we may have mentioned it where
5 the oncologists said let's stop calling
6 patients because we're not sure whether we're
7 giving them the accurate result. Now it
8 turned out to be that the equipment was, in
9 fact, confirmed to be okay, but at that point
10 in time, it was still questionable.
11 MR. BROWNE:
12 Q. That's right, but at that point in time,
13 you're trying to sort of sort out all
14 potential causes of this, and that was one
15 road you were pursuing at that point?
16 MR. TILLEY:
17 A. That's correct.
18 MR. BROWNE:
19 Q. And then after that sort of possibility was
20 ruled out and a decision was made to send all
21 the test results to Mount Sinai -
22 MR. TILLEY:
23 A. Yes.
24 MR. BROWNE:
25 Q. And around that time, I believe and several

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1 witnesses have addressed this, including the
2 then minister, Mr. Ottenheimer, that when you
3 had that meeting, I think it was the second
4 meeting in August, the understanding I believe
5 and I think Minister Ottenheimer or Mr.
6 Ottenheimer confirmed this, is that there will
7 be a turn-around time of about four to six
8 weeks for the results.
9 MR. TILLEY:
10 A. That's what our understanding was from Mount
11 Sinai.
12 MR. BROWNE:
13 Q. And it was the position based on that
14 information of the oncologists that they would
15 prefer to have the results in hand and be in a
16 position when they had to speak to their
17 patients to have the retest results, so as to
18 be able to give their patients a full clinical
19 picture of what this meant for them.
20 MR. TILLEY:
21 A. That's correct.
22 MR. BROWNE:
23 Q. And then later on I think you alluded to the
24 fact that when, as this whole picture was
25 evolving, it became clear that the results

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1 would not be coming back on time, you again
2 spoke to the oncologists and they agreed with
3 your change in views in terms of disclosure,
4 is that -
5 MR. TILLEY:
6 A. Yes, we agreed to consult with them and
7 there's many a day that I thought about that,
8 the oncologists are the people that are
9 talking to individual patients on a daily
10 basis, it's probably one of the most
11 challenging physician positions to be in,
12 recognizing the diagnosis itself. And from my
13 perspective, it was critical that we listen to
14 and give a lot of weight to their opinions,
15 recognizing they are the ones that are dealing
16 with those patients. So yes, the intent was
17 to have information, that was their preference
18 and when the preference was not able to be
19 lived up to because of the delays in returns
20 for the tests, as you know, we started a
21 process of calling and that was supported by
22 the oncologists.
23 MR. BROWNE:
24 Q. Right. So they changed their positions as the
25 dynamic changed within the organization.

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1 MR. TILLEY:
2 A. That's true.
3 MR. BROWNE:
4 Q. Would you agree with me, Mr. Tilley, that
5 everyone, the oncologists, the pathologists,
6 the executive team, everybody was involved in
7 this. At all times when they approached this
8 issue had the best interest of the patient in
9 mind?
10 MR. TILLEY:
11 A. From the very beginning I felt that the focus
12 was on trying to help every patient they could
13 because of a test change.
14 MR. BROWNE:
15 Q. Now, you'll be glad to know this is the last
16 area I have for you. Commissioner Cameron
17 asked you again, your views looking, you know,
18 looking forward what sort of things can be
19 done with testing based on the fact that, I
20 think your views that this situation or
21 aspects of this situation are not unique to
22 Newfoundland in terms of the IHC testing and
23 ER/PR testing. And there was some, I think
24 Commissioner Cameron talked about, you know,
25 Centres of Excellence and so on. Now in some

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1 provinces, cancer is treated in form of an
2 agency, I'm thinking of the B.C. Cancer Agency
3 where there are a number of people under one
4 roof and a number of specialities under one
5 roof. Are you familiar with, generally, the
6 concept of--the Cancer Agency concept?
7 MR. TILLEY:
8 A. Generally, yes.
9 MR. BROWNE:
10 Q. And I think just, again, I haven't done a lot
11 of literature review on this, but there are a
12 number of specialities and let's see if we can
13 sort of put this in perspective, one of the
14 biggest growth areas in say, the past ten to
15 fifteen years in pathology, has been in the
16 area of immunohistochemistry, would you--from
17 what you've read, do you see that as one of
18 the big growth areas?
19 MR. TILLEY:
20 A. I can't disagree with you, I'm really not well
21 informed enough about it.
22 MR. BROWNE:
23 Q. And have you seen as well and again, you may
24 not be able to answer this question, but also
25 an expansion of sub-specialization, both in

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1 pathology and oncology growth in terms of the
2 various treatments?
3 MR. TILLEY:
4 A. Right, well I know from a general perspective
5 that a lot of our physicians are becoming sub-
6 specialized.
7 MR. BROWNE:
8 Q. In these cancer agencies, structures, do you
9 know if there are a number of different sort
10 of areas, for instance pathology, oncology,
11 but besides those two areas, isn't there other
12 areas that are, I think largely devoted to the
13 treatment of cancer? I'm thinking of
14 radiology, would that--there's an element of--
15 quite a degree of radiology used in the
16 treatment of cancer.
17 MR. TILLEY:
18 A. There's radiation treatment, sure.
19 MR. BROWNE:
20 Q. But also radiological investigations and so
21 on.
22 MR. TILLEY:
23 A. Yes, certainly, yes.
24 MR. BROWNE:
25 Q. And also surgery?

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1 MR. TILLEY:
2 A. Uh-hm.
3 MR. BROWNE:
4 Q. And palliative care?
5 MR. TILLEY:
6 A. Yes.
7 MR. BROWNE:
8 Q. And also there's a social economic sort of
9 factors that go around the whole treatment of
10 cancer. So is there, is there any sort of
11 thought, and again, you may not be able to
12 answer this question, but the notion of having
13 an agency, either in an Atlantic scale or on a
14 Provincial scale.
15 MR. TILLEY:
16 A. Well, I suspect if you looked at Eastern
17 Health in itself and pulled out all of the
18 services that were solely there to benefit
19 patients with cancer, you'd be pulling out a
20 fairly large chunk of the organization. And
21 then you'd probably end up, you know, having
22 so many ORs dedicated to cancer and so many OR
23 staff, so somewhere along the way, you're
24 going to fragment certain portions of it.
25 MR. BROWNE:

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1 Q. Right.
2 MR. TILLEY:
3 A. I don't disagree with the thoughts that you
4 are referencing, which is the need to pull
5 together sort of an overall strategy for
6 cancer. When Eastern Health was formed, one
7 of the decisions it made was to create a
8 Cancer Care Program. From up until the time
9 when I left the organization, the Cancer Care
10 Program for the main, had taken over
11 responsibility for the Newfoundland Cancer
12 Treatment and Research Foundation, but there
13 always was a discussion about how then does it
14 expand its horizons to see how other parts of
15 the system may in fact co-ordinate with it.
16 You may not need to have the surgical
17 component under the auspices of a Cancer Care
18 Program, but you do need to have it linked in
19 a matrix way so that the patient flow is given
20 primary attention.
21 MR. BROWNE:
22 Q. So that has been sort of the focus as the
23 Cancer Care Program has moved forward in the
24 province?
25 MR. TILLEY:

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1 A. That's been sort of the general line of
2 thinking that we've had. Now we haven't
3 obviously--well, let me put it this way,
4 Eastern Health has a role with the satellite
5 cancer clinics around the province, so there's
6 a lot of dialogue going on that way, but has
7 not had any discussions with regards to
8 whether the surgical program offered in Grand
9 Falls would fall under a provincial cancer
10 treatment program and I guess that would be
11 for somebody to decide in the future.
12 MR. BROWNE:
13 Q. That's all the questions. Thank you, Mr.
14 Tilley, I appreciate your evidence.
15 THE COMMISSIONER:
16 Q. Thank you, Mr. Browne. Mr. Eaton?
17 EATON, Q.C.:
18 Q. No questions.
19 THE COMMISSIONER:
20 Q. Thank you. Ms. Newbury?
21 MR. GEORGE TILLEY, EXAMINATION BY MS. JENNIFER NEWBURY
22 MS. NEWBURY:
23 Q. Good morning, Mr. Tilley.
24 MR. TILLEY:
25 A. Good morning.

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1 MS. NEWBURY:
2 Q. Jennifer Newbury for the Canadian Cancer
3 Society, Newfoundland and Labrador Division.
4 I have a few questions for you this morning,
5 you're at the end of the wire. First of all,
6 I want to bring you to the area involving the
7 check of the Ventana equipment by the
8 technical representative.
9 MR. TILLEY:
10 A. Okay.
11 MS. NEWBURY:
12 Q. You've been asked about that a couple of times
13 already.
14 MR. TILLEY:
15 A. Yes.
16 MS. NEWBURY:
17 Q. But I think your evidence initially was that
18 you were aware that the Ventana equipment was
19 checked and that, for the most part, it
20 checked out.
21 MR. TILLEY:
22 A. Yes.
23 MS. NEWBURY:
24 Q. I just wondered was there any aspect of this
25 equipment that did not check out?

1 MR. TILLEY:
2 A. Not to my knowledge.
3 MS. NEWBURY:
4 Q. Okay, so there were no major or significant
5 concerns that you were aware of?
6 MR. TILLEY:
7 A. No.
8 MS. NEWBURY:
9 Q. And I believe this occurred some time in early
10 August, the first week of August, is that your
11 recollection of 2005?
12 MR. TILLEY:
13 A. When that issue came up?
14 MS. NEWBURY:
15 Q. When the equipment was checked out.
16 MR. TILLEY:
17 A. Yes, that's correct.
18 MS. NEWBURY:
19 Q. Okay, and I think your note from yesterday
20 indicated that the concern was raised on July
21 19th that there might be an over calling of
22 the Ventana equipment, is that your
23 recollection as well?
24 MR. TILLEY:
25 A. It certainly was early, I can't be specific on

1 the 19th, but it certainly was in July, August
2 time frame.
3 MS. NEWBURY:
4 Q. And now were you aware at that point in time,
5 early August, that there had been an index
6 case, what was considered to be an index case
7 and consultation with an oncologist from the
8 United States, I understand, who raised the
9 concern that invasive lobular carcinoma should
10 rarely be tested as ER negative.
11 MR. TILLEY:
12 A. Yes.
13 MS. NEWBURY:
14 Q. You were aware of that at the time. And that
15 was something, I believe Dr. Cook had been
16 made aware of--Dr. Cook had received a call
17 from the oncologist involved, is that your
18 understanding?
19 MR. TILLEY:
20 A. I don't know who talked to who, but I
21 certainly was aware of the index case.
22 MS. NEWBURY:
23 Q. Okay, and who did you learn that from?
24 MR. TILLEY:
25 A. Dr. Williams.

1 MS. NEWBURY:
2 Q. Now I'm not sure if you are aware of some of
3 the evidence that's occurred early on since
4 the inquiry started, but there was some
5 evidence from Dr. Robert Deane who testified
6 on March 25th that his late wife, Peggy Deane,
7 was considered to be the index patient.
8 MR. TILLEY:
9 A. Yes.
10 MS. NEWBURY:
11 Q. Did you become aware of that?
12 MR. TILLEY:
13 A. I did, yes.
14 MS. NEWBURY:
15 Q. Presumably at the time the index case had been
16 discussed back in 2005, you weren't aware of
17 the patient by name?
18 MR. TILLEY:
19 A. In fact, I may have known the patient by name
20 simply because, as a colleague within the
21 organization being--didn't know it was an
22 index patient, but a colleague's wife was
23 suffering from this disease and subsequently
24 learned later that it turned out to be the
25 index case.

1 MS. NEWBURY:
2 Q. Okay, so you found out through another source,
3 through social sources or -
4 MR. TILLEY:
5 A. I'm not sure if it was a social source, but
6 within the health care setting.
7 MS. NEWBURY:
8 Q. Okay, now Dr. Deane also testified on March
9 25th that following the retesting, which
10 determined that she was indeed ER positive, so
11 basically the retesting was done here, she was
12 confirmed ER positive as had been suspected by
13 the oncologist in the United States and she
14 was prescribed Tamoxifen even though at that
15 point her cancer had progressed. Were you
16 aware of that, that evidence? Or were you
17 aware of the direct circumstances back in
18 2005?
19 MR. TILLEY:
20 A. The integrate details of a particular patient,
21 I confess, I typically would not become
22 informed about.
23 MS. NEWBURY:
24 Q. Right, but this one was the index patient
25 here.

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1 MR. TILLEY:
2 A. Right.
3 MS. NEWBURY:
4 Q. She would be of particular interest.
5 MR. TILLEY:
6 A. But I knew that the results were inconsistent
7 with what they had advised from the U.S. But
8 the intricacies of the clinical piece, I've
9 got to confess, it's not something that I'm
10 knowledgeable about.
11 MS. NEWBURY:
12 Q. Dr. Deane had actually indicated during his
13 evidence and I'm going to lead you up to a
14 question.
15 MR. TILLEY:
16 A. Okay.
17 MS. NEWBURY:
18 Q. Dr. Deane had testified that her particular
19 tumor seemed to be fairly responsive to
20 Tamoxifen and that has actually been
21 confirmed, according to a note of her
22 oncologist, Dr. Laing and I would like to
23 refer to exhibit C-0169 please?
24 MS. NEWBURY:
25 Q. So this is a progress note and you can see in

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1 the top left-hand corner that it's dated June
2 1st of 2005. And if you look under the
3 heading "Plan"--and you can take your time to
4 read the whole report, if you like, certainly,
5 but I want to bring to your attention the
6 reference there to Tamoxifen under the heading
7 "Plan". She says, "Certainly I think the
8 Tamoxifen has to be working because I do not
9 have any explanation for the failure of re-
10 accumulation of the ascites and pleural
11 fluids, even though we did a pleurocentesis, I
12 do not think it would be successful enough to
13 stop the fluid from re-accumulating. She
14 feels better overall." So that seems to be
15 consistent with evidence that Dr. Deane had
16 given that her tumor seemed to be responsive
17 to Tamoxifen.
18 MR. TILLEY:
19 A. Okay.
20 MS. NEWBURY:
21 Q. And I'm wondering because this would tend to
22 support that there was a proper, you know, the
23 retesting on the equipment in St. John's in
24 the summer, spring/summer of 2005 was a proper
25 result.

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1 MR. TILLEY:
2 A. Yes, of the Ventana piece, yes.
3 MS. NEWBURY:
4 Q. Was there any discussion of that with you at
5 that time, particularly the time that they
6 started to question whether the Ventana might
7 be over calling the equipment or the results?
8 MR. TILLEY:
9 A. Well, I certainly remember conversations and
10 don't think it was just one-on-one
11 conversations, but as a part of the group that
12 had come together about Ventana, initially an
13 over call, initially about getting Ventana in
14 and initially--or sorry, next Ventana saying
15 there's nothing here that causes us concern.
16 This specific reference I don't recall being
17 brought up.
18 MS. NEWBURY:
19 Q. Okay.
20 MR. TILLEY:
21 A. My only contribution to this was to say to the
22 vice-president for medical at the time that
23 when you feel satisfied that that piece of
24 technology should be put in circulation or put
25 in use again, then proceed, but you've got to

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1 feel comfortable with that.
2 MS. NEWBURY:
3 Q. So do I take it then that you don't recall
4 this being discussed? This particular issue,
5 basically this seems to be suggesting that the
6 Ventana equipment in the case of Mrs. Deane,
7 had properly determined her to be ER positive.
8 There's some empirical evidence she was given
9 Tamoxifen, it seemed to be working, both her
10 husband and her oncologist indicate that it
11 seemed to be working. I'm just wondering, I'm
12 not asking you to comment on whether that's,
13 you know, appropriate conclusions or not, but
14 was it discussed at any point in time in July
15 or August?
16 MR. TILLEY:
17 A. I don't recall, not in my presence, no.
18 MS. NEWBURY:
19 Q. And do you think you would have remembered it
20 if it happened?
21 MR. TILLEY:
22 A. I'd like to say so, but I got to confess, I've
23 been overwhelmed with the amount of
24 information sometimes and this is just one
25 piece of the thing that's happening at that

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1 time in my world, so it's possible that it
2 could have been said, but I don't recall it.
3 MS. NEWBURY:
4 Q. Now also on the issue of the Ventana, concerns
5 about it potentially over calling the results
6 for ER testing, you indicated that there was a
7 brief pause when there was a possibility of
8 this occurring. And that was around, and I
9 can refer you to the note from yesterday, P-
10 0329, if we could have that exhibit, please?
11 Is this the note that triggered in your mind a
12 recollection of this?
13 MR. TILLEY:
14 A. Of the Ventana?
15 MS. NEWBURY:
16 Q. Yes. Maybe I misunderstood your evidence
17 yesterday.
18 MR. TILLEY:
19 A. No, there was another one that, a note that I
20 just recall seeing, Ventana okay or -
21 MS. NEWBURY:
22 Q. Okay.
23 MR. TILLEY:
24 A. - something of that nature. I'm not sure
25 where it is, but it definitely was connected

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1 to the manufacturer's assessment.
2 MS. NEWBURY:
3 Q. Okay. And now when you described this pause
4 in terms of Easter Health's response, did that
5 refer to the decision to retest or to the
6 communication to patients or to both of those
7 issues?
8 MR. TILLEY:
9 A. Both. If we're talking the same thing, the
10 reference to the pause was when they had
11 summarized the positivity rates for each of
12 the calendar years going back to, I'm not sure
13 exactly which year it went back to, but the
14 initial observation, I think was 2003 had
15 indicated that the positivity rates were up in
16 the recommended zone, for lack of a better
17 word, and therefore, it caused people to say,
18 well, do we have as big a problem as we
19 thought we had. So, that's what caused us to
20 pause before making a decision to pursue the
21 public and patient follow-up.
22 MS. NEWBURY:
23 Q. So, did the issue of overcalling, potential
24 overcalling by the Ventana equipment, did that
25 contribute at all to the pause or was it only

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1 your impression that maybe you're not that far
2 off the mark in terms of positivity rates?
3 MR. TILLEY:
4 A. It was all being talked about at the same time
5 and I don't want to mislead you by saying it
6 didn't because we were clearly having concerns
7 about Ventana. Even when the manufacturer had
8 indicated acceptance, I think Dr. Carter was
9 still expressing some reservations to it. And
10 of course, that decision, rightly or wrongly
11 at the time, precipitated us going to Mount
12 Sinai. And that brought us into a whole new
13 set of issues that we hadn't anticipated.
14 MS. NEWBURY:
15 Q. Okay. So, at around this time, it's a little
16 bit more complex than just being either
17 Ventana or positivity rates, were there any
18 discussions at that time when all this
19 information is coming out and concerns are
20 being raised about other categories of
21 patients who might be expected to be ER
22 positive, but whose tests results show them to
23 be ER negative?
24 MR. TILLEY:
25 A. The only connection that I can recall and we

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1 mentioned it yesterday in the memo that Dr.
2 Ejeckam had written. There were other
3 indicators referenced there.
4 MS. NEWBURY:
5 Q. Okay. This is the memos from 2003?
6 MR. TILLEY:
7 A. Yes.
8 MS. NEWBURY:
9 Q. Okay.
10 MR. TILLEY:
11 A. So, in that discussion I know it come up
12 about, you know, were there other issues that
13 needed to be attended to. And I know that
14 Drs. Cook and Drs. Williams had follow-up
15 discussions on that. Now, did I answer your
16 question or was it -
17 MS. NEWBURY:
18 Q. I think we're getting there.
19 MR. TILLEY:
20 A. Okay.
21 MS. NEWBURY:
22 Q. If I could bring up Exhibit P-0323, please.
23 The second paragraph, the first bullet there
24 indicates that there were samples collected
25 from 25 women initially tested as negative in

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1 2002, were retested, 16 of these came back
2 positive. Testing is currently being done on
3 33 more patients. Do you know, was there any
4 discussion about the types of cancer that
5 these 25 women had been diagnosed with?
6 MR. TILLEY:
7 A. Not in my presence.
8 MS. NEWBURY:
9 Q. Okay. So, you're not aware of any sort of
10 analysis of expectations from a statistical
11 point of view of the samples that have been
12 identified so far.
13 MR. TILLEY:
14 A. No, I'm sorry, I can't add to that.
15 MS. NEWBURY:
16 Q. Okay. And you'd indicated earlier on a couple
17 of occasions that during this time period by
18 early August, ten or eleven patients had
19 already been--who had been retested had been
20 told of their new results.
21 MR. TILLEY:
22 A. Yes.
23 MS. NEWBURY:
24 Q. And was there any discussion by anyone in your
25 presence of whether or not any of these

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1 patients were in a situation that they could
2 be offered Tamoxifen and that any observations
3 could be made as to whether or not the
4 Tamoxifen was having any affect?
5 MR. TILLEY:
6 A. Not in my presence, no.
7 MS. NEWBURY:
8 Q. Okay. Now, I was going to ask you and I think
9 you've already asked the question, once the
10 Ventana equipment was checked out, did that
11 put to rest the concern that the equipment
12 might be oversensitive. And you've indicated
13 that Dr. Carter, notwithstanding the
14 representatives evaluation of the equipment,
15 she still had reservations. Did you share
16 those reservations?
17 MR. TILLEY:
18 A. Well, I only had the advice of the people who
19 were familiar with it to base my conclusions
20 on. I think at that point in time, suffice to
21 say that everyone was concerned that if we
22 were into a situation of this magnitude, we
23 wanted to be all confident that, on a go
24 forward basis, we were using reliable
25 equipment. So, as a consequence, it was held

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1 off. In retrospect, if we could have resolved
2 that issue much quicker, then I suspect the
3 retesting would have been done literally
4 within weeks and maybe the problem would not
5 have precipitated into the one that it did.
6 MS. NEWBURY:
7 Q. Okay. And was the concern of Dr. Carter
8 related to the functioning of the equipment
9 itself or did she have concerns about the
10 ability of the people who were using the
11 equipment, or to provide samples--all of the
12 steps up until the Ventana equipment is used
13 to put that into play?
14 MR. TILLEY:
15 A. I can't be specific other than she had
16 concerns.
17 MS. NEWBURY:
18 Q. Okay. And was there anyone else voicing
19 specific concerns aside from Dr. Carter?
20 MR. TILLEY:
21 A. Not that I'm aware of.
22 MS. NEWBURY:
23 Q. Okay. I'm going to turn to a topic now
24 regarding disclosure. And I take it from your
25 evidence that there appear to have been some

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1 reluctance by you to send a letter directly to
2 a patient advising of the retesting and the
3 results of the retesting.
4 MR. TILLEY:
5 A. That's correct.
6 MS. NEWBURY:
7 Q. And I understand that, in your view, personal
8 communication would be preferable.
9 MR. TILLEY:
10 A. Yes.
11 MS. NEWBURY:
12 Q. Okay. And at the time that you had drawn this
13 conclusion and I take it that this is your
14 conclusion related specifically to responding
15 to the ER/PR issue?
16 MR. TILLEY:
17 A. Yes.
18 MS. NEWBURY:
19 Q. At the time that you had drawn that
20 conclusion, had you considered whether or not
21 a letter to patients in addition to the
22 personal communication would be appropriate?
23 MR. TILLEY:
24 A. I'm not sure immediately at the time we did.
25 I can share with you that into the process of

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1 making contacts with patients, Mrs. Predham,
2 in particular, had made the suggestion that a
3 follow-up letter is something that, in
4 retrospect, they would have factored into the
5 process.
6 MS. NEWBURY:
7 Q. And do you know when she made that suggestion?
8 Is that later on in the process?
9 MR. TILLEY:
10 A. It was later on in the process, but I can't
11 tell you exactly when because I think at that
12 point in time we were getting second calls
13 back from or returned calls and it had to be
14 repeated again and the individual had
15 forgotten the call or thought the call was
16 about something else. So, clearly it showed
17 that we needed to have confirmed the
18 communication.
19 MS. NEWBURY:
20 Q. Okay. And those comments, would that be
21 consistent--the fact that some people might
22 have been confused or didn't understand or
23 thought that the call related to something
24 else--you, yourself, have acknowledge, from a
25 layperson's perspective, you're not a medical

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1 physician or health care worker as such, that
2 the ER/PR issue is somewhat complex?
3 MR. TILLEY:
4 A. Yes.
5 MS. NEWBURY:
6 Q. And do you think that could have been a factor
7 in why some people might have been confused
8 and led to Heather Predham's concerns?
9 MR. TILLEY:
10 A. I'm sure it played a factor. I'm not sure to
11 what extent.
12 MS. NEWBURY:
13 Q. And what other factors might have played a
14 role in that?
15 MR. TILLEY:
16 A. In the confusion?
17 MS. NEWBURY:
18 Q. Yes.
19 MR. TILLEY:
20 A. I suspect that every patient who has cancer is
21 going through a very traumatic experience.
22 So, having a telephone call on the one hand
23 was intended to try to elaborate on any
24 questions that people would have. I know that
25 there were people who were called that took

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1 exception to the fact that the cal was being
2 made, but not enough information was being
3 given to them. So, it really became a
4 situation that individual patients seem to
5 have different preferences in terms of their
6 contact.
7 MS. NEWBURY:
8 Q. And, of course, the contact for each patient
9 was not identical?
10 MR. TILLEY:
11 A. No, because there were a number of people who
12 were making the calls.
13 MS. NEWBURY:
14 Q. Yes. And some people might have had a
15 meeting, if they were actually confirmed to be
16 ER positive. They might have actually been in
17 an office speaking about this with a
18 physician. Whereas other people might have
19 received a call from a patient relations
20 officer.
21 MS. NEWBURY:
22 Q. I can't confirm that.
23 MS. NEWBURY:
24 Q. Had you considered at the time that you drew
25 your own personal conclusion that personal

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1 contact was preferable, that the person
2 contacting the patient may not be known to
3 that individual?
4 MR. TILLEY:
5 A. That was going to be more likely than not, but
6 I was -
7 MS. NEWBURY:
8 Q. You were aware of that?
9 MR. TILLEY:
10 A. Yes, but I was very comfortable knowing the
11 group of patients, sorry, the group of staff
12 that would be drawing upon who had a lot of
13 experience in the system and familiar with
14 dealing with individual patients.
15 MS. NEWBURY:
16 Q. But from the patients' perspective, you know,
17 they might be very competent, but if they
18 haven't had a chance to meet or -
19 MR. TILLEY:
20 A. Right.
21 MS. NEWBURY:
22 Q. - even to see that person face to face, they
23 may not get the same level of comfort that you
24 would have knowing these individuals.
25 MR. TILLEY:

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1 A. Very much so and the reality of the situation,
2 the numbers were such that it would have been
3 impossible to get the immediate caregivers to
4 be taking on that role in light of the demands
5 that they were going through with other
6 patient load.s
7 MS. NEWBURY:
8 Q. And you didn't consider that because some of
9 the perhaps weaknesses of having an unknown
10 individual contacting the patient that perhaps
11 some additional type of disclosure, method of
12 communication might be useful?
13 MR. TILLEY:
14 A. I don't recall any discussion around that at
15 the time.
16 MS. NEWBURY:
17 Q. Had you known that the personal contact might
18 actually be by phone as opposed to in person?
19 MR. TILLEY:
20 A. Yes.
21 MS. NEWBURY:
22 Q. And you hadn't thought about whether that
23 would be an impediment to, you know, full and
24 adequate communication with the patient?
25 MR. TILLEY:

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1 A. Well, we certainly thought about it and you
2 may recall that I did a presentation in the
3 Atlantic region about the challenges of
4 disclosure. And one of the challenges was the
5 distance that patients were. They weren't--it
6 wasn't easy or practical to get patients
7 actually to commute into St. John's to get it
8 directly. So, it really became limited in
9 terms of our ability to make the contact.
10 MS. NEWBURY:
11 Q. But some of the regional health authorities,
12 of course, were engaged as well. It's not
13 like someone from Port aux Basques would have
14 to drive to St. John's, if an in person
15 meeting was desirable?
16 MR. TILLEY:
17 A. That's true, if in fact the service had been
18 delivered through Corner Brook, but I guess
19 there were patients who may have been in one
20 of the smaller communities like Port aux
21 Basques that actually receive treatment out of
22 the Cancer foundation in St. John's.
23 MS. NEWBURY:
24 Q. How about video conference meetings,
25 communication?

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1 MR. TILLEY:
2 A. That wasn't talked about. Whether it would
3 have been an option, certainly a possibility.
4 MS. NEWBURY:
5 Q. Had you considered at the time that you had
6 drawn your personal conclusions preferring
7 personal contact, that some of the patients
8 might be getting a call quite unexpectedly,
9 out of the blue, in some cases, many years
10 after their diagnosis and treatment?
11 MR. TILLEY:
12 A. That was likely to happen.
13 MS. NEWBURY:
14 Q. And had you thought about that in time and did
15 you analyze, well you know, someone might be
16 getting a call. They may have forgotten all
17 about ER/PR -
18 MR. TILLEY:
19 A. Right.
20 MS. NEWBURY:
21 Q. - they're getting a call from someone they've
22 never met before. They might be catching them
23 in the middle of supper.
24 MR. TILLEY:
25 A. Right.

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1 MS. NEWBURY:
2 Q. You know, not at a good time to ask questions.
3 They may not have a pen and paper in their
4 hand.
5 MR. TILLEY:
6 A. Right.
7 MS. NEWBURY:
8 Q. Had you thought about those sort of practical
9 issues?
10 MR. TILLEY:
11 A. Yeah, well, it was very obvious that we were
12 going to be making contact with patients who
13 may not have had any contact in the system.
14 In fact, it was one of the things in my mind
15 that led more credibility to the personal
16 contact, so that somebody could really present
17 this in a way, at a pace that was more
18 acceptable to the individual.
19 MS. NEWBURY:
20 Q. Looking back on it now, you know, in light of
21 how it has evolved, do you have any comments
22 or concerns about that personal contact by an
23 individual, in some cases, on the phone who's
24 not previously known to the patient, being
25 effective? On its own, I'm not suggesting

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1 that as a supplement it wouldn't be
2 appropriate, but relying solely on that as a
3 method of communication -
4 MR. TILLEY:
5 A. No, I think--the large number and the large
6 distances between the individual patients
7 didn't lend itself to face to face follow-up.
8 Clearly that would have been the ideal
9 scenario there. So, in the absence of that
10 you have to fall back on others. I still
11 prefer one-on-one conversation. The telephone
12 is the most obvious option. Teleconferencing,
13 it's a possibility. I'm not sure it's as
14 accessible as we'd like it to be. I do think
15 though that after the telephone contact had
16 been made, it became more and more obvious
17 that a written confirmation of it would have
18 been a strengthening of the process.
19 MS. NEWBURY:
20 Q. And in fact, the guidelines, Canadian Patient
21 Safety Institute Guidelines actually does
22 contemplate disclosure through registered
23 mail, particularly in large cases of a multi-
24 patient event. Is that correct? I can show
25 you the reference.

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1 MR. TILLEY:
2 A. I'll accept that, yes.
3 MS. NEWBURY:
4 Q. Okay. Now, you've mentioned a number of times
5 the terms probabilistic nature of the ER/PR
6 test and this, I take it, is the fact that
7 there's no guarantee with the test, is that a
8 correct understanding?
9 MR. TILLEY:
10 A. Well, that was the terms that were being used
11 by the physicians around. And I sort of base,
12 I interpreted as the responsibility or the
13 task in front of the pathologist, when he's
14 looking under that microscope is to make a
15 judgment call as to how many cells, I believe
16 it is, picked up the stain. So, it's possible
17 that one person could say it was 35 percent
18 and pass it over to the next person who was
19 say 30 percent and then be passed back to the
20 same person who may say 40 percent. This is
21 obviously a very complex area and these people
22 are trained to deal with that, but in terms of
23 the probabilistic term, that's how I interpret
24 it, but it was a term that was being used by
25 the physicians quite regularly.

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1 MS. NEWBURY:
2 Q. Okay. And was it your understanding that this
3 was something that was well understood by
4 pathologists and oncologists by 2005 or was
5 this a new revelation at that time?
6 MR. TILLEY:
7 A. I know there was discussions early in the game
8 about the changing treatment thresholds.
9 MS. NEWBURY:
10 Q. Going from 10 percent to 30 percent -
11 MR. TILLEY:
12 A. Right.
13 MS. NEWBURY:
14 Q. - or 30 percent to 10 percent.
15 MR. TILLEY:
16 A. Yes, thank you. And there was discussions
17 with regards to the European literature. I
18 think the latter was somewhat of a surprise to
19 the oncologists about some of the reliability
20 questions that were being raised. But to say
21 to you whether the probabilistic term was
22 something that was new, I really can't speak
23 to it.
24 MS. NEWBURY:
25 Q. So, there was some new information coming

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1 forward that you think caught the oncologists
2 and pathologists by surprise and that was the
3 literature out of Europe showing some lower
4 than expected rates of successfulness in the
5 ER/PR testing?
6 MR. TILLEY:
7 A. And I believe it was initially Heather Predham
8 who was the source of a lot of that
9 literature. So, that was my take on it.
10 MS. NEWBURY:
11 Q. And did Ms. Predham give you this literature
12 directly?
13 MR. TILLEY:
14 A. I know I had a significant amount of
15 literature that I subsequently sent on to the
16 Canadian Patient Safety Institute. I think in
17 the initial meeting she would have been just
18 speaking from notes she had taken after she
19 had read the articles.
20 MS. NEWBURY:
21 Q. Did you actually read the articles yourself?
22 MR. TILLEY:
23 A. I'd be surprised if I read the articles
24 myself. The clinical literature is extremely
25 technical and the few times over my career

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1 when I've tried to do that, I've usually
2 gotten stopped somewhere in middle of the
3 first page.
4 MS. NEWBURY:
5 Q. Okay. Do you know if any of the other
6 physicians who were involved in the response
7 to the ER/PR problem read the literature?
8 MR. TILLEY:
9 A. It was shared with them. So, I can't say
10 beyond that where it went from there.
11 MS. NEWBURY:
12 Q. Okay. And the literature, from your
13 recollection, focused on the successful or
14 concern about the success of the ER/PR
15 testing. Were there any other literature
16 searches conducted by Ms. Predham?
17 MR. TILLEY:
18 A. I'm sure there were, but I can't say what they
19 were.
20 MS. NEWBURY:
21 Q. So, the ones that are focused in your mind are
22 the ones relating to problems in successfully
23 conducting the ER/PR testing.
24 MR. TILLEY:
25 A. Right.

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1 MS. NEWBURY:
2 Q. Okay. Given that there was apparently some
3 new concerns being raised at that time about
4 the successfulness or possible concerns about
5 the test, aside from what you're finding in
6 your lab generally, was that something that
7 was ever discussed in terms of disclosing to
8 patients that, you know, we were doing a test
9 before this was thought to be reliable. Now,
10 we're having doubts about it. Not only
11 because of concerns in our own lab -
12 MR. TILLEY:
13 A. Right.
14 MS. NEWBURY:
15 Q. - but also because there seems to be some
16 general issues experienced by people even
17 outside of this province.
18 MR. TILLEY:
19 A. Um-hm. I wasn't involved in the disclosure
20 piece. So, I can't speak to say that. It
21 wouldn't surprise me if that issue had come
22 up, but again, I can't say that.
23 MS. NEWBURY:
24 Q. Were you ever privy or aware of any
25 conversations about triaging, I don't know if

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1 that's an appropriate word to use in the
2 circumstance, but from a communications
3 perspective, making a priority to communicate
4 with patients who might be--whose results for
5 their initial ER/PR testing might be more in
6 doubt than others. Was that concept ever
7 discussed, that you're aware of?
8 MR. TILLEY:
9 A. Not to my knowledge.
10 MS. NEWBURY:
11 Q. And you don't know if there was any research
12 into lab procedures, quality assurance
13 procedures, trend sin ER/PR testing itself?
14 You didn't see any of that type of literature?
15 MR. TILLEY:
16 A. Nothing comes to mind.
17 MS. NEWBURY:
18 Q. Okay. Now, I'm going to ask the Registrar to
19 bring up Exhibit P-0137, please. Now, this is
20 an e-mail that I think originated from you and
21 if you look down at the bottom part of the
22 page, your name is at the bottom and you're
23 sending this on to John Abbott. Now, if you
24 look down at the third bullet, it states that,
25 "I learned that for the specimens that we

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1 recently retested and reported as converting
2 to positive, we included in that sample, those
3 that originally reported as weak positive. It
4 would be expected that this would happen.
5 What I'm interested in are those that went
6 from negative to positive. From the
7 oncologists perspective, they don't
8 distinguish between positive and weak
9 positive". Where did you gain that
10 understanding?
11 MR. TILLEY:
12 A. That would have been through the meetings that
13 I would have attended.
14 MS. NEWBURY:
15 Q. And can you say more specifically who might
16 have told you that information?
17 MR. TILLEY:
18 A. Well, it would have been the oncologists, I
19 would have gleaned that from and, of course,
20 during the discussions, the oncologists that I
21 would have been in the presence of would have
22 been Dr. Laing, for certain, Dr. McCarthy at
23 another time. I'm not sure if I was there
24 when Dr. Ganguly was there or not.
25 MS. NEWBURY:

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1 Q. Do you have any understanding as to how
2 patients who are determined to be weak
3 positive for ER are typically treated?
4 MR. TILLEY:
5 A. No.
6 MS. NEWBURY:
7 Q. Was there ever any discussion around this
8 topic about any risk benefit analysis that
9 might be considered when a patient and an
10 oncologist is making a decision whether or not
11 to offer that patient Tamoxifen?
12 MR. TILLEY:
13 A. Um-hm.
14 MS. NEWBURY:
15 Q. Did that ever come up?
16 MR. TILLEY:
17 A. It may have, not that I recall if it did in my
18 presence, but it typically wouldn't be issues
19 that I would typically be involved in.
20 MS. NEWBURY:
21 Q. Okay. So, it may have come up, but you
22 wouldn't have paid attention.
23 MR. TILLEY:
24 A. That's correct.
25 MS. NEWBURY:

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1 Q. Now, if I can bring up Exhibit P-0046, please.
2 Now, on page four under the heading
3 "Interlaboratory Variability"--and you're
4 already answered some questions about this.
5 It states "that a number of publications
6 indicate poor concordance between laboratories
7 for ER assays especially for the weakly
8 positive cases. And this is attributed to
9 variation on antigen retrieval protocols".
10 Now, you've already indicate to Mr. Coffey
11 that you didn't understand that paragraph when
12 you read it.
13 MR. TILLEY:
14 A. Right.
15 MS. NEWBURY:
16 Q. Did you make any link at all or any connection
17 between that paragraph and your earlier e-mail
18 to Mr. Abbott?
19 MR. TILLEY:
20 A. No, because as you probably know this one was
21 a month or so later. And my e-mail to Mr.
22 Abbott would have been some time -
23 MS. NEWBURY:
24 Q. Yeah, it's about three months in the
25 difference.

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1 MR. TILLEY:
2 A. Okay. And I'm certainly not technically
3 knowledgable enough to be able to explain
4 this.
5 MS. NEWBURY:
6 Q. Okay. Now, you've talked about a concern, I
7 guess your own personal concern and you've
8 taken it nationally is the absence or lack of
9 national standards in Canada. And from time
10 to time in your evidence I note that you've
11 referred to no standards in Canada.
12 MR. TILLEY:
13 A. Yes.
14 MS. NEWBURY:
15 Q. As opposed to no national standards in Canada.
16 Is that what you intended to say? When you
17 say no standards in Canada, are you referring
18 to the absence of national standards? Or are
19 you actually suggesting that there are no
20 standards anywhere in Canada?
21 MR. TILLEY:
22 A. Well, there's not--no stand--well, it wouldn't
23 be accurate to say that there are no standards
24 in Canada.
25 MS. NEWBURY:

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1 Q. Okay.
2 MR. TILLEY:
3 A. I think a couple of facilities in recent years
4 seem to have taken this issue on with a
5 significant amount of interest and have really
6 developed it and taken out what I would
7 anticipate to be the weak elements of it.
8 When I talked to the doctor from Mount Sinai
9 whose name totally eludes me, Dr. Prit -
10 MS. NEWBURY:
11 Q. Pritzker.
12 MR. TILLEY:
13 A. - Pritzker, thank you. I apologize to that
14 gentleman. He had indicated that this issue
15 was lacking attention nationally, that there
16 needed to be a lot of attention given to it.
17 He gave Newfoundland credit for making it an
18 issue. And left me clearly with the
19 impression that there needed to be some
20 standardized approaches to this.
21 MS. NEWBURY:
22 Q. Okay. And was his concern about the lack of
23 consistency across the country in standards or
24 did he actually suggest that there are a lot
25 of labs out there that have absolutely no

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1 standards at all in terms of their ER/PR
2 testing?
3 MR. TILLEY:
4 A. I can't imagine there wouldn't be labs out
5 there that would have no standards at all.
6 MS. NEWBURY:
7 Q. Um-hm.
8 MR. TILLEY:
9 A. So, my general sense is, is that there needs
10 to be more of a national consensus reached in
11 terms of how this process should be handled.
12 MS. NEWBURY:
13 Q. And presumably, the two health organizations
14 that Eastern Health sought advice from, Mount
15 Sinai and the BC Cancer Agency, they, in your
16 view, would have standards and good standards?
17 MR. TILLEY:
18 A. Well, it was the pathologists who pointed us
19 in that direction in the first instance.
20 MS. NEWBURY:
21 Q. Which pathologist was that, sorry?
22 MR. TILLEY:
23 A. Dr. Cook made the initial contact, now whether
24 there were others that were confirming his
25 decision, I can say that in one of the

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1 contacts that I made which was with Dr. Robert
2 Bell, the chief executive officer of the
3 University Health Network in Ontario, who is
4 also an oncologist, he had recommended to me
5 that or reaffirmed, depending on how you
6 phrase it, that Mount Sinai would be a good
7 place to have the retesting completed.
8 MS. NEWBURY:
9 Q. What was your understanding of the efforts of
10 the appropriate personnel at Eastern Health
11 and its predecessor, the Health Care
12 Corporation, in this case, to see out
13 standards for hormone receptor testing between
14 1997 and 2005?
15 MR. TILLEY:
16 A. I don't have any knowledge of that.
17 MS. NEWBURY:
18 Q. Did you ask Dr. Williams or Dr. Cook or any of
19 the pathologists or technologists who might
20 have this knowledge what efforts have been
21 made over those years to ascertain what
22 standards are generally being used across the
23 country in other labs, or to conduct research
24 of literature to find out what standards might
25 be available?

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1 MR. TILLEY:
2 A. Well my expectation for the organization as a
3 whole is that we strive for excellence and
4 that I would expect any and all areas to be
5 looking to put in whatever measures are seen
6 to be appropriate to ensure a high quality of
7 service. I had lots of discussions with Drs.
8 Cook and Williams. I think they'll be better
9 able to answer that question.
10 MS. NEWBURY:
11 Q. But did you discuss that with him at the time?
12 MR. TILLEY:
13 A. I don't recall having that specific
14 discussion.
15 MS. NEWBURY:
16 Q. Now on the same exhibit, on the same page,
17 under "Conclusions about the reasons for test
18 failure" and you've been shown this, I think,
19 several times now. Number one "Is the DAKO
20 system faulty? This is unlikely as there are
21 many laboratories using the DAKO system
22 successfully. The reason for test failure was
23 most likely due to a lack of test
24 optimization, including antigen retrieval
25 method and antibody detection system titration

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1 as positive controls showed weak staining in
2 general and internal controls failed in all of
3 the false negative cases." Now in light of
4 that comment and I understand that you read
5 this report sometime in the fall of 2005 -
6 MR. TILLEY:
7 A. Uh-hm.
8 MS. NEWBURY:
9 Q. When you read that, did you think, well maybe
10 we should check to see what other labs have
11 been doing across the country? They seem to
12 have been successfully using the DAKO
13 equipment.
14 MR. TILLEY:
15 A. Uh-hm. Well, I certainly didn't get into it
16 in that level of detail. I do remember being
17 given an indication that the lab in St. John's
18 was considered to be in the middle of a pack
19 in the country, which, I guess, I took some
20 comfort in, but not total comfort. And to the
21 end, to the extent that that was something
22 that was particular to the lab, then I would
23 have expected the lab people to be looking at
24 that issue.
25 MS. NEWBURY:

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1 Q. And the middle of the pack comment, you've
2 referred to it before, was that told to you
3 directly by an external physician?
4 MR. TILLEY:
5 A. No, it wasn't because I didn't meet any of
6 them during the reviews, it would have been
7 information that would have been passed on to
8 me based upon what had been passed on to them.
9 MS. NEWBURY:
10 Q. And who had passed that information on to you?
11 MR. TILLEY:
12 A. I'm assuming it would either have been Drs.
13 Williams or Cook.
14 MS. NEWBURY:
15 Q. And did they say who gave them that
16 information?
17 MR. TILLEY:
18 A. I'm sure they must have, but I don't recall at
19 the moment.
20 MS. NEWBURY:
21 Q. Is it one or the other, Dr. Banerjee or Ms.
22 Wegrynowski?
23 MR. TILLEY:
24 A. I'm assuming so, yes.
25 MS. NEWBURY:

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1 Q. So, you're not aware--I wouldn't expect you to
2 conduct any, sort of, research into this, but
3 did you make an effort to find out or suggest
4 or ensure that someone else did a survey to
5 find out what else is going on across the
6 country at any point in time, not necessarily
7 connected -
8 MR. TILLEY:
9 A. Well, I know that Dr. Cook, in particular, was
10 making calls to many of his contacts
11 throughout the country. He had also been
12 involved in the Canadian Pathologists
13 Association where a lot of his peers was
14 represented. And I have a sense that there's
15 been a lot of discussion going on since then
16 about this.
17 MS. NEWBURY:
18 Q. Would that be sort of informal discussion
19 conferring with colleagues or would there be
20 any sort of formal documentation about that
21 type of contact?
22 MR. TILLEY:
23 A. Well, both. I know that he had discussions,
24 but I also was, I think we've seen here and in
25 the evidence, a letter that Dr. Cook had

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1 written to the Canadian Pathology Association
2 and the reason I remember it is because in it
3 he says, I've been asked by the CEO to ask the
4 Canadian Pathology Association to look into
5 this.
6 MS. NEWBURY:
7 Q. Okay. Now, that's relaying concerns that he
8 has triggered by the problem at Eastern
9 Health, but I'm wondering if there was a more
10 direct seeking out of information from other
11 labs to see what they have been doing. And we
12 can ask him that directly, I'm just wondering
13 if you happen to be aware of -
14 MR. TILLEY:
15 A. In my mind I know that there's been contact
16 made with labs throughout the country on
17 various points of issue. I can't tell you
18 who, within the organization had done that,
19 nor what the list of issues were, but there
20 has been some contact with those labs.
21 MS. NEWBURY:
22 Q. Okay. I'd like to turn to Exhibit P-0075,
23 please? This is a briefing note that was
24 prepared by Eastern Health for the minister.
25 You see in the top right-hand corner there's a

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1 note there, "Meet with minister July 21st,
2 2005." So this is in the initial stages. And
3 I think on the bottom there's a date,
4 "Prepared July 20th, 2005."
5 MR. TILLEY:
6 A. Okay.
7 MS. NEWBURY:
8 Q. On page 3, second paragraph there's a note,
9 "Extra resources have been identified within
10 the Health Care Corporation of St. John's lab
11 to undertake identification and retesting.
12 The list of" all patients-- or "the lost of
13 patients will be double checked with the names
14 on the Cancer Registry to insure none have
15 been missed." And I want to show you another
16 exhibit now, keeping that one in mind, P-0785,
17 please? Now, you may not be aware of this e-
18 mail here, it was sent from Heather Predham to
19 Pamela King-Jesso, Deanne Emberley and David
20 McCormack. And scroll down a bit. Actually,
21 it was sent, as well, the original message
22 sent to Dr. Williams, Dr. Cook, Terry Gulliver
23 and Patricia Pilgrim. And under the heading
24 "Database" it says, "I've got the lab database
25 and NCRTF database combined, but I still have

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1 issues to clarify. There are data quality
2 issues such as people with the same name and
3 address and different MCP numbers and people
4 with different names and addresses but with
5 the same MCP numbers, or the same MCPs. Also,
6 there are a lot of individuals with incomplete
7 MCP numbers. I'll work on that today. There
8 are a couple of issues that came to light
9 during this process. We haven't discussed the
10 process for informing or providing hotline
11 services." The next bullet I'll skip. The
12 third bullet, "Rough numbers from the combined
13 database show 4510 people overall. The cancer
14 registry does not identify almost 2100 of
15 individuals who had ER/PR testing." The next
16 bullet, "Current status: Living or deceased is
17 only identified in 1245 of those people. It's
18 going to be difficult to determine this for
19 the rest of the individuals." The next
20 bullet, "ER/PR status is indicated in 1230
21 people with an overall ER positivity rate of
22 55 percent." Were you aware of these apparent
23 deficiencies in the information contained in
24 the Cancer Registry?
25 MR. TILLEY:

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1 A. Not specifically, though I do know that they
2 were having real challenges in terms of
3 getting accurate addresses and pulling out the
4 names, so they were working diligently to try
5 to resolve them.
6 MS. NEWBURY:
7 Q. Okay. And were you made aware of those
8 positivity rates there that are indicated on
9 the next bullet, which I didn't read, "Overall
10 ER positivity by year, and remember this is
11 rough, it's 2003, 61 percent; 2002, 48
12 percent; and 2001, 46 percent. The Cancer
13 Registry only indicates P and N, not
14 percentage." Were you ever made aware of that
15 information?
16 MR. TILLEY:
17 A. I don't recall seeing that piece.
18 MS. NEWBURY:
19 Q. Okay. But aside from being--seeing the actual
20 e-mail itself, did anyone ever relay that
21 information to you?
22 MR. TILLEY:
23 A. I know I did see a chart broken down by year
24 which showed positivity rates. I don't recall
25 2003 showing 61, though. So I'm not sure if

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1 that's an earlier or a later figure.
2 MS. NEWBURY:
3 Q. Yeah, this is dated, the e-mail, if this helps
4 you at all, is dated August the 8th, 2005. So
5 this is right around the time, I think, that
6 you had paused because -
7 MR. TILLEY:
8 A. Right. That would be around the time -
9 MS. NEWBURY:
10 Q. - possible overcalling of the Ventana and also
11 the comfort that you seemed to be getting
12 about your positivity rates?
13 MR. TILLEY:
14 A. Right. Well, it says, "Remember the number is
15 rough," so I'm not sure if they drew on two
16 different sources.
17 MS. NEWBURY:
18 Q. Right.
19 MR. TILLEY:
20 A. But, I'm sorry, just go back to your original
21 question, did I -
22 MS. NEWBURY:
23 Q. I'm just wondering if you were made aware of
24 that specific set of data about the positivity
25 rates?

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1 MR. TILLEY:
2 A. Well, I certainly saw positivity rates for
3 years around that time.
4 MS. NEWBURY:
5 Q. Okay. But this is not the information that
6 you saw, this would not give you any comfort
7 if you'd known this?
8 MR. TILLEY:
9 A. No.
10 MS. NEWBURY:
11 Q. If you had any reason to believe this was
12 reliable, you would not take any comfort from
13 those positivity rates, I take it?
14 MR. TILLEY:
15 A. No, that was without--outside of the range.
16 MS. NEWBURY:
17 Q. Yeah. I wonder if I could refer to Exhibit P-
18 0786, please? If I could go to page 24 of
19 that, please?
20 REGISTRAR:
21 Q. Twenty-four?
22 MS. NEWBURY:
23 Q. Yes, please. Now this document is the
24 Canadian Cancer Statistics published in the
25 year 2005. And I think we might be off by a

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1 page.
2 MR. TILLEY:
3 A. I'm sorry, this was 2005, annual publication -
4 MS. NEWBURY:
5 Q. I'm going to go back to the front page and
6 show you that.
7 MR. TILLEY:
8 A. Okay. All right, sorry.
9 MS. NEWBURY:
10 Q. Let you see what that is.
11 MR. TILLEY:
12 A. Yeah.
13 MS. NEWBURY:
14 Q. So the Canadian Cancer Statistics for the year
15 2005.
16 MR. TILLEY:
17 A. Um-hm.
18 MS. NEWBURY:
19 Q. And you can see a number of contributors up at
20 the top, Canadian Cancer Society, the National
21 Cancer Institute of Canada, Public Health
22 Agency of Canada and Statistics Canada. Have
23 page--try 25, please? On the next page, 26 of
24 the exhibit on the top right-hand page, this
25 is under a heading called "Geographic Patterns

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1 of Cancer Occurrence." And it indicates there
2 that "There are differences in the reporting
3 procedures used in cancer registration.
4 Example, registration of secondary and primary
5 cancers and use of death certificates. See
6 Appendix 2 regarding the Cancer Registry
7 methodology. For example, death certificate
8 information has not been available for
9 registry purposes in Newfoundland until now
10 and this falsely lowers the number of incident
11 cases with short life expectancy such as cases
12 of lung and pancreatic cancer." Were you
13 aware of that information?
14 MR. TILLEY:
15 A. No.
16 MS. NEWBURY:
17 Q. Okay. If I can go to page, try 96? I think
18 I'm off by a couple of pages here in my notes.
19 And actually, I'm going to refer you to page
20 98 on the top page, and that's the Appendix 2
21 that had just been referenced on -
22 MR. TILLEY:
23 A. Okay.
24 MS. NEWBURY:
25 Q. - page 25. It says, "For all cancers, even

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1 those with poor survival, such as pancreas and
2 lung, the annual number of incident cases is
3 expected to be similar to or larger than the
4 number of deaths. However, there are
5 situations in which the number of deaths,
6 either observed or projected, is larger than
7 the corresponding number of new cases. In the
8 case of Newfoundland and Labrador this is
9 caused by the Registry not receiving
10 information on death certificates that mention
11 cancer. This results in an underestimate of
12 the number of cases for the years used to
13 generate the estimates. Once the Newfoundland
14 Registry begins receiving information in order
15 to register these cases, the difference will
16 disappear. Deaths may correspond to cases
17 diagnosed in previous years so year-to-year
18 variation is also a factor for rare cancer
19 sites." Now, there are other publications
20 here and I can go through them with you, but
21 there's similar information in the following
22 years, 2006, 2007 and 2008, and basically
23 suggesting that the issue that's been pointed
24 out here with the Cancer Registry and death
25 certificates has not yet been rectified. Was

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1 that ever brought to your attention at all?
2 MR. TILLEY:
3 A. No.
4 MS. NEWBURY:
5 Q. Okay. And are you aware that Eastern Health
6 is responsible for the Cancer Registry?
7 MR. TILLEY:
8 A. Eastern Health took over the Cancer Foundation
9 in 2005.
10 MS. NEWBURY:
11 Q. Okay. So as part of its restructuring it then
12 assumed responsibility?
13 MR. TILLEY:
14 A. Right.
15 MS. NEWBURY:
16 Q. So the foundation would not have been a part
17 of Health Care Corporation of St. John's
18 previously?
19 MR. TILLEY:
20 A. No.
21 MS. NEWBURY:
22 Q. Okay. So it assumed that commencing at the
23 same moment that Eastern Health came into
24 being?
25 MR. TILLEY:

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1 A. Yes.
2 MS. NEWBURY:
3 Q. Okay. And who at Eastern Health is
4 responsible for management of that, in -
5 MR. TILLEY:
6 A. Of the registry?
7 MS. NEWBURY:
8 Q. Yeah. Starting at, you know, the highest
9 level?
10 MR. TILLEY:
11 A. Well, the CEO.
12 MS. NEWBURY:
13 Q. Right. Next to that?
14 MR. TILLEY:
15 A. Vice president--sorry, chief operating officer
16 would be Ms. Pilgrim and the director of
17 cancer care would be Mrs. Smith.
18 MS. NEWBURY:
19 Q. Okay. Would you have expected to be alerted
20 to an issue such as this?
21 MR. TILLEY:
22 A. No. I would have expected the individual
23 areas to be following up on any recommended
24 deficiencies.
25 MS. NEWBURY:

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1 Q. Now you had spoken a little bit about board
2 governance. And it was your evidence, as I
3 understand it, that Eastern Health has a
4 policy governance model?
5 MR. TILLEY:
6 A. Well, it was hoping to work towards a policy
7 governance model and that work was under way.
8 MS. NEWBURY:
9 Q. Okay. And generally speaking, at the time
10 that you were CEO of the organization, would
11 there ever be circumstances where the board of
12 trustees would intervene to give direction or
13 to otherwise get itself involved in an
14 operational matter?
15 MR. TILLEY:
16 A. Well, the board up until my departure was two
17 years old.
18 MS. NEWBURY:
19 Q. Um-hm.
20 MR. TILLEY:
21 A. It was learning as much as governing. So
22 there were times that it may have made
23 suggestions, but the board made every effort
24 to try to stay focused in on the broader
25 picture issues.

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1 MS. NEWBURY:
2 Q. But would there ever be a circumstance where
3 an operational issue is of such significance
4 or magnitude that, you know, once the policy
5 governance is fully in place you still would
6 feel it necessary as a board under that model
7 to get involved or is it completely off
8 limits?
9 MR. TILLEY:
10 A. Yes, I certainly would not see policy
11 governance limiting that in key issues.
12 MS. NEWBURY:
13 Q. Okay. And was there ever any criteria
14 developed to ascertain when it might be
15 appropriate for the board to engage -
16 MR. TILLEY:
17 A. It hadn't been advanced that far.
18 MS. NEWBURY:
19 Q. Okay. Still part of the learning process?
20 MR. TILLEY:
21 A. I suspect so.
22 MS. NEWBURY:
23 Q. And do you have any thoughts on what would be
24 appropriate criteria for that?
25 MR. TILLEY:

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1 A. Well, I think from time to time, but not
2 regularly, there are obviously very
3 significant issues that an organization will
4 face and the CEO needs to insure that the
5 board is apprised of some of those issues
6 probably in more detail that it would any
7 other issue it would be dealing with and once
8 you do that, you engage into discussions. I
9 think all of the board members have learned to
10 respect the policy governance approach, but I
11 think as a part of the more discussion you
12 have, you're going to anticipate that people
13 will want to have--make a greater contribution
14 in whether it's just their views or in
15 recommendations as to things, how they should
16 be followed up on. I'd have to say I'd have
17 to look at it more on a one-on-one case than
18 to say that there's certain guidelines that
19 may be put in place that there's one size fits
20 all.
21 MS. NEWBURY:
22 Q. Okay. I actually have a new area of
23 questions, if you -
24 COMMISSIONER:
25 Q. We'll take the morning break before you move

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1 on to that. We'll take 15 minutes.
2 (RECESS)
3 COMMISSIONER:
4 Q. Ms. Newbury.
5 MS. NEWBURY:
6 Q. Thank you. Mr. Tilley, you've mentioned a few
7 times the term blameless culture and
8 blameless-culture approach. And I wonder if
9 you can just explain for me what that means?
10 MR. TILLEY:
11 A. Well, the first contact that I came into or
12 the first time that I came into contact with
13 that word was through my involvement with the
14 Canadian Patient Safety Institute.
15 MS. NEWBURY:
16 Q. You'd never heard of that before?
17 MR. TILLEY:
18 A. It may have come up, but it certainly didn't
19 stick to my agenda until it reached that
20 point. The whole issue of the Canadian
21 Patient Safety Institute came about because of
22 the research that had been done about adverse
23 events within health care organizations and
24 confirmation that the number of events were
25 certainly far greater than what was seen in

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1 terms of what was being reported. So, not
2 sure if I can say this is solely a Canadian
3 issue, because I suspect it's much larger than
4 that because the U.S. in particular had been
5 further advanced in the Canadian patient
6 safety movement. But the premise is, is that
7 if you can create an environment where staff
8 feel comfortable coming forward and saying, "I
9 believe I just made a mistake" that a number
10 of positive things can happen. One, there is
11 a potential that you can correct the mistake.
12 Secondly, you avoid the potential of the
13 mistake not being disclosed. Thirdly, you
14 have the potential of learning from that
15 mistake, because people don't feel threatened
16 if, in fact, they come forward and acknowledge
17 that, that they will all of a sudden be
18 looking for work elsewhere or that their
19 reputation may have been destroyed. The
20 experience in the few health professionals
21 that I have been involved in is such that
22 anybody who has gone through an adverse event,
23 I believe is much more astute in terms of
24 looking out for those potential adverse events
25 on a go-forward basis. So it is something

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1 that one never forgets and will certainly
2 learn from.
3 MS. NEWBURY:
4 Q. Now, I think you'd indicated yesterday you
5 weren't exactly sure when you became a board
6 member with the Canadian Patient Safety
7 Institute. And perhaps you can refer to your
8 curriculum vitae at P-0315, please? There it
9 shows--there we go, on page 5 at the top it
10 says, "Canadian Patient Safety Institute,
11 founding board member, 2003-2006."
12 MR. TILLEY:
13 A. Yes.
14 MS. NEWBURY:
15 Q. Okay. Now, so this board came into existence
16 in 2003?
17 MR. TILLEY:
18 A. That's correct.
19 MS. NEWBURY:
20 Q. Did the Canadian Patient Safety Institute
21 evolve out of some other organization or was
22 this a brand new organization?
23 MR. TILLEY:
24 A. It was a brand new organization.
25 MS. NEWBURY:

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1 Q. Now, when was the blameless-culture approach
2 adopted at either Eastern Health or Health
3 Care Corporation of St. John's?
4 MR. TILLEY:
5 A. I can't say there was a definitive time, but
6 it was an evolving issue. I remember there
7 were certain cases that we were dealing with.
8 There were one, like, single employee cases.
9 MS. NEWBURY:
10 Q. Um-hm.
11 MR. TILLEY:
12 A. That we would talk about. The traditional
13 response was to take a disciplinary action.
14 MS. NEWBURY:
15 Q. Um-hm.
16 MR. TILLEY:
17 A. But we started to change it and look at it as
18 more of how do we insure that this doesn't
19 happen again approach.
20 MS. NEWBURY:
21 Q. Okay. So would that be at about the same time
22 that you got involved with the CPSI board?
23 MR. TILLEY:
24 A. I wouldn't put it down to 2003, but by
25 certainly towards the end of my time on that

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1 board we were talking more about it. And by
2 this time Canadian Patient Safety Institute
3 was advocating a blameless culture throughout
4 the system and you'll find other organizations
5 have really started speaking about that more
6 frequently.
7 MS. NEWBURY:
8 Q. Um-hm. By, say, July of 2005, had the
9 blameless-culture approach gained any
10 credibility or was that being relied upon in
11 Eastern Health as a potential method of
12 responding?
13 MR. TILLEY:
14 A. Well, it certainly was an issue that was in my
15 mind in terms of how this thing was going to--
16 or as this issue was unfolding.
17 MS. NEWBURY:
18 Q. So by the time you had to respond as an
19 organization to the ER/PR issue, you were
20 already looking towards responding through the
21 blameless culture -
22 MR. TILLEY:
23 A. That's correct.
24 MS. NEWBURY:
25 Q. And would you consider that the adoption of

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1 the blameless-culture approach to be a
2 fundamental shift in philosophy or functioning
3 or culture of a health organization such as
4 Eastern Health?
5 MR. TILLEY:
6 A. I think that would be correct to say.
7 MS. NEWBURY:
8 Q. Okay. And I wonder if you can go into a
9 little bit more detail as to how the approach
10 would achieve the goal of patient safety?
11 You've indicated generally how that would
12 work.
13 MR. TILLEY:
14 A. Well, first of all, because if somebody is
15 willing to disclose immediately that they
16 participated in an adverse event, maybe it was
17 an over injection of a medication, then they
18 could draw upon the help of colleagues to see
19 if there was a ready solution to mitigate
20 against any potential damage, so that would
21 certainly be one thing.
22 MS. NEWBURY:
23 Q. And that's for that particular patient at that
24 particular time?
25 MR. TILLEY:

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1 A. That's correct.
2 MS. NEWBURY:
3 Q. Right. I assume after this is reported we can
4 look at is there any sort of particular course
5 of treatment that we would now engaged in to
6 correct the problem?
7 MR. TILLEY:
8 A. Right. An antidote or something of that
9 nature.
10 MS. NEWBURY:
11 Q. Sure.
12 MR. TILLEY:
13 A. Then it's a question of disclosing it to be
14 familiar with it so that we could learn from
15 it. The potential that that could be--the
16 potential of that reoccurring could be
17 minimized if, in fact, we were able to see
18 that it was something that an extra control or
19 an extra person might, in fact, been able to
20 avoid that in the long term.
21 MS. NEWBURY:
22 Q. Okay.
23 MR. TILLEY:
24 A. So that was certainly a part of it. When you
25 push a patient-safety culture, you got to have

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1 the support of staff to be participating in
2 this. And how you are seen in terms of
3 whether you support your staff or not will in
4 the main influence the degree to which they
5 are committed to it.
6 MS. NEWBURY:
7 Q. And the people that are to learn from the
8 reporting of an adverse event, that would
9 include the staff or medical health care
10 workers involved in that particular incident.
11 Would it go beyond those particular
12 individuals?
13 MR. TILLEY:
14 A. That would certainly be the intent.
15 MS. NEWBURY:
16 Q. Okay. Would it go throughout the entire
17 organization?
18 MR. TILLEY:
19 A. There were newsletters that the quality
20 initiatives department in Eastern Health sent
21 out from time to time talking about adverse
22 events either that had gone on in the
23 organization or that they had picked up from
24 other organizations to signal things that were
25 known to be problematic, therefore encouraging

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1 them to look out for.
2 MS. NEWBURY:
3 Q. And would you, in fact, go even further and
4 share your learnings with other regional
5 health authorities or perhaps other health
6 care organizations throughout Canada?
7 MR. TILLEY:
8 A. There is certainly an openness to doing that,
9 yes.
10 MS. NEWBURY:
11 Q. Was there ever a newsletter produced by the
12 quality initiatives department relating to the
13 ER/PR?
14 MR. TILLEY:
15 A. I'm not aware of one.
16 MS. NEWBURY:
17 Q. Now, are there any formal procedures there for
18 the reporting to insure that the goal of the
19 patient safety is actually met, are there
20 formal procedures in place?
21 MR. TILLEY:
22 A. I would expect there to be, but I'm not at a
23 level to be able to give you any details
24 around it.
25 MS. NEWBURY:

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1 Q. Did you, at the time that you were involved in
2 the ER/PR issue and the response to that
3 event, you would consider that to be an
4 adverse event, I take it?
5 MR. TILLEY:
6 A. Yes.
7 MS. NEWBURY:
8 Q. Did you see any signs of there being a formal
9 procedure in place consistent with the
10 blameless-culture approach?
11 MR. TILLEY:
12 A. A formal procedure which would -
13 MS. NEWBURY:
14 Q. Any sort of mechanisms, is there a formal, do
15 you keep a binder with all of your adverse
16 events, the reports of that -
17 MR. TILLEY:
18 A. Yes, there's -
19 MS. NEWBURY:
20 Q. - and your analysis of those events?
21 MR. TILLEY:
22 A. Right. Well, the organization has an
23 occurrence reporting process so that any
24 adverse events or potential adverse events is
25 logged and maintained and trended and

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1 reviewed, analyzed in terms of follow up.
2 This particular one was of such a magnitude
3 I'm not sure if it would have fitted nicely
4 into an adverse--sorry, into an occurrence
5 reporting form.
6 MS. NEWBURY:
7 Q. Um-hm.
8 MR. TILLEY:
9 A. But there was certainly a process for the
10 logging and follow up of that.
11 MS. NEWBURY:
12 Q. Okay. Why would you not find some way to
13 modify this to have an occurrence reporting
14 form?
15 MR. TILLEY:
16 A. The amount of--maybe there is one. I really
17 can't be saying with assurance. But there is
18 mounds of information on the ER/PR and I
19 suspect that that would probably be a fairly
20 complete document.
21 MS. NEWBURY:
22 Q. Can you think of anything specifically in your
23 mind that would constitute such a complete
24 document? I know there's lots of
25 documentation around, but I wonder if you can

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1 focus me on a particular document that you
2 would consider to be the formal response to
3 the particular occurrence?
4 MR. TILLEY:
5 A. No, I can't.
6 MS. NEWBURY:
7 Q. Okay. I'd like to refer to Exhibit P-0161,
8 please? Now these are the Canadian Patient--
9 or Canadian Disclosure Guidelines.
10 MR. TILLEY:
11 A. Yes.
12 MS. NEWBURY:
13 Q. I take it you're familiar with these?
14 MR. TILLEY:
15 A. I am vaguely familiar with them, yes.
16 MS. NEWBURY:
17 Q. Okay. Now, I understand that these came out
18 in 2008?
19 MR. TILLEY:
20 A. Um-hm.
21 MS. NEWBURY:
22 Q. And it's the Canadian Patient Safety
23 Institute. So they weren't in place at the
24 time you were on the board, nor were they in
25 place at the time you were CEO of Eastern

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1 Health.
2 MR. TILLEY:
3 A. Right.
4 MS. NEWBURY:
5 Q. But were you involved in some of the
6 preparatory work?
7 MR. TILLEY:
8 A. I certainly knew that this process was under
9 way, that there was a major consultation of
10 stakeholders throughout Canada.
11 MS. NEWBURY:
12 Q. Okay. I wonder if we can turn to page 30 of
13 that exhibit, please? Now, this is an
14 appendix with a number of terms, glossary of
15 terms.
16 MR. TILLEY:
17 A. Um-hm.
18 MS. NEWBURY:
19 Q. Defined. And I just want to refer you to a
20 couple. Number one, at the top of the page,
21 "Adverse event is an event which results in
22 unintended harm to the patient and is related
23 to the care and/or services provided to the
24 patient rather than to the patient's
25 underlying medical condition." And is that a

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1 term that was your understanding of the
2 meaning of adverse event during 2005, 2006,
3 2007?
4 MR. TILLEY:
5 A. Well, there's been a lot of definitions of an
6 adverse event, but generally speaking there's
7 a tendency to try to adopt one that's
8 nationally recognized and this would certainly
9 fall into that category.
10 MS. NEWBURY:
11 Q. But is that essentially the--your
12 understanding of what an adverse event would
13 be back in 2005 -
14 MR. TILLEY:
15 A. Yes.
16 MS. NEWBURY:
17 Q. - 2006, 2007, okay. There's also a reference
18 there to root cause analysis.
19 MR. TILLEY:
20 A. Um-hm.
21 MS. NEWBURY:
22 Q. And it says "It's an analytic tool that can be
23 used to perform a comprehensive system based
24 review of critical incidents. It includes the
25 identification of the root and contributory

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1 factors, identification of risk reduction
2 strategies and development of action plans
3 along with measurement strategies to evaluate
4 the effectiveness of the plans." Now, is that
5 something, a root cause analysis, was that a
6 term that had been discussed, known, talked
7 about by you or anyone else within Eastern
8 Health from 2005 to 2006?
9 MR. TILLEY:
10 A. I've heard of root cause analysis in a number
11 of areas. Certainly the Canadian Patient
12 Safety Institute were offering educational
13 programs for individuals who could undertake
14 such reviews. I know internal to Eastern
15 Health, it's been referenced on a couple of
16 occasions, but I can't say if it was
17 referenced specifically related to ER/PR.
18 MS. NEWBURY:
19 Q. Okay, but you were aware of this as being a
20 tool?
21 MR. TILLEY:
22 A. Yes.
23 MS. NEWBURY:
24 Q. At the time, 2005, 2006, 2007?
25 MR. TILLEY:

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1 A. I certainly would have known it somewhere in
2 that time frame.
3 MS. NEWBURY:
4 Q. Okay. Now would you say that a root cause
5 analysis is an important tool when dealing
6 with an adverse event?
7 MR. TILLEY:
8 A. Well, it's one of a number of tools that one
9 would use. This is one that the Canadian
10 Patient Safety Institute had sort of adopted
11 and agreed to provide education on, but it's
12 not the only tool.
13 MS. NEWBURY:
14 Q. Okay, so this is a tool endorsed by or
15 promoted by the Canadian Patient Safety
16 Institute. Do they promote other tools as
17 well?
18 MR. TILLEY:
19 A. They typically offer educational programs to
20 talk about how do you analyze adverse events.
21 I suspect they would put in that one as their
22 prime one, but there's always advocates for
23 other approaches, but I suspect this is the
24 one that they espouse mostly.
25 MS. NEWBURY:

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1 Q. And is this generally, you know, from your
2 understanding of how other health
3 organizations operate, would this be a popular
4 or a typical method of dealing with an adverse
5 event?
6 MR. TILLEY:
7 A. It certainly is one that's growing in terms of
8 use.
9 MS. NEWBURY:
10 Q. Okay, and if a Root Cause Analysis were not to
11 be utilized in a response to an adverse event,
12 is there another type of typical investigation
13 that might occur?
14 MR. TILLEY:
15 A. Yes, there could be, but the names elude me
16 now. There's some sort of decision tree
17 process or fish bone technique, but I'm not
18 conversant enough to be able to give you any
19 more details on that.
20 THE COMMISSIONER:
21 Q. Does the procedure adopted in this case,
22 within the organization, to analyze the event
23 fall into any of those?
24 MR. TILLEY:
25 A. I couldn't answer that, Madam Commissioner.

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1 THE COMMISSIONER:
2 Q. All right, thank you.
3 MS. NEWBURY:
4 Q. And you aren't able to comment, are you, on
5 the criteria to determine whether a root cause
6 analysis might be used in the circumstance
7 versus some other type of tool that you
8 mentioned?
9 MR. TILLEY:
10 A. No, I'm really not familiar enough with it.
11 MS. NEWBURY:
12 Q. Okay. Would you say it's important that one
13 of those tools--I know you can't get into
14 detail there, but would you say it's important
15 for a root cause analysis or the decision tree
16 process or some other type of investigation be
17 used in response to an adverse event?
18 MR. TILLEY:
19 A. Yes.
20 MS. NEWBURY:
21 Q. And failing that, if such an analysis or
22 investigation doesn't take place, how would or
23 how could a patient population benefit from
24 the blameless culture approach?
25 MR. TILLEY:

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1 A. Well, in this case, of course, peer review
2 processes were used. So you brought in
3 experts in those areas to make those
4 investigations.
5 MS. NEWBURY:
6 Q. Okay, and the peer review process would be a
7 substitute, in your view, for the--that's the
8 external review reports of Dr. Banerjee -
9 MR. TILLEY:
10 A. Yes, right.
11 MS. NEWBURY:
12 Q. - and Ms. Wegrynowski?
13 MR. TILLEY:
14 A. Right.
15 MS. NEWBURY:
16 Q. Okay, and that to you would be an appropriate
17 substitute?
18 MR. TILLEY:
19 A. It certainly would be a mechanism in place to
20 help identify what could potentially be a
21 problem here and what potential improvement
22 opportunities there might be.
23 MS. NEWBURY:
24 Q. Now prior to adopting this new blameless
25 culture approach, was there any consultation

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1 with any stakeholders about the advisability
2 of taking on such an approach, or the
3 framework, looking for feedback or providing
4 information, and some of the stakeholders that
5 I'm thinking about, and I'll go through them
6 one by one, Board of Trustees, number one, was
7 there any consultation with the Board of
8 Trustees?
9 MR. TILLEY:
10 A. Well, the Board Chair and I, the Vice-
11 President of Medical and the chief operating
12 officer overseeing quality did partake in a
13 regional atlantic conference organized by CPSI
14 and clearly one of the issues that was
15 referenced was the blameless culture. Having
16 said that, the Board has not been, to my
17 knowledge, since I was there at least,
18 adopting any formal policy, nor did we talk
19 about whether it was at the stage where the
20 Board needed to adopt a policy. It certainly
21 was something that was actively talked amongst
22 the executive team, the quality initiatives
23 department and the human resources department,
24 and any time that I would speak to patient
25 safety in the organization, I would reference

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1 that as a dimension of it.
2 MS. NEWBURY:
3 Q. Okay. But were you informing these different
4 groups about it after essentially the
5 blameless culture approach had been adopted or
6 did you seek feedback and input from them
7 prior to that approach being adopted?
8 MR. TILLEY:
9 A. No, it was more saying this is the direction
10 we're heading into.
11 MS. NEWBURY:
12 Q. Okay. Was there any consultation with other
13 regional health authorities, keeping in mind
14 that Eastern Health does provide some tertiary
15 care services for other authorities?
16 MR. TILLEY:
17 A. No, that issue would be one that would be
18 specific to each organization, so I know that
19 those CEOs also participated in this, but I
20 can't really speak on their behalf.
21 MS. NEWBURY:
22 Q. I'm not asking whether or not they were going
23 to be putting in the same sort of approach.
24 MR. TILLEY:
25 A. Okay.

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1 MS. NEWBURY:
2 Q. But the fact that you're now adopting or
3 planning to adopt a blameless culture
4 approach, you provide tertiary care services
5 to other regional health authorities. Did you
6 seek feedback--say, if these other regional
7 health authorities want to stick with a
8 traditional approach, did you seek feedback
9 from them as to how you can integrate the two
10 different approaches, given that Eastern
11 Health does provide tertiary care services?
12 MR. TILLEY:
13 A. I don't recall, no.
14 MS. NEWBURY:
15 Q. Was there any consultation with the Department
16 of Health, Minister of Health or other
17 officials?
18 MR. TILLEY:
19 A. Not that I'm directly aware of, though the
20 Department of Health had a quality committee
21 and, from Eastern Health's perspective, the
22 director of quality initiatives, Pamela
23 Elliott, was the representative. So it may be
24 an opportunity there to get some insight as to
25 how far that item was discussed.

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1 MS. NEWBURY:
2 Q. You're not aware personally of any
3 consultation with the Department of Health?
4 MR. TILLEY:
5 A. No.
6 MS. NEWBURY:
7 Q. They might have been aware of the concept
8 generally through other means, but you're not
9 aware whether there was a specific
10 consultation by Eastern Health?
11 MR. TILLEY:
12 A. No, I'm not aware, other than you might want
13 to refer to that committee and it might help
14 you there.
15 MS. NEWBURY:
16 Q. Sure, she might have some other independent
17 knowledge of that.
18 MR. TILLEY:
19 A. Right.
20 MS. NEWBURY:
21 Q. But just in terms of the fact that Eastern
22 Health is going to go down this new road, you
23 know -
24 MR. TILLEY:
25 A. Yes.

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1 MS. NEWBURY:
2 Q. - just to alert someone at the Department of
3 Health that this is happening and look for
4 their specific input into, you know, how the
5 approach might be handled.
6 MR. TILLEY:
7 A. Yeah.
8 MS. NEWBURY:
9 Q. Was there any consultation with any advocacy
10 groups?
11 MR. TILLEY:
12 A. No, not at the provincial level. Of course,
13 on the national level, there were advocacy
14 groups that were connected to the Canadian
15 Patient Safety Institute and I believe that
16 there was a general concurrence for the value
17 of this direction.
18 MS. NEWBURY:
19 Q. And was there any input into, not just, you
20 know, is this a good idea or not, but how do
21 we go about implementing this? What types of
22 things do we have to keep in mind, given the
23 particular concerns or structure of Eastern
24 Health as an organization? Did you get down
25 into that detail?

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1 MR. TILLEY:
2 A. Well, there would have certainly been
3 discussions between the quality department and
4 the human resources department, because I
5 remember there were some cases in particular
6 where they had to talk through how this was
7 going to be handled.
8 MS. NEWBURY:
9 Q. But you didn't seek any input from advocacy
10 groups, you know, by Eastern Health to say
11 "listen, we're planning to go down this new
12 road. We want you, as an advocacy group, you
13 interact with patients. You're aware of some
14 particular concerns there. We would invite
15 your input, because if this is going to work,
16 we want to engage all of the stakeholders
17 here," as opposed to just saying, here it is.
18 MR. TILLEY:
19 A. I understand, and not at the provincial level,
20 no.
21 MS. NEWBURY:
22 Q. Okay, and how about the NLMA, College of
23 Physicians and Surgeons, other professional
24 organizations or other licensing bodies?
25 MR. TILLEY:

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1 A. No. Now on the Board of the Canadian Patient
2 Safety Institute, there would have been
3 representative of some of those organizations,
4 so in any discussions that I've had with any
5 of those groups, there never seemed to be
6 anybody that was out of sync with that
7 direction.
8 MS. NEWBURY:
9 Q. Okay, and that would be sort of the philosophy
10 of it, is this a good way to go, more so than
11 how do we actually implement this for our
12 particular organization?
13 MR. TILLEY:
14 A. Yes.
15 MS. NEWBURY:
16 Q. Because I assume that different organizations
17 might have different challenges in how this
18 would get rolled out in an organization.
19 MR. TILLEY:
20 A. That's possible.
21 MS. NEWBURY:
22 Q. And how about any consultation with patients
23 or patient groups?
24 MR. TILLEY:
25 A. Same as the advocacy groups. I'm not aware of

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1 anything at the provincial level, but there
2 were certainly public representatives on the
3 Board of the Canadian Patient Safety
4 Institute.
5 MS. NEWBURY:
6 Q. And the public generally, would that also be
7 similar to the patient groups, patients
8 individually?
9 MR. TILLEY:
10 A. I mean, that's what would be, I think, hoped,
11 if a member of the public would not have any
12 particular relationship to the health care
13 system would bring. I'd have to go back and
14 look at the full membership now over the years
15 in CPSI. I know there was other disciplines.
16 There were physicians there. There were
17 pharmacists there in the duration that I
18 spent, but I can't tell you who the rest of
19 the group were, nor who has been there since.
20 MS. NEWBURY:
21 Q. And I take it from your evidence that whenever
22 you had a chance to speak to health care
23 workers within the organization, you would
24 discuss this approach?
25 MR. TILLEY:

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1 A. I think my general sense is that people in the
2 organization knew the direction we were
3 pursuing with this.
4 MS. NEWBURY:
5 Q. Before implementing this approach in your own
6 organization, and I'm not talking about is
7 this a good idea or not, but I'm looking at
8 the mechanics of how this works, was there any
9 consultation with other health organizations
10 in other parts of Canada or internationally to
11 look for guidance as to how to go about
12 implementing the approach?
13 MR. TILLEY:
14 A. I had talked to a number of my counterparts
15 throughout the country and everybody seemed to
16 be moving in the same direction and realized
17 that they were applying it as best fitted
18 their own organization, but that was sort of a
19 new direction that we were all trying to
20 promote.
21 MS. NEWBURY:
22 Q. So there's no one that said, listen, I've got
23 this great guideline or checklist on how we
24 can put this into place in our organization?
25 MR. TILLEY:

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1 A. Other than what the Canadian Patient Safety
2 Institute would have provided and I'm not sure
3 where else in the country there might have
4 been a source, but I would look to there, if
5 there was anything to be given.
6 MS. NEWBURY:
7 Q. I assume that Eastern Health wasn't the first
8 of the organizations to actually go ahead with
9 what CPSI had put together in theory and what
10 their philosophy was?
11 MR. TILLEY:
12 A. I think that would be a safe conclusion. I
13 know there were others that had already been
14 actively discussing and promoting it.
15 MS. NEWBURY:
16 Q. Okay, and did you discuss with any of those
17 organizations the actual mechanics, how do we
18 get this to work, what are the things that we
19 ought to keep in mind? Who are the people we
20 ought to consult? Who are the people that we
21 ought to inform about this?
22 MR. TILLEY:
23 A. No.
24 MS. NEWBURY:
25 Q. And was there any sort of a public campaign?

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1 Once the decision was made and once you
2 started to put this in place, was there a
3 public campaign or a campaign among patients
4 or advocacy groups to explain this new
5 approach, to explain what it means and how
6 it's expected to benefit the patient
7 population?
8 MR. TILLEY:
9 A. Not generally. I would tend to speak to it
10 any opportunity that I had. But there was
11 certainly no public campaign to take that
12 message forward.
13 MS. NEWBURY:
14 Q. Were there any specific guidelines in place,
15 from the Canadian Patient Safety Institute, as
16 to how to mechanically go about implementing
17 this approach?
18 MR. TILLEY:
19 A. I can't say that. There might be.
20 MS. NEWBURY:
21 Q. Okay. I know that there's a number of bits of
22 material on the website now, but I'm not sure
23 what of it was in place, say, in the year
24 2005, 2006, and you can't recall?
25 MR. TILLEY:

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1 A. No.
2 MS. NEWBURY:
3 Q. You wouldn't have kept any of that information
4 yourself, would you?
5 MR. TILLEY:
6 A. No.
7 MS. NEWBURY:
8 Q. Once the blameless culture approach had been
9 adopted, did Eastern Health, to your
10 knowledge, seek any feedback from various
11 stakeholders as to, you know, follow the
12 success or to look for any comments or
13 suggestions for improvement of the approach?
14 MR. TILLEY:
15 A. Not that I'm personally aware of. I can tell
16 you that I was getting feedback from the
17 organization that people were starting to take
18 this patient safety issue very seriously and
19 this whole issue of blameless culture was seen
20 to be an integral part of that. So from what
21 I received, it was a positive reaction from
22 the staff.
23 MS. NEWBURY:
24 Q. And that's the staff only, but there are a
25 number of other potential stakeholders, you

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1 would agree, in this new blameless culture
2 approach?
3 MR. TILLEY:
4 A. Well, that's true, though this new strategy
5 really had been vetted at a national level and
6 all of the dimensions of it were certainly
7 searched out and discussed at that point in
8 time.
9 MS. NEWBURY:
10 Q. I guess my focus is not so much on the theory
11 of whether this worked, but actually how it's
12 implemented, how it's communicated, how people
13 are perceiving this, do patients see that
14 they're benefitting from it, do they have any
15 concerns that aren't being addressed. That's
16 more the focus that I have, not the theory,
17 but the implementation.
18 MR. TILLEY:
19 A. Yes, and I would expect those types of issues,
20 in terms of the patients benefitting from this
21 would certainly be something that the Canadian
22 Patient Safety Institute would have been
23 mindful of in the development of it.
24 MS. NEWBURY:
25 Q. Yes, they would be mindful of that in the

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1 development of the theory, but in terms of how
2 Eastern Health does it, as opposed to a health
3 care organization in Ontario, versus a health
4 care organization is Saskatchewan, would they
5 be up at the ground level monitoring it to see
6 if there's any implementation problems by
7 Eastern Health?
8 MR. TILLEY:
9 A. CPSI?
10 MS. NEWBURY:
11 Q. Yes.
12 MR. TILLEY:
13 A. I'd be surprised, but certainly would be
14 available for consult, and part of me thinks
15 that there's not going to be a lot of
16 opportunity for variation in approach here.
17 It's a fairly standard technique, and it's how
18 you deal with staff who have been involved in
19 one of these, and instead of pushing a
20 punitive model, you're pushing more of a
21 developmental one and a non-threatening one
22 and creating a learning culture as a part of
23 that.
24 MS. NEWBURY:
25 Q. Would you agree that if the blameless culture

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1 approach is going to be viewed as acceptable
2 to the patient population and to the public
3 generally that has to be some level of
4 understanding of the approach and acceptance
5 of the approach by the patients and the public
6 generally?
7 MR. TILLEY:
8 A. I fully agree with that.
9 MS. NEWBURY:
10 Q. Okay, and is that an angle that you think has
11 been canvassed by Eastern Health?
12 MR. TILLEY:
13 A. Well, no, but it's one that we talked about at
14 the Canadian Patient Safety Institute to say,
15 you know, you're a national organization now
16 and as opposed to having every institution in
17 the country trying to go out and speak to
18 this, that they probably have a role in
19 ensuring that that's articulated to the
20 community at large.
21 MS. NEWBURY:
22 Q. Now I'd like to refer to Exhibit P-0046. I
23 think you've been shown this before. This is
24 Dr. Banerjee's report. You've called there
25 peer review reports?

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1 MR. TILLEY:
2 A. Yes.
3 MS. NEWBURY:
4 Q. As opposed to a root cause analysis. So you
5 wouldn't suggest that these reports would
6 constitute a root cause analysis?
7 MR. TILLEY:
8 A. I'm not sure that the--I'm not understanding
9 that they use the root cause analysis in their
10 approach, but I'm just looking at the results
11 of the report rather than the technique that
12 they applied.
13 MS. NEWBURY:
14 Q. Okay. If you conduct a root cause analysis,
15 regardless if you know the actual mechanics of
16 how they're doing that, would you expect that-
17 -and I'll use the Swiss cheese model as an
18 example. You're familiar with that model?
19 MR. TILLEY:
20 A. I am.
21 MS. NEWBURY:
22 Q. Okay, so if you have a Swiss cheese model, the
23 theory is that you have a bunch of holes that
24 line up together and an event, an unintended
25 event, manages to go through all the holes and

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1 ends up harming or coming into contact with
2 the patient, and would you say that a root
3 cause analysis would basically have an
4 outcome, hopefully, of identifying all of the
5 holes that were in that line and to identify
6 the cause or the source of each of those
7 holes?
8 MR. TILLEY:
9 A. Yes. Whereas the peer review, I think, with
10 the recommendations, the strategy that I glean
11 from it is that they've essentially said let's
12 plug all the holes, not just the ones that
13 might have lined up that day to cause ER/PR
14 issue to have the result it did.
15 MS. NEWBURY:
16 Q. Okay. So you have a block of swiss cheese
17 with many holes, some of which line up to
18 allow an event to slip through to the patient,
19 and other holes that have no bearing on that
20 particular patient?
21 MR. TILLEY:
22 A. On that day, but the next day, those set of
23 holes could line up. So the way I took the
24 external reviews was that they really focus in
25 on how do you make this a centre of

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1 excellence. You put in all of these
2 initiatives, and I took a level of confidence
3 away from it that, you know, it was really
4 going after an all-inclusive way of responding
5 to this issue.
6 MS. NEWBURY:
7 Q. Now would you say that the Wegrynowski and
8 Banerjee reports just plug the holes, or would
9 you say that they actually determine the
10 source of each of those holes?
11 MR. TILLEY:
12 A. I just think they plugged all the holes. When
13 they talk about putting in directors of
14 certain areas, I mean, what they're basically
15 talking about is having dedicated resources to
16 be able to focus solely in on this and working
17 on the presumption that if you have that type
18 of person there, it can cause greater
19 oversight and greater ability to keep up on
20 what new developments may be happening
21 throughout the country. So it really is an
22 attempt to bring us to that highest level.
23 MS. NEWBURY:
24 Q. And it's been suggested, I think, by at least
25 one other witness that those reports were more

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1 to go forward as to stepping back and
2 analysing all of the different problems.
3 MR. TILLEY:
4 A. That's correct.
5 MS. NEWBURY:
6 Q. Just to carry the swiss cheese analogy a
7 little further, the traditional approach,
8 would that essentially be looking at the hole
9 closest to the patient and saying that's the
10 cause of the problem and blaming whichever
11 physician or health care worker happened to be
12 the source of that hole? Is that too
13 simplistic?
14 MR. TILLEY:
15 A. Well, it would certainly be looking at the
16 whole incident and who and what contributed to
17 the outcome, and it certainly may not be the
18 person who is closest to the patient. It may
19 have been, you know, further indirectly
20 connected with the patient. But the
21 traditional approach would be to go there and
22 with an assumption of somebody being wrong,
23 you'd take punitive action to deal with that.
24 THE COMMISSIONER:
25 Q. What's the difference in the traditional

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1 approach and the swiss cheese approach then?
2 Is it merely once you figured it out what you
3 do?
4 MR. TILLEY:
5 A. The swiss cheese is sort of a separate
6 descriptor that's often used when adverse
7 events occur, and I can't source the creator
8 of it, but -
9 THE COMMISSIONER:
10 Q. Actually, we can, but I've forgotten where the
11 reference is.
12 MR. TILLEY:
13 A. Okay. Well -
14 THE COMMISSIONER:
15 Q. But in any point, that's beside the point.
16 MR. TILLEY:
17 A. - you know, it's meant to say that look, if
18 you have a solid block of cheese, then if you
19 took a slice of that block of cheese, then no
20 matter which slice you have, there's no holes
21 there that could potentially be a trap for an
22 adverse event. The swiss cheese approach is
23 that, you know, there are holes and usually
24 the health care system has enough controls in
25 it that the hole would not go completely

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1 through from one end to the other, and when
2 there is a hole that goes right through to the
3 end, that's where you potentially have room or
4 propensity for an event to occur. So it's
5 just describing, in a very light way, -
6 THE COMMISSIONER:
7 Q. Yes, okay, so when you're using the swiss
8 cheese model and you're going to figure out
9 what went wrong in an adverse event, as I
10 understand what you've said earlier, you
11 figure out what each of the individual little
12 holes were that lined up?
13 MR. TILLEY:
14 A. Right.
15 THE COMMISSIONER:
16 Q. So what's the difference in that and the
17 traditional model where you're looking at
18 everything that contributed to the result?
19 MR. TILLEY:
20 A. Well, the traditional--it's not to suggest
21 that the swiss cheese model is the new
22 approach, i.e. the blameless culture approach.
23 It's just one way that somebody decided to
24 say, if you took a block of cheese and sliced
25 it all up, if you had swiss cheese, you're

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1 going to see holes, and depending on how you
2 lined it up, you'd have the adverse event. So
3 that's just one sort of side issue in my way
4 of analysing it. The difference in terms of
5 an event, adverse event occurring, if it was
6 something like a medication overdose, then
7 obviously you'd look at whether the actual
8 vial of medication was the correct one,
9 whether it was labelled inappropriately or
10 whether it was the individual that took the
11 correct amount, but ended up filling up the
12 syringe more. So the traditional way of
13 dealing with that is that that person would be
14 dealt with in a punitive way for having made
15 that mistake.
16 THE COMMISSIONER:
17 Q. Yes, but that was my question.
18 MR. TILLEY:
19 A. Okay.
20 THE COMMISSIONER:
21 Q. Is there any real difference between the
22 traditional approach of analysing the problem
23 and the swiss cheese approach, other than by
24 your description, other than what you do once
25 you figured out what the problem was?

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1 MR. TILLEY:
2 A. That's right. That's where the difference
3 really is. It's what you do when you find out
4 what the problem is.
5 THE COMMISSIONER:
6 Q. Okay.
7 MS. NEWBURY:
8 Q. So basically then the difference, once you've
9 moved from the traditional approach to the
10 blameless culture approach is that you're
11 taking out the punitive aspects of it, in the
12 hopes that you'll get more people reporting so
13 you can respond quicker and you can learn from
14 the events.
15 MR. TILLEY:
16 A. Right.
17 MS. NEWBURY:
18 Q. Now, it's also, as I understand it, part of
19 the new guidelines from the Canadian Patient
20 and Safety Institute that adverse events would
21 have to be communicated to patients?
22 MR. TILLEY:
23 A. Yes.
24 MS. NEWBURY:
25 Q. And on page--I wonder if we could have P-0161

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1 again, please? Page 21 of that document,
2 please. Now this is, again this was a 2008
3 document and I'm not sure what components of
4 this were in play back in 2005, but this
5 indicates under item No. E "What to Disclose"
6 and if you look down at the fourth bullet, it
7 says, "A brief overview of the investigative
8 process that will follow, including
9 appropriate time lines and what the patient
10 can expect to learn from the analysis." And
11 then if you look at the next column, about
12 halfway down the column, it says "subsequent
13 and post analysis disclosure discussions with
14 patient and those support people that the
15 patient chooses to have present should
16 include"--and it lists a number of items. The
17 last bullet, "Actions taken as a result of
18 internal analysis that have resulted in system
19 improvements." So this appears to contemplate
20 that some sort of analysis will take place
21 following an adverse event, otherwise, you
22 can't communicate this information to the
23 patient unless the analysis has taken place.
24 And I also understand it--and that was in
25 place at the time, was it, 2005, was that a

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1 general understanding or is this completely
2 brand new?
3 MR. TILLEY:
4 A. I don't think it was completely brand new and
5 I can't speak to actually the communication
6 that went on with the patients, other than to
7 say the feedback that I was getting is that
8 the approach that Eastern Health was using was
9 very similar to what was being contemplated by
10 the Canadian Patient Safety Institute.
11 MS. NEWBURY:
12 Q. So that the patients were informed about a
13 brief overview of the investigative process,
14 the time lines for that investigative process
15 and what the patient can expect to learn from
16 the analysis?
17 MR. TILLEY:
18 A. Right, well I can't say it in that detail, the
19 only thing I can say to you is that the
20 approach that Eastern Health was using was
21 seen to be similar to what CPSI was
22 recommending.
23 MS. NEWBURY:
24 Q. And where did you draw that conclusion?
25 MR. TILLEY:

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1 A. Well that had come back to me on a couple of
2 occasions from the people who, in our--in
3 Eastern Health's organization that would have
4 been in the quality area that were
5 contributing to any input into CPSI.
6 MS. NEWBURY:
7 Q. So you just accepted at face value their
8 conclusions that what Eastern Health was
9 doing, the approach it was taking, was
10 consistent with the Canadian Patient Safety
11 general guidelines, which had not yet been
12 formalized, okay.
13 MR. TILLEY:
14 A. That's correct.
15 MS. NEWBURY:
16 Q. Now, I take it as well that they're
17 contemplating an analysis, also a root cause
18 analysis is something from this document that
19 seems to be a model endorsed by the Canadian
20 Patient Safety Institute?
21 MR. TILLEY:
22 A. Root cause is, but it doesn't say there that
23 it's got to be root cause, I guess that's just
24 one technique -
25 MS. NEWBURY:

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1 Q. I accept that, no, I think you're right, I
2 don't think it says anywhere that you must do
3 that. I think it just puts it out there. I
4 don't see other types of models offered, so I
5 wonder if this would be sort of the more
6 typical approach.
7 MR. TILLEY:
8 A. It's one example, yes.
9 MS. NEWBURY:
10 Q. And which, in your view, would that type of an
11 approach be--would a decision whether to use
12 this type of an approach depend upon the
13 magnitude or significance of the event?
14 MR. TILLEY:
15 A. From my perspective, yes.
16 MS. NEWBURY:
17 Q. The more serious the event, the greater harm
18 caused to patient or patients, the more likely
19 a root cause analysis.
20 MR. TILLEY:
21 A. Maybe, I'm not familiar with the root cause
22 approach as to whether it is best designed for
23 single-patients or multiple, but I'd have to
24 leave that to those who are more experienced
25 in it.

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1 MS. NEWBURY:
2 Q. Either way, whether there's another approach,
3 would you see it important to get to the root
4 of the problem?
5 MR. TILLEY:
6 A. Well, in this particular situation, my focus
7 was really in on how do we restore confidence
8 in the system, how do we make this situation
9 such that we can make a difference in a
10 positive way to patients who have been treated
11 or tested under this procedure. So the focus
12 clearly for me was what recommendations can we
13 make to move forward?
14 MR. TILLEY:
15 A. Did you have any concerns that without being
16 able to explain to patients, you know, the
17 source of the problem, the root of the
18 problem, that they may not have their
19 confidence restored?
20 MR. TILLEY:
21 A. That's clearly a challenge and as I've alluded
22 to in other evidence, there is, in my mind, a
23 portion of what's happening here that's being
24 replicated throughout Canada right now. And
25 there's a portion that's probably related

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1 specifically to the lab in St. John's. I'm
2 not sure to the extent that they overlap or
3 what portion of the issue is, same as been
4 experienced in many other labs in the country
5 or not, so that really made it a challenge,
6 from my perspective.
7 MS. NEWBURY:
8 Q. But had a root cause analysis been conducted,
9 do you think that those answers might be
10 available?
11 MR. TILLEY:
12 A. It would only be speculation on my part.
13 MS. NEWBURY:
14 Q. I wanted to refer again to exhibit P-0046
15 please, page 4. I'm just going to refer to a
16 couple of items here. So this is the report
17 again of Dr. Banerjee and there's a heading,
18 "Conclusions about the reasons for test
19 failure." Item No. 3--and I'm just throwing
20 this out as an example. "Is there a problem
21 with tissue fixation?" The answer is, "There
22 appears to be inadequate attention paid by the
23 gross pathologist to the thickness of tissue
24 slices, quality inadequacy of fixation and
25 there is no standardized fixation protocol

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1 that everyone adheres to." Now, I take it
2 that recommendations were made to correct that
3 particular problem there, but do you know if
4 there is any analysis to ascertain why that
5 particular type of methodology was being used,
6 that there was inadequate attention paid by
7 the grossing pathologists?
8 MR. TILLEY:
9 A. Not that I can speak to.
10 MS. NEWBURY:
11 Q. And would you say that that might be
12 information that's important to addressing the
13 ER/PR problem?
14 MR. TILLEY:
15 A. It may be, but I'm not convinced that it's an
16 issue that's any different than anywhere else
17 in the country. If the issue of thickness of
18 tissue slices is not consistently applied,
19 then it could be a problem throughout the
20 country.
21 MS. NEWBURY:
22 Q. Right.
23 MR. TILLEY:
24 A. There's obviously a lot of information in this
25 report that could potentially be a

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1 contributing factor and trying to explain that
2 from a patient's perspective, would be a real
3 challenge, but also how you pull that in--
4 sorry for looking in over my glasses, but how
5 you pull that in, in terms of the national
6 context, adds another complication to it.
7 MS. NEWBURY:
8 Q. I'm just going to refer to another item or two
9 in this. On the next, same page, Item No. 4,
10 "Inadequate or no attention is being paid by
11 the reporting pathologist to the status of
12 internal controls with inappropriately
13 exclusive reliance on external positive
14 controls. Negative test results in the
15 absence of positive internal controls should
16 have triggered corrective procedures.
17 Optimization of method, choice of a better
18 fixed block, choice of a block with a benign
19 ductal epithelium included, et cetera, and
20 should not have been released without
21 troubleshooting and in the event that poor
22 fixation resulted in internal control failure
23 in all of available blocks, this should have
24 been noted in the reports as an
25 uninterpretable case, due to failure or

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1 absence of internal controls."
2 MR. TILLEY:
3 A. Uh-hm.
4 MS. NEWBURY:
5 Q. Aside from adopting new procedures, would you
6 see it as being important to find out the
7 source of that problem?
8 MR. TILLEY:
9 A. Well the issue there is whether the controls
10 have been documented, that's my interpretation
11 of it.
12 MS. NEWBURY:
13 Q. I think it gets into other issues than that,
14 some--as I could take it from that paragraph,
15 some results were released, even though they
16 hadn't been--there hadn't been any
17 troubleshooting to determine if there was some
18 problems, as a result of the negative or the
19 absence of positive internal controls, which
20 should have triggered some corrective
21 procedures, and if they troubleshooting didn't
22 work and there was poor fixation as a result
23 of the internal control failure, then this
24 should have been noted in the reports.
25 MR. TILLEY:

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1 A. Uh-hm.
2 MS. NEWBURY:
3 Q. So I take it that the report shouldn't have
4 been released?
5 MR. BROWNE:
6 Q. Commissioner, I'm not sure, again this line of
7 questioning with this witness is necessarily
8 productive in terms of asking this level of,
9 the detail being asked by counsel to have Mr.
10 Tilley extracting reports may be beyond his
11 expertise and I'm just wondering whether -
12 THE COMMISSIONER:
13 Q. I don't think there's any expectation from the
14 question that she's going--that is being made
15 or being put that the witness understands the
16 science. My understanding of the question as
17 it was directed to whether or not the witness
18 was aware of what within his particular
19 organization might have occurred to deal with
20 this particular problem. Is that the
21 question?
22 MS. NEWBURY:
23 Q. That's correct, I just wondered whether or not
24 there was any thought given to the need to get
25 to the root of that particular problem through

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1 a root cause analysis or through some other
2 appropriate technique.
3 MR. TILLEY:
4 A. And I'm, unfortunately, not in a position to
5 be able to give you a good answer on that.
6 MS. NEWBURY:
7 Q. And the person who would be able to provide an
8 answer to that -
9 MR. TILLEY:
10 A. Would be the clinical chief for the Laboratory
11 Medicine Program.
12 MS. NEWBURY:
13 Q. Okay, and that was Dr. Cook at the time?
14 MR. TILLEY:
15 A. Yes, and then Dr. Denic.
16 MS. NEWBURY:
17 Q. And would Dr. Williams also be able to speak
18 to that?
19 MR. TILLEY:
20 A. He may be able to.
21 MS. NEWBURY:
22 Q. Now, I take it -
23 THE COMMISSIONER:
24 Q. Before you go on, I just want to clarify this
25 with Mr. Browne, my take on--and indeed with

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1 counsel who is asking the question, my take on
2 this line of questioning has been that there
3 are methods of analyzing problems and the
4 direction of these questions goes to whether
5 either those methods were used or
6 consideration was given to using those
7 particular methods to determine what, in one
8 phrase, is the root cause of a particular
9 problem.
10 MS. NEWBURY:
11 Q. Yes, that was my line of questioning,
12 absolutely, thank you. Now I understand from
13 your evidence generally that you haven't been
14 able to answer what is the cause of the ER/PR
15 problem and I take it you said numerous times
16 that your reluctance to specify a cause is the
17 fact that there is a number of things going
18 on, it's a complex issue, and then overlying
19 all of that is the fact that there are
20 concerns nationally about ER/PR testing.
21 MR. TILLEY:
22 A. Yes.
23 MS. NEWBURY:
24 Q. So you don't know if it's a broader national
25 issue of, you know, lack of specific

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1 literature or standards available to guide
2 Eastern Health or whether it was problems
3 within the lab that happened nowhere else in
4 Canada or some combination of that?
5 MR. TILLEY:
6 A. That's correct.
7 MS. NEWBURY:
8 Q. Okay, and this has been a concern that lingers
9 with you to this very day, I take it?
10 MR. TILLEY:
11 A. Uh-hm.
12 MS. NEWBURY:
13 Q. If that were the case and taking into account,
14 you know, the purpose of responding to an
15 adverse event, would you not see it as being
16 important to conduct a survey of other labs to
17 find out what types of protocols and
18 procedures were in place? And I don't expect
19 that you would have done this yourself, but to
20 make sure that someone who could speak
21 intelligently about these various issues would
22 conduct that survey to find out is this--are
23 these particular problems here, problems being
24 experienced elsewhere or is there something in
25 Eastern Health.

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1 MR. TILLEY:
2 A. Right. I know there have been contacts with
3 other labs, but I don't think they've been on
4 particularly controversial issues. It's a
5 very sensitive issue in terms of going into
6 another lab to find what or what not is in
7 place. The direction that Eastern Health
8 chose was to go to the Canadian Pathology
9 Association which is a national arm that has
10 representation or all organizations in the
11 country have a relationship in some way or
12 another and that they would identify what they
13 acceptable standards would be for this
14 particular treatment protocol.
15 MS. NEWBURY:
16 Q. Now, I take it that--this is my
17 interpretation of it and correct me if I'm
18 wrong, that the blameless culture approach,
19 there was an obvious advantage to health care
20 workers in the sense that they don't face, you
21 know, losing their job or having their
22 reputation damaged if they report an adverse
23 event. I understand that feature of it. And
24 there hopefully will be long term benefits for
25 patients as a result of the response to these

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1 more frequent and earlier reporting of adverse
2 events. So, there's a bit of trade off there.
3 Maybe the patient who might otherwise under
4 the traditional approach like to see someone
5 disciplined for--I'm not suggesting that they
6 do, but in some cases maybe they would, but
7 there is a trade off here and in the long run
8 patients could be expected to benefit from it
9 because they will see improvements in their
10 health care system. Is that an accurate -
11 MR. TILLEY:
12 A. I think that's an accurate summary.
13 MS. NEWBURY:
14 Q. And to ensure that that tradeoff works for the
15 patient, would it not be important for the
16 organization to take responsibility for making
17 all of the necessary changes and to
18 investigate everything leading up to the
19 adverse event and to correct all of those
20 different issues and to take its own
21 responsibility for that response.
22 MR. TILLEY:
23 A. Yes.
24 MS. NEWBURY:
25 Q. And then once that's done, of course, to

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1 communicate with the patient obviously in a
2 language that's acceptable -
3 MR. TILLEY:
4 A. Yes.
5 MS. NEWBURY:
6 Q. - depending on the level of knowledge of the
7 patient and the complexity of the issue. And
8 if is fair to say that the Canadian Patient
9 Safety Institute and the values that it
10 supports, there's some expectation that health
11 organizations would, once they've dealt with
12 an adverse event and responded to it, they
13 would share their information with other
14 organizations across the country and perhaps
15 internationally as well?
16 MR. TILLEY:
17 A. Yes.
18 MS. NEWBURY:
19 Q. Okay. And is there any expectation that once
20 a problem has been identified that the sole
21 response of a health organization under this
22 new approach, the Canadian Patient Safety
23 Movement generally, that it would be
24 acceptable to just alert people, there's a
25 problem here, other people might be

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1 experiencing the same problem.
2 MR. TILLEY:
3 A. Yes.
4 MS. NEWBURY:
5 Q. And wait for that organization to deal with
6 it?
7 MR. TILLEY:
8 A. Well, of course, you probably will recall that
9 I made contact with the CEO. I did send a
10 fair amount of information to them. I don't
11 think they saw themselves yet poised to be
12 able to take on that type of responsibility,
13 but they did reaffirm the other direction that
14 we were pursuing which is the Canadian
15 Pathologists Association.
16 MS. NEWBURY:
17 Q. But might you expect, as an organization, some
18 delay in having a national organization,
19 whoever it might be, taking this on as an
20 issue, mobilizing to, you know, take whatever
21 steps are necessary to say, implement national
22 standards, if that's the goal -
23 MR. TILLEY:
24 A. Right.
25 MS. NEWBURY:

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1 Q. - maybe not all organizations as we saw here,
2 DAKO systems were operating successfully in
3 other labs. Maybe other health organizations
4 are not as motivated to do that. And I'm
5 wondering whether Eastern Health might be
6 better -
7 MR. TILLEY:
8 A. Should take it on its own.
9 MS. NEWBURY:
10 Q. - served to take it on its own just to delve
11 into this a bit further.
12 MR. TILLEY:
13 A. Well, you know, you make a good point there.
14 If we really want to get it out. I think if
15 we reach the stage where we got a good handle
16 on what the issues are, it would have been
17 inappropriate, for example, for us to go out
18 and make suggestions that one particular piece
19 of technology didn't work because that brings
20 on a whole host of other issues that one could
21 expect to be challenged on. But I'm not sure
22 what the timing would be, but you know,
23 there's a legitimate issue for it.
24 MS. NEWBURY:
25 Q. And would you think that if Eastern Health, as

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1 an organization were to take more of an active
2 role into delving into these issues that it
3 could start with a root cause analysis or some
4 other analysis of what actually had gone on in
5 its own labs?
6 MR. TILLEY:
7 A. Sure.
8 MS. NEWBURY:
9 Q. In terms of disclosure to patients, I spoke
10 earlier about education of patients, but in
11 terms of the specific disclosure upon the
12 happening of an adverse event, do you think
13 that it would be beneficial both to the
14 organization and to the patients to explain to
15 the patients that there is a new approach
16 adopted by Eastern Health, the blameless
17 culture approach to explain what that means
18 for them and how, you know, it's expected that
19 that approach will ultimately benefit patients
20 in the long run.
21 MR. TILLEY:
22 A. I think it's a lot of information to be
23 passing over in a call of that nature. I
24 don't think it would be realistic to do that.
25 I think that would be more designed, we need

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1 to talk about that more openly in a very broad
2 way.
3 MS. NEWBURY:
4 Q. How about, you know, if you have information
5 brochures, information that could be sent out,
6 by letter -
7 MR. TILLEY:
8 A. Right, as opposed to dealing with the specific
9 incident, it's more of a general educational
10 issue.
11 MS. NEWBURY:
12 Q. Now I understand from your evidence that there
13 might still be some opportunity for discipline
14 procedures to be in play and even in the case
15 of incompetence, but certainly that would not
16 be, if there's any sign of incompetence by a
17 health care worker, you might still have to
18 move to discipline, but that's a last resort
19 of the organization, is that fair to say?
20 MR. TILLEY:
21 A. Depending on the circumstances, if it was felt
22 that it was something more than an accident,
23 if it was obviously a deliberate attempt, then
24 that certainly would result in severely
25 extensive follow up on a punitive basis.

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1 MS. NEWBURY:
2 Q. But what about if there's absolutely no sign
3 of anything deliberate, but there's just sheer
4 incompetence?
5 MR. TILLEY:
6 A. Well I think then it would be dealt with in a
7 constructive way to see if there's any other
8 opportunities for the person to be involved in
9 the organization in another role. Health care
10 professionals, by nature, invest a significant
11 amount in their training and to throw all of
12 that out, I think would be a true injustice,
13 so I think we need to work to see if we can
14 overcome what those issues are. But it's not
15 to say that every issue can be resolved that
16 way and maybe the solution is to part ways and
17 choose another field.
18 MS. NEWBURY:
19 Q. Now disciplinary measures I don't think are
20 necessary so extreme that you either keep your
21 job or you lose your job -
22 MR. TILLEY:
23 A. Right.
24 MS. NEWBURY:
25 Q. There's lots of other things, I think, under

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1 the legislation that could be brought into
2 play, such as, you know, some continuing
3 education on a particular issue for
4 physicians.
5 MR. TILLEY:
6 A. That's correct.
7 MS. NEWBURY:
8 Q. So it's not an all or nothing situation.
9 MR. TILLEY:
10 A. No.
11 MS. NEWBURY:
12 Q. And how would a determination be made as to
13 whether or not a particular adverse event
14 should be channelled into the more traditional
15 approach, as opposed to staying within the
16 realm of the blameless culture approach?
17 MR. TILLEY:
18 A. Well that would be a discussion that would go
19 on between the human resource specialist, the
20 quality department and the actual area where
21 the event would have occurred and those line
22 programs in particular.
23 MS. NEWBURY:
24 Q. Are there any other exceptions, I guess, to
25 staying in the realm of the blameless culture

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1 approach where you're dealing with adverse
2 events, for example, if you have, you know,
3 hundreds of adverse events all happening at
4 the same time, all of similar nature, but
5 happening at the same time.
6 MR. TILLEY:
7 A. Coming from the same person?
8 MS. NEWBURY:
9 Q. Or a series of events.
10 MR. TILLEY:
11 A. I don't doubt that each case is going to have
12 to be looked at in its own merits.
13 MS. NEWBURY:
14 Q. So is it fair to say that there is no
15 automatic rule, that everything is going to be
16 held within a blameless culture approach,
17 we're going to have to evaluate it -
18 MR. TILLEY:
19 A. With a direction that that's--with an
20 agreement that that's a direction we're headed
21 into, but it's not to say that everybody will
22 be captured by that piece.
23 MS. NEWBURY:
24 Q. Has there been any consideration given to
25 applying or the appropriateness of applying or

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1 not applying the blameless culture approach
2 where you have events that commenced long
3 before the blameless culture approach was
4 adopted?
5 MR. TILLEY:
6 A. It's possible.
7 MS. NEWBURY:
8 Q. Was that considered in this case here.
9 MR. TILLEY:
10 A. I don't recall anything in particular, but if
11 an event that had happened years earlier, and
12 just becoming aware of it now, the question
13 would have to be looked at in terms of where
14 can the system and the person and the patient
15 be best served in terms of dealing with the
16 person involved.
17 MS. NEWBURY:
18 Q. What about considering whether or not a
19 blameless culture approach might be
20 appropriate or not, where there's a
21 significant issue which might call into doubt
22 or might cause some concerns among the public
23 regarding their ability to have confidence in
24 the health care system?
25 MR. TILLEY:

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1 A. That may or may not be a factor. I think that
2 the public in general would want to be sure
3 that the system is doing all in its power to
4 ensure that staff are training to do the jobs
5 at hand. If there is an incident that occurs,
6 I think we'd generally be leaning towards how
7 do you rehabilitate or how do you ensure that
8 that person learns from this experience, as
9 well as the rest of the organization. I do
10 take exception to the comments that get made
11 in the media that "heads should roll". I've
12 heard them many times, in fact, too many
13 times, it's just a lack of understanding of
14 what we're trying to achieve here.
15 MS. NEWBURY:
16 Q. Do you think that Eastern Health might have
17 spend some more time explaining its approach,
18 in terms of the whole theory about blameless
19 culture approach, even before this issue, you
20 know, really became prominent in the media? I
21 mean, speaking generally -
22 MR. TILLEY:
23 A. Would there be any difference -
24 MS. NEWBURY:
25 Q. - about this new approach here, even having

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1 posters in your different hospitals and just
2 to get the word out there, you know, what's
3 happening, what's going on. Do you think that
4 might have allowed patients to have a little
5 bit more understanding as to why people aren't
6 being penalized or disciplined for this?
7 MR. TILLEY:
8 A. There's always opportunities to improve upon
9 things and that certainly is a thought worth
10 pursuing.
11 MS. NEWBURY:
12 Q. And do you think that there would be a need
13 for the public to fully understand all of the
14 contributing factors to a particular problem
15 that was of such a large scale and occurred
16 for such a long period of time, could that be
17 a contributing factor as well to the, you
18 know, the sentiments that were just referenced
19 by you in the media.
20 MR. TILLEY:
21 A. Yeah, certainly. I can't rule that out, I
22 think this certainly would have been a
23 dimensional that -
24 MS. NEWBURY:
25 Q. Okay. Looking at it with hindsight, do you

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1 think that perhaps more procedures or
2 protocols could have been in place before
3 moving into the blameless culture approach?
4 MR. TILLEY:
5 A. No. I think as an organization we had said
6 that in future we are going to take patient
7 safety and move it to the top of our agenda,
8 one of the dimensions of that was a blameless
9 culture. We had the areas who were going to
10 be involved in that, astute to what the
11 implications of that meant, but these
12 situations are not occurring every day, but
13 they do occur from time to time and the people
14 who are involved in those issues, quite
15 frankly deal with them on an individual basis.
16 MS. NEWBURY:
17 Q. So you don't think that there was any room for
18 consultation or feedback with any of the other
19 stakeholders, even if just to educate them as
20 to why Eastern Health is responding in the way
21 that it is?
22 MR. TILLEY:
23 A. Well, no, I was taking your comments about
24 procedures in terms of how to follow up
25 internally on individual cases.

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1 MS. NEWBURY:
2 Q. No, no, sorry, talking more about the
3 blameless culture approach -
4 MR. TILLEY:
5 A. Right, I understand.
6 MS. NEWBURY:
7 Q. - and communication with the patients -
8 MR. TILLEY:
9 A. There's always room to do that, I can tell you
10 that at the national scene there was an
11 expectation that the Canadian Patient Safety
12 Institute was going to be taking a greater
13 lead in that and I know that in conferences
14 that have been held throughout the country,
15 that that issue has been talked about, but it
16 doesn't seen to have gotten on the agenda in
17 terms of why general public, media coverage.
18 MS. NEWBURY:
19 Q. Okay. After the blameless culture approach
20 was adopted by Eastern Health, would you
21 expect that incidents of a conversation of
22 ER/PR results would be reported as an
23 occurrence or as a report, as contemplated by
24 the guidelines, Canadian Patient Safety
25 Guidelines?

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1 MR. TILLEY:
2 A. Yes.
3 MS. NEWBURY:
4 Q. And you've been referred to the memos of Dr.
5 Ejeckam, if I could bring up exhibit P- 0113
6 please? This is the last memo there and if
7 you want to take some time to read that, I'll
8 just let you -
9 MR. TILLEY:
10 A. No, I've got a general sense of what it says.
11 MS. NEWBURY:
12 Q. Go down to the end of that. Do you think that
13 the concerns outlined in this particular
14 report had the blameless culture approach and
15 your encouraging of reporting incidents, et
16 cetera, had been in place at the time, that
17 this type of event ought to have been reported
18 as an occurrence and followed up upon by
19 whatever tool necessary?
20 MR. TILLEY:
21 A. I would like to think that it would be
22 followed up as an occurrence, but anything
23 beyond that, I'd be just speculating.
24 MS. NEWBURY:
25 Q. I wonder if I could refer to exhibit P- 0168

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1 please. Now this is a memo, you may not be
2 familiar with the e-mail itself, but I think
3 you might be familiar with the information in
4 it, so I'm just pulling this up now for ease
5 of reference. There's a discussion there
6 about patients who were diagnosed as ductal
7 carcinoma in situ and that was upon the
8 retesting, so basically their initial results
9 were different from what was ultimately tested
10 at Mount Sinai, and also retro converters were
11 a group of patients who were initially ER
12 positive but converted to ER negative.
13 MR. TILLEY:
14 A. Yes.
15 MS. NEWBURY:
16 Q. So you're familiar with those kinds of -
17 MR. TILLEY:
18 A. Vaguely, yes.
19 MS. NEWBURY:
20 Q. Would those incidents here warrant an
21 occurrence report and to follow the procedures
22 in keeping with the blameless culture
23 approach?
24 MR. TILLEY:
25 A. Well, I would see it as a misdiagnosis and

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1 it's been some time since I looked at that
2 form, but I would think that it would be
3 something that would be referenced there.
4 MS. NEWBURY:
5 Q. Okay, so there is an actual occurrence form in
6 place that you expect would be filled out for
7 -
8 MR. TILLEY:
9 A. Yes, and it does sort of outline the types of
10 things that would be reported. So it may be
11 the best source to look at, in terms of
12 whether that would fit the criteria.
13 MS. NEWBURY:
14 Q. And there are no special forms for large-scale
15 events that you're aware of?
16 MR. TILLEY:
17 A. No.
18 MS. NEWBURY:
19 Q. Okay. So you think that if you have a large-
20 scale event involving hundreds of patients,
21 they're not going to fill out hundreds of
22 forms?
23 MR. TILLEY:
24 A. No.
25 MS. NEWBURY:

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1 Q. But there's no other alternative special form
2 to complete?
3 MR. TILLEY:
4 A. Other than there's probably a file down there
5 that's got an overwhelming amount of
6 information on the issue, so it wouldn't be a
7 question of not knowing about it or not
8 keeping a comprehensive file on it.
9 MS. NEWBURY:
10 Q. In terms of the communication issues and the
11 decisions regarding those issues, and I'm
12 speaking about both to the patients and to the
13 public generally, there were numerous meetings
14 and discussions and telephone calls and
15 exchanges of e-mails back in July and August
16 of 2005. Are you able to identify the pivotal
17 meeting or pivotal meetings where decisions
18 were made with respect to those communication
19 issues and in particular the disclosure to
20 patients?
21 MR. TILLEY:
22 A. Well, the meeting that immediately comes to
23 mind is the one that we had with the minister
24 and the oncologists and that had to do with
25 the timing of when we would make the contact.

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1 There was a compelling argument put forward by
2 the oncologists that it would be preferable on
3 their part if, in fact, information was
4 available from the retests so that when the
5 call was made, the patient didn't have to wait
6 for that information to come through. So that
7 would be one of the key meetings.
8 MS. NEWBURY:
9 Q. Okay.
10 MR. TILLEY:
11 A. Or key points.
12 MS. NEWBURY:
13 Q. Was there any other key meeting or pivotal
14 meeting that stand out in your mind?
15 MR. TILLEY:
16 A. Post public release, then obviously there were
17 discussions about the need to fast track this,
18 that the original intent was no longer going
19 to be achievable. So can't say it was a
20 meeting that I recall specifically, but it was
21 a decision, I believe, that would have been in
22 October that would have talked about making
23 preliminary calls to the patients advising
24 them that their specimens were being retested.
25 MS. NEWBURY:

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1 Q. Now, the impression I had from a couple of the
2 witnesses, John Abbott stands out in my mind,
3 regarding the meeting with the minister about
4 communication issues where the oncologists
5 were in attendance, my impression was that he
6 viewed that meeting as a briefing for the
7 minister, information was relayed by Eastern
8 Health to the minister, but it wasn't, the
9 minister didn't feel that he was there to
10 contribute to the decision making process, he
11 expressed a view, I think, but wasn't part of
12 a decision making process, an analysis. Is
13 that your understanding?
14 MR. TILLEY:
15 A. I do recall the minister making words--making
16 comments to the effect that I'm prepared to
17 accept that for now.
18 MS. NEWBURY:
19 Q. Okay.
20 MR. TILLEY:
21 A. So that one would think that he had seen
22 himself into a role of being a part of the
23 decision. The whole reason that we were in
24 there was precipitated by a telephone
25 conversation that I had had with the assistant

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1 deputy minister, Moira Hennessey, about the
2 contact with the patients and I had indicated
3 to them at that time that we were getting
4 feedback from the oncologists what their
5 preference would be. She subsequently called
6 me back and said that the minister has
7 concerns with that. I'm just trying to
8 remember my notes now. So that precipitated
9 that face-to-face meeting. So it certainly
10 wasn't intended just to be a one-way flow of
11 information.
12 MS. NEWBURY:
13 Q. Okay. Did everyone attending that meeting
14 that day, in your mind, understand that we're
15 going to this meeting today with the purpose
16 of making a decision about disclosure to
17 patients?
18 MR. TILLEY:
19 A. It certainly was an intent to go in and speak
20 to the disclosure issue and have a common
21 discussion about the pros and cons of the
22 approach.
23 MS. NEWBURY:
24 Q. Okay. I guess I'm a little surprised, given
25 the magnitude of the problem, the number of

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1 people involved and the complexity of the
2 issues and the importance of the issues not to
3 see a formal strategic plan or minutes of
4 meeting or preliminary report about a decision
5 being made. Is there any reason why there's
6 no formal set of documents, you know, to
7 basically capture exactly when, how the
8 decision was made, who contributed to the
9 decision.
10 MR. TILLEY:
11 A. Right.
12 MS. NEWBURY:
13 Q. All of the underlying data, criteria that were
14 relied upon to make that decision?
15 MR. TILLEY:
16 A. No, it's a good question. Things were
17 happening fairly quickly. As you can see that
18 I made significant notes for the meetings that
19 I was involved in and you'll find that Dr.
20 Williams did the same. But at no point in
21 time did we actually stop and try to record
22 this in a common document that was signed off
23 by all.
24 MS. NEWBURY:
25 Q. Right. And do you think that, looking back at

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1 it now, that that might have been beneficial
2 just to make sure that everyone understood
3 that they were expected to contribute to the
4 decision, to make sure that there was no
5 confusion, that everyone understood the issues
6 that others were seeing as important, that
7 everyone understood the information being
8 relayed by various individuals at the meeting?
9 MR. TILLEY:
10 A. Yes, I do.
11 MS. NEWBURY:
12 Q. Okay. And even if, you know, a formal report
13 or a formal strategic plan weren't ready to be
14 made at that time, was there any--because of,
15 you know, the issues were going quickly, was
16 there any thought given in the days or weeks
17 following to sit down and to draft up a report
18 for the purpose of making sure you've got the
19 official record there?
20 MR. TILLEY:
21 A. It certainly was something that I had not
22 contemplated, but I can't tell you if the
23 quality group were involved in preparing it or
24 not.
25 MS. NEWBURY:

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1 Q. But as CEO of an organization, would you not,
2 you know, expect to be made aware of or to
3 take some steps to insure that this type of
4 formal documentation is done?
5 MR. TILLEY:
6 A. In retrospect, I can see it as very clear
7 value in doing that, but it's something that
8 was not entertained at the time. We were
9 clearly on a moving train, a lot of things
10 happening.
11 MS. NEWBURY:
12 Q. Do you think it might have been of benefit as
13 well to have a plan for follow up to assess
14 the progress, formal plan for follow up to
15 assess the progress of the decisions made at
16 that meeting and to look at the status of the
17 action items to consider whether or not you
18 needed a change in tactic, aside from that
19 occassion when the media broke and you had to
20 deal with the issue, but was there any formal
21 structure in place?
22 MR. TILLEY:
23 A. There was a formal structure in place to
24 follow up on the recommendations of the
25 review, but I'm not sure which issues you're

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1 referring to.
2 MS. NEWBURY:
3 Q. After the--well, particularly the
4 communication issues for the patients and also
5 to the public. But decisions were made back
6 in August, we're going to send off some tests
7 for retesting at Mount Sinai, we have an
8 expectation as to when the results are going
9 to be back and our decisions are made about
10 the disclosure based on those expectations.
11 Did you set deadlines to say we will have a
12 status meeting in three weeks time. In the
13 meantime we'll find out what percentage Mount
14 Sinai has completed, we're going to reevaluate
15 our plan to see if we can actually meet this
16 goal and if we can't, if there's anything
17 interfering with it, if there are problems
18 with the flights getting out or anything else
19 that interferes with your plan, we're going to
20 have to reevaluate our decision about
21 disclosure?
22 MR. TILLEY:
23 A. Right. Well I can tell you that issue was
24 being discussed on an ongoing basis.
25 MS. NEWBURY:

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1 Q. Um-hm.
2 MR. TILLEY:
3 A. And concerns with regards to the delays that
4 Mount Sinai, for no fault of their own, were
5 experiencing. You may recall that Dr. Cook
6 followed up but so did I to see if there's any
7 way we could expedite this. We talked about
8 the value of having some of the tests re-
9 diverted to another facility, but knowing the
10 precarious nature of the test itself, to bring
11 in another variable was seen as undesirable.
12 So there very much was sort of a very living
13 ongoing discussion as to where we were, what
14 the experience was and whether there were any
15 other options available to us.
16 MS. NEWBURY:
17 Q. I do appreciate and I'm familiar with the
18 information that you refer to that contacts
19 were made with Mount Sinai to see, you know,
20 how they were, see how they were doing and
21 whether they could speed up the process. I'm
22 not sure the dates of those in my head. But I
23 guess my question was more focused on did you
24 have a plan to look at that with a view to
25 saying or to seeing whether or not you should

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1 modify your plan about disclosure and
2 particularly in the months of August and
3 September?
4 MR. TILLEY:
5 A. Yes, we--those sort of conversations were
6 going on simultaneous to all that we were
7 doing, and in the end we held the course with
8 regards to the original plan. And then, I
9 guess, in August, or sorry, October, it
10 culminated in the point where we changed our
11 strategy.
12 MS. NEWBURY:
13 Q. Would you agree that had a written report and
14 supplemental reports, whether they're
15 strategic plans or minutes of meeting or just
16 ad hoc reports about the process been produced
17 that the very exercise of writing such an
18 official report might have provided some
19 clarity of thought on the issue?
20 MR. TILLEY:
21 A. It's possible, but again, there were a lot of
22 people involved in this, there was a lot of
23 conversation, so I'm not sure at that point in
24 time what the advantage would have been.
25 MS. NEWBURY:

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1 Q. But would you not agree that perhaps because
2 there are so many people having so many
3 discussions with one another that that
4 probably increases the chance that maybe not
5 everyone is working with the same set of
6 facts?
7 MR. TILLEY:
8 A. Right. It does.
9 MS. NEWBURY:
10 Q. And that might be a reason why an official
11 report could be drafted, circulated to
12 everyone for their input -
13 MR. TILLEY:
14 A. Right.
15 MS. NEWBURY:
16 Q. - and then corrections could be made if
17 necessary?
18 MR. TILLEY:
19 A. Right. Well, the key players were certainly
20 meeting on a regular basis, so never did I
21 feel that anybody might have been out of the
22 loop in this process, but nor can I say that
23 that wouldn't have been beneficial.
24 MS. NEWBURY:
25 Q. And could that, such a report actually have

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1 helped the decision making team as it comes
2 back from time to time to reevaluate the
3 status? This issue obviously went on for
4 several years after it came to light and the
5 decision making team would have to look back
6 and reevaluate what happened before. Would an
7 official record help that, rather than relying
8 on someone's memory or someone's handwritten
9 notes?
10 MR. TILLEY:
11 A. Perhaps, but at no point in time did I feel
12 that the right people weren't being consulted
13 in this process either.
14 MS. NEWBURY:
15 Q. Just more in terms of the level of detail, to
16 make sure that there are no inconsistencies or
17 people haven't mixed up the dates or -
18 MR. TILLEY:
19 A. Understand, yeah, but as you can see there's
20 literally thousands of pieces of information
21 here. The objective, I understand from what
22 you're referring to, is sort of to summarize a
23 lot of what we had.
24 MS. NEWBURY:
25 Q. Well, to pull it all together.

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1 MR. TILLEY:
2 A. Yes.
3 MS. NEWBURY:
4 Q. Because, you know, we're here trying to sort
5 out what went on
6 MR. TILLEY:
7 A. Right.
8 MS. NEWBURY:
9 Q. And sometimes it's not entirely clear what the
10 basis was for a decision, for example, the
11 pause of the testing and the pause of the
12 communication. It's not--you know, I accept
13 that you've got some recollection of that and
14 some notes and appreciate that, but it may not
15 be entirely clear to everyone involved or not
16 everyone might necessarily have the same
17 understanding as to the reasons for that. So
18 that's why I'm wondering whether an official
19 report would help for that purpose.
20 MR. TILLEY:
21 A. Right, and I don't doubt that there would be
22 some value added. Certainly the people
23 involved in this, this had become probably
24 their primary focus over the two years that I
25 was involved in it, and there was nobody

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1 designated to sort of be the writer to pull
2 all this together.
3 MS. NEWBURY:
4 Q. Would such an official record also be
5 beneficial in terms of dealing with
6 accreditors, for example, if they ever wanted
7 to analyze how Eastern Health responded to
8 this particular event?
9 MR. TILLEY:
10 A. Well, I know that since my departure from
11 Eastern Health, there was an accreditation
12 process. The third hand feedback that I got
13 is that there was, I'll use my word, support
14 for the direction taken. So obviously there
15 was some means of accessing or being briefed
16 on the issues.
17 MS. NEWBURY:
18 Q. Yes, and I think you're correct, but I guess
19 my question is whether or not they had a full
20 picture of that. Whether there was something
21 that really pulled together all of the
22 elements of the various decisions made, their
23 complex issues, a number -
24 MR. TILLEY:
25 A. Sure.

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1 MS. NEWBURY:
2 Q. - of things changed over the years, whether
3 there's an official record that everyone at
4 Eastern Health acknowledges to be an accurate
5 depiction of what went on.
6 MR. TILLEY:
7 A. The accreditors work--accreditation works on
8 the basis of individual surveyors who go out
9 and pretty much given a free-for-all in terms
10 of what they're able to access. They're given
11 a briefing. I'm not sure, in this case,
12 whether there had been a written report, but
13 if there was, it would have been supplemented
14 by them being able to interview whoever, and
15 as part of the accreditation process, there's
16 usually an expectation that you identify
17 significant events that you'd been involved in
18 and do some sort of written analysis, so that
19 they are given a heads up as to what issue
20 they're going to try to assess.
21 MS. NEWBURY:
22 Q. But the outcome of their accreditation really,
23 it's going to depend upon the completeness and
24 accuracy of information provided to them.
25 MR. TILLEY:

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1 A. Yes, and to the extent that they have a good
2 dialogue with the people that they're
3 interviewing.
4 MS. NEWBURY:
5 Q. And then of course, you might get into
6 people's memories and whether they had a
7 complete source of information to begin with.
8 If they're selecting two or three people to
9 talk to, without the benefit of either of
10 those people either being involved in every
11 single aspect of this, or having access to an
12 official record that captures all of the
13 elements of the events as they unfolded, then
14 that particular person may not provide the
15 complete picture to the accreditors.
16 MR. TILLEY:
17 A. A possibility.
18 THE COMMISSIONER:
19 Q. Ms. Newbury, we're at the luncheon break.
20 MS. NEWBURY:
21 Q. Oh, okay.
22 THE COMMISSIONER:
23 Q. Can you tell me how much longer you're going
24 to be?
25 MS. NEWBURY:

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1 Q. Probably about five or ten minutes.
2 THE COMMISSIONER:
3 Q. In that case, why don't you carry on, and we
4 can then break.
5 MS. NEWBURY:
6 Q. Thank you. Would such an official record also
7 be a source of information for Eastern Health
8 itself, in terms of looking back in say five
9 years time or eight years time as to how it
10 responded to this adverse event and whether
11 there are any things they can learn from that.
12 MR. TILLEY:
13 A. Absolutely.
14 MS. NEWBURY:
15 Q. Okay, and how about communication with, for
16 example, the Department of Health? If you had
17 a ready official record that everyone has
18 signed off on, we all know this is accurate,
19 and then you could easily take from that and
20 provide information to the Department of
21 Health if they so request.
22 MR. TILLEY:
23 A. It would have multiple benefits, yes.
24 MS. NEWBURY:
25 Q. The Provincial Cancer Control Strategy, is

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1 this something that you're familiar with?
2 MR. TILLEY:
3 A. In a very limited way.
4 MS. NEWBURY:
5 Q. Okay, and can you describe its intentions?
6 MR. TILLEY:
7 A. The only involvement that I can speak to is
8 when the organization came to be, the Canadian
9 Cancer Society was an advocate for a
10 provincial strategy. They approached the
11 Department of Health, as well as Eastern
12 Health, and then there was a joint
13 consultation process put in place to begin to
14 develop that.
15 MS. NEWBURY:
16 Q. How about the other regional health
17 authorities?
18 MR. TILLEY:
19 A. I can't speak to it, with any knowledge.
20 MS. NEWBURY:
21 Q. And would all of these players that you
22 mentioned, three of the players that you just
23 mentioned, would they be considered equal
24 partners or would one, say, Eastern Health,
25 have more control over the strategy than

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1 another? How did you see that relationship
2 working?
3 MR. TILLEY:
4 A. Well, each contributed a different role. In
5 the end, a lot of these things you want to be
6 sure they're evidence based. You want to be
7 sure that you have the resources to deliver on
8 them. It all had to be set then in terms of
9 the priorities. So, you know, I guess,
10 without knowing the eventual outcome, I'm
11 assuming that a report must have originated
12 from it and then it's back to Eastern Health
13 and government in terms of follow through.
14 MS. NEWBURY:
15 Q. Do you think that had this Provincial Cancer
16 Control Strategy been implemented some time
17 prior to 2005 that it might have assisted in
18 avoiding or reducing the problems faced with
19 the hormone receptor testing, and in
20 particular, the response to that?
21 MR. TILLEY:
22 A. I'd only speculate.
23 MS. NEWBURY:
24 Q. And are you aware with some of the, I guess,
25 negative comments about Peter Dawe that have

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1 been found in some of the documents here,
2 about perhaps not wanting to fully communicate
3 with Mr. Dawe because of his commentary in the
4 media from time to time? Were you aware of
5 any sentiments of those concerned of that
6 type?
7 MR. TILLEY:
8 A. Well, I knew there was one reference to--in an
9 e-mail with regard to three individuals, and
10 Mr. Dawe was one of those. I just put that
11 down to a way of trying to describe the
12 situation and the importance of Eastern Health
13 coming forward to it. Mr. Dawe's reputation
14 in Eastern Health was certainly well known to
15 me, both in his role as executive director of
16 the Canadian Cancer Society, but also he had
17 worked for the organization in earlier years
18 and actually sat on the Board of Trustees of
19 the Health Care Corporation back in the late
20 90s. So he was somebody who was very familiar
21 to the organization and I know that Dr.
22 Williams, in particular, met with Mr. Dawe on
23 a number of occasions, as this process was
24 unfolding, just to exchange information.
25 MS. NEWBURY:

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1 Q. Did you have any concerns though that if there
2 are some negative attitudes within Eastern
3 Health that it may--if it, you know, were more
4 extensive than you might have guessed or if it
5 increased over time that it might impair a
6 relationship with a key stakeholder?
7 MR. TILLEY:
8 A. No, not at all. I mean, I think--I didn't
9 look at it in that context. It was more
10 probably some frustration, the events of the
11 day, but I think Mr. Dawe's reputation in our
12 organization is well respected.
13 MS. NEWBURY:
14 Q. Okay. So you didn't see any global problems
15 in that regard?
16 MR. TILLEY:
17 A. No, I did not.
18 MS. NEWBURY:
19 Q. Okay. Thank you, Mr. Tilley. Those are all
20 the questions I have. Thank you.
21 THE COMMISSIONER:
22 Q. Thank you, Ms. Newbury. I'm sorry, I'm having
23 trouble getting my words out today. Could we
24 do a short run around the room in terms of the
25 timing required? As you know, I rather

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1 publicly said I promised Mr. Tilley to get him
2 out of here today, so I'd really like to know
3 what's going on.
4 MS. TAYLOR:
5 Q. I estimate about an hour.
6 THE COMMISSIONER:
7 Q. All right. Mr. Pike?
8 MR. PIKE:
9 Q. I won't be very long at all. There's one
10 point that I wanted to touch on, but I believe
11 that my learned friend, Ms. Taylor, might
12 cover that. So I may have nothing.
13 THE COMMISSIONER:
14 Q. All right, thank you. Mr. Simmons?
15 MR. SIMMONS:
16 Q. I expect 30 to 45 minutes.
17 THE COMMISSIONER:
18 Q. All right. It looks like we will be able to
19 keep our promise to you, Mr. Tilley.
20 MR. TILLEY:
21 A. Thank you.
22 THE COMMISSIONER:
23 Q. 2:15, thank you.
24 (LUNCH BREAK)
25 THE COMMISSIONER:

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1 Q. Please be seated. Ms. Taylor.
2 MR. GEORGE TILLEY, EXAMINATION BY MS. PAMELA TAYLOR
3 MS. TAYLOR:
4 Q. Thank you, Commissioner. Good afternoon, Mr.
5 Tilley. My name is Pam Taylor. I'm here on
6 behalf of the Breast Cancer Testing Class
7 Action Group.
8 MR. TILLEY:
9 A. Yes.
10 MS. TAYLOR:
11 Q. So I have a number of different questions to
12 ask you. I'll try to get through them on
13 time. Now the first thing that I want to ask
14 you about is the IH service itself. That
15 service was instituted some time in 1997? Is
16 that right?
17 MR. TILLEY:
18 A. I can't confirm that. I'm not knowledgeable
19 of when it was formed actually.
20 MS. TAYLOR:
21 Q. Do you know--my understanding was it was
22 adopted in North America and Europe around the
23 mid to late 1990s, in terms of for ER/PR and
24 other stains.
25 MR. TILLEY:

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1 A. I'm sorry, I can't confirm, just not
2 knowledgeable about it.
3 MS. TAYLOR:
4 Q. Was it instituted as a new service while you
5 were involved with the St. John's Health Care
6 Corporation?
7 MR. TILLEY:
8 A. You referenced 1997?
9 MS. TAYLOR:
10 Q. Yes.
11 MR. TILLEY:
12 A. And I was certainly there then.
13 MS. TAYLOR:
14 Q. Okay.
15 MR. TILLEY:
16 A. But the actual implementation date or the
17 rationale for it, I wouldn't be able to add
18 anything.
19 MS. TAYLOR:
20 Q. When a new service is being implemented, I'll
21 ask you some general questions in terms of
22 management practice.
23 MR. TILLEY:
24 A. Okay.
25 MS. TAYLOR:

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1 Q. You'd expect that a service assessment or a
2 cost benefit analysis would be performed to
3 establish what sort of resources would be
4 needed before embarking on implementing a new
5 service. Would that be correct?
6 MR. TILLEY:
7 A. That's correct, but not always the practice.
8 MS. TAYLOR:
9 Q. Okay. Would it be fair to say that if you're
10 embarking on that sort of analysis, that
11 training that might be needed for individuals,
12 physical space, equipment, in particular for
13 IHC, whether the pathology staff had necessary
14 expertise, whether it would require
15 professional time to be taken away from other
16 lab services, those are some of the things
17 that might have to be considered?
18 MR. TILLEY:
19 A. Yes, you're correct.
20 MS. TAYLOR:
21 Q. Okay. There should be a budget drawn up when
22 a new service is being implemented?
23 MR. TILLEY:
24 A. Yes, I'd like to think so, but as I said, it
25 wasn't necessarily all the practice.

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1 MS. TAYLOR:
2 Q. Okay. A decision would have to be made as to
3 the objective of the service, in terms of the
4 quality of service that would be provided?
5 MR. TILLEY:
6 A. I would expect so, yes.
7 MS. TAYLOR:
8 Q. It would be desirable, I'd suggest, I'm saying
9 in particular with the IHC service, but it
10 would be desirable to know if it would be
11 cheaper to refer it out, pay a reference lab
12 to do it versus doing it in house?
13 MR. TILLEY:
14 A. That would -
15 MS. TAYLOR:
16 Q. Would that be a consideration?
17 MR. TILLEY:
18 A. I would think that would be a consideration,
19 then the question of other dimensions such as
20 accessibility and timeliness in turnaround and
21 so on.
22 MS. TAYLOR:
23 Q. Okay. In terms of with IHC and Eastern Health
24 and its predecessor organization, the
25 pathology service offers a residency training

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1 program?
2 MR. TILLEY:
3 A. Yes.
4 MS. TAYLOR:
5 Q. Would you want to know whether or not the
6 service had to be offered or whether that
7 would impact if the service is not offered
8 jeopardizing the residency program? If it
9 would be a requirement to have such a service?
10 MR. TILLEY:
11 A. Would that -
12 MS. TAYLOR:
13 Q. Would that be something -
14 THE COMMISSIONER:
15 Q. (inaudible) understand the question.
16 MS. TAYLOR:
17 Q. In terms of one of the considerations, the
18 pathology service offers a residency training
19 program and in terms of knowing whether or not
20 an IHC service would be something that the
21 facility would need to offer in terms of being
22 able to have that residency program, would
23 that be a consideration as well?
24 MR. TILLEY:
25 A. Possible. From time to time, Madam

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1 Commissioner, that in order to maintain a
2 teaching program, you have to have a
3 comprehensive list of services that students
4 could actually be working on. So I'm assuming
5 that's the relationship to the question.
6 MS. TAYLOR:
7 Q. I'm making an assumption that, you know, this
8 would involve all of these things and putting
9 a service like that into place would involve a
10 budgetary commitment into the hundreds of
11 thousands of dollars.
12 MR. TILLEY:
13 A. Right, but specifically in relation to whether
14 the IHC service would need to be a service
15 that a facility that has a teaching program
16 would need to have in order to maintain its
17 teaching program -
18 MS. TAYLOR:
19 Q. Right.
20 MR. TILLEY:
21 A. - efforts would be made to try to ensure that
22 we offer all of the services, but over the
23 years, there have been occasions when certain
24 elements of the teaching program have not been
25 offered, and they've either been sought

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1 through other organizations or some other way
2 of dealing with it would have been developed,
3 I suspect.
4 MS. TAYLOR:
5 Q. Okay, and doing such an analysis, would that
6 normally be routed through the VP of Medical
7 Services to the CEO for any final decisions?
8 MR. TILLEY:
9 A. Well, if it was a new program that was being
10 espoused then the recommendation would be put
11 through the budgetary process and then
12 considered as a part of the formal submission
13 to government. The reason I alluded to
14 earlier about, in most cases, and sometimes
15 it's not done, when I left the organization in
16 the late 90s and came back in 2000, I did do a
17 financial or entertain financial discussions
18 with each of the programs and services, and
19 there were services learned at that time that
20 had been incorporated without the necessary
21 funding being pre-approved, and that was done
22 as a part of trying to get a handle on why our
23 expenditures were not keeping within budget.
24 MS. TAYLOR:
25 Q. Do you know if IHC, where that fit in terms of

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1 -
2 MR. TILLEY:
3 A. No, I don't recall that one in particular.
4 MS. TAYLOR:
5 Q. Okay. In terms of the things that I've just
6 gone through, in embarking on a new program,
7 considering those sorts of elements, would you
8 agree that it would be good management
9 practice to consider those sorts of things, in
10 terms of whether or not a new service would be
11 implemented?
12 MR. TILLEY:
13 A. Yes, they're all things that would be
14 realistically considered before bringing in a
15 new program.
16 MS. TAYLOR:
17 Q. Okay. Now I'm going back to that 1997 time
18 period, my understanding that the service
19 would have been implemented around then. I
20 can't find any such analysis from that time
21 period or thereabouts that that sort of
22 consideration was made, in terms of
23 implementing the program, assuming it was
24 around that period.
25 THE COMMISSIONER:

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1 Q. Mr. Simmons? (inaudible) point us to
2 something?
3 MR. SIMMONS:
4 Q. It might be--I can't point to a particular
5 document, but I think it might be helpful to
6 know that I think '97 was when ER/PR tests
7 were instituted, but there was
8 immunohistochemical testing already being
9 carried on for some period of time before
10 that. So '97 wasn't when IHC service was
11 implemented. It was when this test was added.
12 THE COMMISSIONER:
13 Q. Testing by IHC for ER/PR?
14 MR. SIMMONS:
15 Q. Yes, correct.
16 MS. TAYLOR:
17 Q. But in terms of implementing a new type of
18 service, ER/PR testing, in 1997, would some of
19 the same considerations have to be made at
20 that time?
21 MR. TILLEY:
22 A. It's possible, depending on whether it's seen
23 as an adjunct to an existing program or not.
24 It's possible that it may not. If, in fact,
25 the program thought that it could absorb the

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1 cost within its own budget, possibly not. But
2 you know, each case would have to be looked
3 at, in that case, under its own merits.
4 MS. TAYLOR:
5 Q. If I could ask the Registrar to pull up P-
6 0697, please? Now at the time--let me just
7 scroll down to make sure it's on the screen
8 there for you. There's a specific part there
9 I want to ask you about on page one. Now at
10 the time that ER/PR testing was being
11 implemented in '97, according to this, the
12 laboratory at time, you'll see under financial
13 issues, the laboratory was $120,000 in the
14 red.
15 MR. TILLEY:
16 A. Yes.
17 MS. TAYLOR:
18 Q. So obvious statement, but it was over budget
19 at that time.
20 MR. TILLEY:
21 A. Right.
22 MS. TAYLOR:
23 Q. Okay, and then when I look at the paragraph
24 that starts "Mr. Whelan" and you've been
25 referred to this before, Mr. Whelan and Mr.

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1 Haegert?
2 MR. TILLEY:
3 A. Haegert, yeah.
4 MS. TAYLOR:
5 Q. "Met with George Tilley on Friday regarding
6 their concerns with the ability of the
7 laboratory program to save one million dollars
8 in the coming year's budget." So is it fair
9 to say, at that time, you, as CEO, were
10 experiencing some pressure to find savings in
11 different areas and you were passing along,
12 you know, that directive?
13 MR. TILLEY:
14 A. Right. Just a minor adjustment. Of course,
15 at that point in time, this is 1997?
16 MS. TAYLOR:
17 Q. Right.
18 MR. TILLEY:
19 A. I wasn't CEO. I would have been senior vice-
20 president in that period of time, and
21 secondly, what it talks about is in the coming
22 year's budget, so this is in January, did I--
23 sorry, I'm going to scroll up a little bit.
24 No. Yeah, okay, so this is in March of '04,
25 so the fiscal year starts in April. So it

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1 shows that towards the end of the year, they
2 were $120,000 year to date and by that time,
3 I'm thinking that February--maybe it would be
4 only the January financial statements would be
5 available. So this one million dollars was
6 being talked about in terms of the next year's
7 budget, and I had mentioned earlier this
8 morning that as part of the restructuring and
9 the decision to close physical plants, the
10 organization had invited in three consultants
11 who were involved in the site closures in
12 British Columbia and gave some benchmarks with
13 regards to what was realistically achievable
14 in terms of savings. So that's where that
15 million dollars came from, and I can't tell
16 you what percentage they had given us, and I
17 don't know, unfortunately, off the top of my
18 head, what the annual operating budget might
19 be for the laboratory medicine program. I'm
20 thinking it's tens of millions of dollars. So
21 they were--I would have met with them as the
22 leadership team for laboratory medicine and
23 indicated that at this point in time, the
24 target for the organization that would have
25 been proposed from laboratory medicine would

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1 be a million dollars, and of course, that was
2 being replicated through all programs and
3 services in the organization.
4 MS. TAYLOR:
5 Q. Right, and I should have actually identified
6 the document in the beginning. It was the
7 minutes of a laboratory meeting, divisional
8 managers meeting, and that was 97/03/04. Now
9 whether or not that's March 4th or April 3rd -
10 MR. TILLEY:
11 A. It's close, yeah.
12 MS. TAYLOR:
13 Q. Right. So then the next document that I'm
14 going to refer you to is P-0698. This again
15 is minutes of laboratory meeting, divisional
16 managers meeting. This is 1997, June 24th,
17 and in this one, I don't see that you would be
18 present for that, but I just had a few
19 questions on it for you.
20 MR. TILLEY:
21 A. Try it.
22 MS. TAYLOR:
23 Q. Now at that one, it shows that Terry Gulliver
24 is present. What was his role at that time?
25 MR. TILLEY:

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1 A. I'm assuming he would have been one of the
2 division managers within the lab that would
3 report to Vern Whelan.
4 MS. TAYLOR:
5 Q. Okay, and you've already referenced it, that
6 the 1997/98 budget, last year's actual as
7 projected as of February minus there was
8 $700,000 that was deducted from the laboratory
9 budget, and the reference actually is towards
10 the bottom of the first page.
11 MR. TILLEY:
12 A. Okay.
13 MS. TAYLOR:
14 Q. Do you see it there, the last paragraph?
15 MR. TILLEY:
16 A. Yes, I'm just going to read it. Okay.
17 MS. TAYLOR:
18 Q. In terms of the money that was being deducted
19 from the lab budget, again this is a question
20 on documentation and correct me if I'm wrong,
21 I haven't seen anything in terms of
22 documentation which outlines the impact of the
23 cut on the ability of the lab to deliver a
24 quality IHC service. Are you aware of
25 anything around that time you could point me

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1 to?
2 MR. TILLEY:
3 A. It's going back about eight or nine years now,
4 so I really can't be specific, though what we
5 would expect with every program is a
6 discussion with regards to what their funding
7 should be and we would also expect them to
8 work through what strategies they'll put in
9 place in order to achieve that amount. My
10 general recollection is that the laboratory
11 medicine program, I'm not sure if it ever
12 balanced its budget over the years, which is a
13 reflection that the targets have not been met.
14 I can't tell you if there was anything that
15 was raised.
16 I don't recall anything that would have
17 been raised around a quality of service issue
18 because of this. I do remember some things
19 about because now we were moving to fewer
20 sites that there was some economies of scale
21 that were going to be gotten. There were some
22 supply reagents which we would have gotten
23 because we bought new equipment, some managers
24 that may have had their positions declared
25 redundant and so on.

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1 MS. TAYLOR:
2 Q. And keeping that one in mind for one minute,
3 I'm going to ask the Registrar to pull up P-
4 0121. Now this is a review of the
5 immunohistochemistry lab, the General Hospital
6 site, which was done in October 13th, 2005.
7 MR. TILLEY:
8 A. Okay.
9 MS. TAYLOR:
10 Q. It says it's prepared for Dr. Williams and it
11 was prepared by Terry Gulliver, who's program
12 director at that point, and Dr. Cook, clinical
13 chief, Laboratory Medicine.
14 MR. TILLEY:
15 A. Okay.
16 MS. TAYLOR:
17 Q. Have you seen this before?
18 MR. TILLEY:
19 A. I'm not sure if it was referenced earlier in
20 my time on the stand here, but it's not
21 something that I would generally expect to
22 see.
23 MS. TAYLOR:
24 Q. Okay.
25 THE COMMISSIONER:

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1 Q. Do we know a date on this?
2 MS. TAYLOR:
3 Q. October 13th, 2005.
4 THE COMMISSIONER:
5 Q. Thank you.
6 MS. TAYLOR:
7 Q. And the reason that I'm asking you about it,
8 and if you can, just take some time and have a
9 look down through the document and let me know
10 when you're ready.
11 MR. TILLEY:
12 A. Okay.
13 MS. TAYLOR:
14 Q. It's more so, for me, the overall view of the
15 document, the sort of areas it covers.
16 MR. TILLEY:
17 A. Sure.
18 MS. TAYLOR:
19 Q. Take your time.
20 MR. TILLEY:
21 A. I got a sense as to what it's about, yes.
22 MS. TAYLOR:
23 Q. Okay. So when I look through this, this seems
24 to be--even though it says a review of
25 immunohistochemistry lab, there's particular

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1 references to ER/PR in here.
2 MR. TILLEY:
3 A. Okay.
4 MS. TAYLOR:
5 Q. But there's an overview in terms of the
6 objective of the lab, you know, technical
7 processes, quality assurance, and then there's
8 recommendations that are made in terms of, you
9 know, space issues, lab technician being--a
10 position being upgraded to a pathologist
11 assistant's position, new positions being
12 created. There's budgetary amounts placed on
13 those items.
14 MR. TILLEY:
15 A. Yes.
16 MS. TAYLOR:
17 Q. There's additional things that are referenced
18 in terms of being purchased. There's training
19 and there's costs laid out for all of those
20 various things. Would something like that,
21 would that be a process that would be followed
22 back in--something similar back in 1997 to see
23 what, you know, the review of the lab to see
24 what the costs would be in order to see how
25 $700,000 being taken away from that budget

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1 would impact on it?
2 MR. TILLEY:
3 A. I can say that in 2000 and onwards, there was
4 certainly a more comprehensive process, in
5 terms of budgeting, put in place, and that we
6 would have a designated team which would have
7 representatives from the budgeting department
8 and from our decision support areas actually
9 meet with the directors to get a better
10 appreciation for the impact of anything that
11 was being proposed or changed. I suspect in
12 the late 90s, when the organization came
13 together and there was site closures, I don't
14 recall that the same level of protocol being
15 in place to deal with some of these issues.
16 If there were concerns with regards to the
17 achievability of the recommendations, there
18 certainly would be an expectation that those
19 issues would be raised from the perspective of
20 to whether any recommendations being proposed
21 were achievable or not.
22 I guess the other thing is that at this
23 point in time, the program would have been
24 given a target and what it would do in order
25 to achieve that target was then with the

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1 program to put forward in terms of
2 recommendations.
3 MS. TAYLOR:
4 Q. But without an analysis such as that, without
5 a written analysis, I would suggest, it would
6 be very difficult for a service such as the
7 IHC lab and the laboratory service in general
8 to analyze the impact of a funding cut on
9 their ability to deliver a quality service.
10 Would you agree?
11 MR. TILLEY:
12 A. No, I wouldn't. I got to say that I've never
13 felt that anybody in the health system were
14 short of determination to make a concern
15 known, if in fact they had a concern that was
16 going to impact on the quality of the service.
17 Each of the clinical programs had access
18 points. Certainly in the case of the program
19 leadership team, with me as a senior vice-
20 president, Dr. Haegert would still have the
21 Medical Advisory Committee to use, and/or the
22 vice president of medical services, if in fact
23 there was a belief that they were proposing
24 something that in the end would impact on the
25 quality of service.

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1 MS. TAYLOR:
2 Q. So even if there's not something in writing,
3 it may have been something that verbally was
4 communicated through the chain of command,
5 let's just say, to make the concerns known?
6 MR. TILLEY:
7 A. I would have no doubt about that.
8 MS. TAYLOR:
9 Q. Okay. Now just to go back to P-0121 for a
10 minute, and this analysis that was done in
11 October of '05, and a review of the IHC lab at
12 that time. This was--the document is dated
13 October 13th, 2005. This is done after the
14 problems emerge with ER/PR testing and I'd
15 suggest at that point, at the time when the
16 service could be considered to be in crisis
17 because of the things that are coming to
18 light. Would it have been better to have an
19 analysis like this done at an earlier point in
20 time rather than later, at the time when the
21 service is now being--when the problems are
22 coming to light? Wouldn't it have been better
23 to have a written analysis like this?
24 MR. TILLEY:
25 A. Yes.

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1 MS. TAYLOR:
2 Q. Just as a matter of good hospital management.
3 MR. TILLEY:
4 A. Yes. If, in fact, there were concerns by
5 technologists, pathologists, physicians or any
6 other person in the organization, over the
7 years there have been many a physician that
8 would have come to me to suggest that we
9 needed to do more in a particular area or if
10 we were looking to put more people through
11 that might jeopardize the quality of service,
12 and I have no reason to think that this
13 program would do anything any different.
14 MS. TAYLOR:
15 Q. Okay. Now in terms of, I believe it was with
16 respect to the lab, but also with ER/PR
17 testing, I think that you had answered a
18 question about the gold standard, but there
19 was some reference to volume in that answer.
20 MR. TILLEY:
21 A. Yes.
22 MS. TAYLOR:
23 Q. Can you just reiterate that for me, if you
24 could?
25 MR. TILLEY:

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1 A. Well, there is a growing discussion across
2 Canada, and it's one that I had shared when I
3 was CEO here, and it has to do with this
4 connection that often gets lost with regards
5 to quantity and quality, and every service
6 that's in place or every service that gets
7 introduces needs to have that question as a
8 part of the analysis. In order, like any
9 skilled professional, the proficiency, the
10 level of quality improves with the volume of
11 services, and from time to time, there are
12 other factors that tend to override or not
13 override but become predominant in terms of
14 whether a service gets incorporated or not.
15 And one of the questions that I know has been
16 raised nationally is whether in fact this is
17 one of the services that lends itself to a
18 review under that lens.
19 MS. TAYLOR:
20 Q. But volume in and of itself wouldn't guarantee
21 excellence in terms of the service?
22 MR. TILLEY:
23 A. No, but it would certainly go a long way to
24 helping it. If a person is focusing in on
25 that day in, day out, if they have enough

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1 peers that they could consult with, if in
2 fact, they have difficult cases, you know, and
3 I think we could easily pick any profession
4 and draw similar relationships.
5 COMMISSIONER:
6 Q. Is it the other way around, perhaps, Mr.
7 Tilley, does the lack of volume of certain
8 things affect quality?
9 MR. TILLEY:
10 A. Oh, I would agree, Madam Commissioner. If, in
11 fact, you're not doing it on a regular basis,
12 then there is potential that you are not
13 picking up things that you should be picking
14 up or that your techniques are not as precise
15 as you'd like them to be.
16 MS. TAYLOR:
17 Q. In terms of Eastern Health's lab and in terms
18 of its affiliations, it's part of a university
19 teaching centre?
20 MR. TILLEY:
21 A. That's correct.
22 MS. TAYLOR:
23 Q. The same way Mount Sinai would be associated
24 with a university?
25 MR. TILLEY:

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1 A. Yes.
2 MS. TAYLOR:
3 Q. Okay. Now, Eastern Health itself, it would be
4 associated with, I believe it's, correct me if
5 I'm wrong on the number, but I think it's
6 about 337 beds in acute care hospital, that's
7 part of the hospital where the lab is located?
8 MR. TILLEY:
9 A. Yeah, that would probably be the General
10 Hospital site that would have that number of
11 beds.
12 MS. TAYLOR:
13 Q. Right. There's a children's hospital
14 associated with it?
15 MR. TILLEY:
16 A. Yes.
17 MS. TAYLOR:
18 Q. There's a medical school?
19 MR. TILLEY:
20 A. Yes.
21 MS. TAYLOR:
22 Q. Residency program and pathology and other
23 specialties?
24 MR. TILLEY:
25 A. Yes.

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1 MS. TAYLOR:
2 Q. There's a nursing school?
3 MR. TILLEY:
4 A. Yes.
5 MS. TAYLOR:
6 Q. Pharmacy school?
7 MR. TILLEY:
8 A. Yes.
9 MS. TAYLOR:
10 Q. There's a cancer treatment centre attached to
11 the main hospital?
12 MR. TILLEY:
13 A. Yes.
14 MS. TAYLOR:
15 Q. All of them are part of the Health Sciences
16 Complex?
17 MR. TILLEY:
18 A. Yes.
19 MS. TAYLOR:
20 Q. Okay. Now, if I could just turn to P-0278?
21 Now this is the pathology workload review that
22 was commissioned by the government. It says,
23 "Mr. John Abbott," and it's done by Dr.
24 Raymond Maung. Now, have you see this, Mr.
25 Tilley?

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1 MR. TILLEY:
2 A. I don't recall seeing that, no.
3 MS. TAYLOR:
4 Q. Okay. There's one particular reference that
5 I'm going to make to it and that is on page 9.
6 I'll take you down to it. It's about the
7 middle of the page. I'm going to put the
8 cursor right by -
9 MR. TILLEY:
10 A. Okay, yes, I see it.
11 MS. TAYLOR:
12 Q. No, sorry, it's the next paragraph.
13 MR. TILLEY:
14 A. Okay.
15 MS. TAYLOR:
16 Q. It's a description in terms of the St. John's
17 laboratory in terms of the area that it
18 serves.
19 MR. TILLEY:
20 A. Um-hm.
21 MS. TAYLOR:
22 Q. And within that paragraph you'll see it says
23 that "The lab serves the province as the
24 tertiary esoteric referral and academic centre
25 with undergraduate and graduate training

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1 programs and time allocated to research
2 activities."
3 MR. TILLEY:
4 A. Yes.
5 MS. TAYLOR:
6 Q. Now, would you agree that that's a fair
7 description of the lab and the facilities that
8 it's attached to?
9 MR. TILLEY:
10 A. Well, it certainly is tertiary, the General
11 Hospital and the Janeway. It's academic.
12 Yes, I think you're -
13 MS. TAYLOR:
14 Q. Okay. So if I could turn back to P-0121,
15 please? And actually, it's right there on the
16 screen. On page 2 there is an objective which
17 is listed under this report. And again, just
18 so we're clear, this is back to the review of
19 the immunohistochemistry lab that was prepared
20 for Dr. Williams.
21 MR. TILLEY:
22 A. October, '05, was it?
23 MS. TAYLOR:
24 Q. Right.
25 MR. TILLEY:

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1 A. Yeah, okay.
2 MS. TAYLOR:
3 Q. Okay. And in that if you look at 1.2 under
4 the, it says "Objective" it says that "The
5 objective of this proposal is to identify the
6 requirements needed to implement a complete
7 quality assurance program of the
8 immunohistochemistry lab insuring that we
9 provide a standardized and reliable service
10 equivalent to Mount Sinai reference lab in
11 Toronto." Not inferior, obviously, but
12 equivalent, that was the aim? Is that fair to
13 say that was the aim -
14 MR. TILLEY:
15 A. Yes.
16 MS. TAYLOR:
17 Q. - in terms of -
18 MR. TILLEY:
19 A. Right.
20 MS. TAYLOR:
21 Q. - the standard that the lab would operate -
22 MR. TILLEY:
23 A. And Mount Sinai had taken on this reputation
24 of being a gold standard in the country.
25 MS. TAYLOR:

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1 Q. Okay. So the philosophy of Eastern Health was
2 that the IHC lab should be regarded as a peer
3 lab of Mount Sinai?
4 MR. TILLEY:
5 A. That's correct.
6 MS. TAYLOR:
7 Q. Okay. And therefore held to the same
8 standards or level in terms of reliability?
9 MR. TILLEY:
10 A. It's clear to me from this statement that that
11 was the goal.
12 MS. TAYLOR:
13 Q. Okay. Would that be--now, in terms of from
14 1997 to 2005 the university affiliation and
15 other features that we've listed in terms of
16 the General Hospital and the, you know, as a
17 Health Science Complex and the various items,
18 schools that would be attached and associated
19 with it, would that be the same in 1997 as
20 2005, approximately?
21 MR. TILLEY:
22 A. I suspect there would be little difference.
23 MS. TAYLOR:
24 Q. Little difference?
25 MR. TILLEY:

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1 A. Um-hm.
2 MS. TAYLOR:
3 Q. So would the objective of the lab in 1997 be
4 the same as it was in 2005, to provide a
5 standard and reliable service equivalent to
6 the Mount Sinai reference lab in Toronto?
7 MR. TILLEY:
8 A. Well I don't know where Mount Sinai was at
9 that point in time because it seems to me that
10 this has been very evolutionary. But I can
11 say that the objective would be to offer a
12 first-class service.
13 MS. TAYLOR:
14 Q. And that would be the objective in '97 or
15 2005?
16 MR. TILLEY:
17 A. Yes.
18 MS. TAYLOR:
19 Q. Yeah. And if I can just go to P-0110, please?
20 This is a transcript of a interview that you
21 would have done with Nancy Wilson. It's dated
22 May 18th, 2007.
23 MR. TILLEY:
24 A. Okay.
25 MS. TAYLOR:

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1 Q. Do you remember that news conference?
2 MR. TILLEY:
3 A. The news conference?
4 MS. TAYLOR:
5 Q. Yeah.
6 MR. TILLEY:
7 A. Or was it just -
8 MS. TAYLOR:
9 Q. I'm sorry, it was a news conference.
10 MR. TILLEY:
11 A. Okay, yes, I'm with you now, sure.
12 MS. TAYLOR:
13 Q. Yeah. And on page 3 there's a reference,
14 actually, to the way you describe the lab.
15 Let me just get down to that. Unfortunately,
16 I'm not as proficient with the mouse as some
17 of the individuals.
18 COMMISSIONER:
19 Q. If you want to go to a particular page, the
20 registrar would be happy to help you.
21 MS. TAYLOR:
22 Q. Thank you. I've laid the cursor at the
23 paragraph, Mr. Tilley.
24 MR. TILLEY:
25 A. Yes.

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1 MS. TAYLOR:
2 Q. Okay. And in that paragraph you said at that
3 time that there was--I recall--it says in the
4 middle of the paragraph.
5 MR. TILLEY:
6 A. Yes.
7 MS. TAYLOR:
8 Q. "I recall that the comments of the physician,"
9 because someone, I think your evidence was
10 somebody had informed you -
11 MR. TILLEY:
12 A. Right.
13 MS. TAYLOR:
14 Q. - "that a physician had said that he
15 considered us to be in the middle of pack in
16 terms of laboratory services with regards to
17 ER/PR. And to be quite frank with you, we're
18 not satisfied with being in the middle of the
19 pack, we're interested in becoming amongst the
20 top laboratories for this procedure in the
21 country."
22 MR. TILLEY:
23 A. Yes.
24 MS. TAYLOR:
25 Q. So that obviously echoes what you were saying

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1 in terms of being a first-class service?
2 MR. TILLEY:
3 A. Yes.
4 MS. TAYLOR:
5 Q. That was the goal. Now, I'm going to,
6 Registrar, if you could, move to P-0375?
7 REGISTRAR:
8 Q. (Inaudible).
9 MS. TAYLOR:
10 Q. 0375, Exhibit P-0375. Thank you. Now, Mr.
11 Tilley, this is an affidavit which was filed
12 in the Supreme Court of Newfoundland and
13 Labrador in relation to the ongoing class
14 action involving Eastern Health.
15 MR. TILLEY:
16 A. Okay.
17 MS. TAYLOR:
18 Q. Okay. Have you seen this before?
19 MR. TILLEY:
20 A. No.
21 MS. TAYLOR:
22 Q. Okay.
23 MR. TILLEY:
24 A. Is this a patient, the name here, is this a
25 patient or -

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1 MS. TAYLOR:
2 Q. This, I don't want to give -
3 MR. TILLEY:
4 A. Okay, sorry.
5 MS. TAYLOR:
6 Q. - evidence on it.
7 MR. TILLEY:
8 A. Yeah, yeah, yeah.
9 MS. TAYLOR:
10 Q. - but there are a couple of questions that I
11 have on it.
12 MR. TILLEY:
13 A. Okay.
14 MS. TAYLOR:
15 Q. There's a lot of technical detail in this that
16 I'm not going to get into with you.
17 MR. TILLEY:
18 A. Okay. Thank you.
19 MS. TAYLOR:
20 Q. But if you could read for yourself, read the
21 first paragraph there, the gentleman's name as
22 well as the first paragraph?
23 MR. TILLEY:
24 A. This is Michael Gown?
25 MS. TAYLOR:

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1 Q. Yes.
2 MR. TILLEY:
3 A. Starting there?
4 MS. TAYLOR:
5 Q. Yes.
6 MR. TILLEY:
7 A. "City of Seattle, State of Washington, may go
8 with and say as follows."
9 MS. TAYLOR:
10 Q. You can just read it, actually, to yourself.
11 MR. TILLEY:
12 A. Oh, okay, thank you.
13 MS. TAYLOR:
14 Q. Yeah.
15 MR. TILLEY:
16 A. Okay. Should I move on after that?
17 MS. TAYLOR:
18 Q. Well, I'm going to ask you, are you familiar
19 at all with Dr. Gown, do you know who he is?
20 MR. TILLEY:
21 A. No.
22 MS. TAYLOR:
23 Q. Okay. You haven't heard the name before?
24 MR. TILLEY:
25 A. I have heard the name as a person that would

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1 have done some analysis here, but this
2 background I wasn't familiar with.
3 MS. TAYLOR:
4 Q. Okay. You didn't--you haven't met with him?
5 MR. TILLEY:
6 A. No.
7 MS. TAYLOR:
8 Q. You haven't spoken with him on the telephone?
9 MR. TILLEY:
10 A. No.
11 MS. TAYLOR:
12 Q. Okay. Did you know that he made a visit to
13 the site in February of 2006 to the IHC lab at
14 the General Hospital, did you know that?
15 MR. TILLEY:
16 A. That's possible, now that you've mentioned it,
17 but the date I couldn't be sure about.
18 MS. TAYLOR:
19 Q. Okay.
20 MR. TILLEY:
21 A. I'm more familiar with Dr.--the physicians
22 that we talked about earlier.
23 MS. TAYLOR:
24 Q. Right.
25 MR. TILLEY:

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1 A. The technologist and the other one.
2 MS. TAYLOR:
3 Q. And in paragraph 2, just so, in terms of the
4 date and where I got the date from.
5 MR. TILLEY:
6 A. Okay.
7 MS. TAYLOR:
8 Q. Okay. It says here that, "My opinions
9 concerning the laboratory were formed on the
10 information obtained during a visit to St.
11 John's, Newfoundland and Labrador in February
12 of 2006."
13 MR. TILLEY:
14 A. Yes, okay.
15 MS. TAYLOR:
16 Q. Okay. He goes on to say in that same
17 paragraph, "During the visit I met with
18 laboratory technologists and pathologists
19 involved in the determination of estrogen and
20 progesterone receptor status of breast cancers
21 at the laboratory and toured the facility."
22 MR. TILLEY:
23 A. Okay.
24 MS. TAYLOR:
25 Q. So you wouldn't have--and he also said,

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1 actually, that he attended St. Clare's
2 Hospital to view some of the slides immuno
3 stained using the DAKO instrument.
4 MR. TILLEY:
5 A. Okay.
6 MS. TAYLOR:
7 Q. You wouldn't have been involved in arranging
8 or being-setting up that visit or -
9 MR. TILLEY:
10 A. No.
11 MS. TAYLOR:
12 Q. - having any contact on that?
13 MR. TILLEY:
14 A. No.
15 MS. TAYLOR:
16 Q. Would you know who would be?
17 MR. TILLEY:
18 A. I would presume it would be either or both of
19 the -
20 MR. SIMMONS:
21 Q. Excuse me, Commissioner. I expect Ms. Taylor
22 knows that this particular affidavit was filed
23 as part of the civil proceedings regarding the
24 class action and that Dr. Gown, as I
25 understand it, was, this affidavit was filed

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1 in the midst of that action by the solicitors
2 at the Eastern Health and their insurer's own
3 end and any questions concerning the retainer
4 of that position and so on, I would think
5 would be subject to privilege in that action
6 and wouldn't be a proper line of inquiry here,
7 so -
8 COMMISSIONER:
9 Q. Wait now. How far are we going with this? So
10 far we've looked at the -
11 MR. SIMMONS:
12 Q. (Inaudible).
13 COMMISSIONER:
14 Q. - content of an--if you're just saying you're
15 raising it -
16 MR. SIMMONS:
17 Q. I'm raising it (inaudible, no microphone)
18 COMMISSIONER:
19 Q. - as a point that you have to be careful in
20 respect of solicitor/client privilege, that's
21 good.
22 MR. SIMMONS:
23 Q. (Inaudible).
24 COMMISSIONER:
25 Q. If you're telling me we have already gotten

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1 over that line, I haven't seen it.
2 MR. SIMMONS:
3 Q. I don't know where the questioning is going,
4 but I raise it as (inaudible).
5 COMMISSIONER:
6 Q. Okay. Well, let's find out where Ms. Taylor
7 is going. Ms. Taylor.
8 MS. TAYLOR:
9 Q. My point, Mr. Tilley, in asking you about who
10 may have arranged that meeting is that my next
11 question to you is going to be if you had been
12 involved in it, whether or not you would have
13 known which technologists or pathologists he
14 would have met with?
15 MR. TILLEY:
16 A. No, I'm sorry, I don't know.
17 MS. TAYLOR:
18 Q. And in terms of that, if I can go back to the
19 other question, do you know who would have
20 arranged that site visit and arranged those
21 interviews?
22 MR. TILLEY:
23 A. My presumption, but I don't know this as a
24 fact, is that it would be the leadership team,
25 which would be the clinical team and/or the

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1 program director.
2 MS. TAYLOR:
3 Q. Okay. Now, there are a couple of other points
4 that I just want to mention in that affidavit.
5 And if I can take you to paragraph, actually,
6 paragraph 3. And there's a reference here to
7 the techniques that are employed, but it says,
8 "At the St. John's Regional Hospital
9 laboratory."
10 MR. TILLEY:
11 A. Um-hm.
12 MS. TAYLOR:
13 Q. There wouldn't be an entity the St. John's
14 Regional Hospital? That would be incorrect?
15 MR. TILLEY:
16 A. It's not one that I use.
17 MS. TAYLOR:
18 Q. Okay. And if I can take you to paragraph 24?
19 And again, in paragraph 24 that's repeated,
20 you can see it there in the second line, "St.
21 John's Regional Hospital."
22 MR. TILLEY:
23 A. Um-hm.
24 MS. TAYLOR:
25 Q. He's talking about the General Hospital,

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1 obviously, because that's where the lab is.
2 You'd agree with that?
3 MR. TILLEY:
4 A. I can't speak to it, honestly. You mentioned
5 he was visiting St. Clare's?
6 MS. TAYLOR:
7 Q. Yeah. But it says in terms of, I can give you
8 the description of the--I think we had said in
9 three that "The St. John's Regional Hospital
10 laboratory" is how it's described. So you're
11 not sure what site that he visited?
12 MR. TILLEY:
13 A. No, I can't speak to that.
14 MS. TAYLOR:
15 Q. Okay. Would you characterize, if I move away
16 from that for a second, would you characterize
17 the General Hospital as a regional hospital?
18 MR. TILLEY:
19 A. Actually, in fact, all the St. John's
20 hospitals are really regional. They also have
21 a tertiary element. So it's, in my mind while
22 he uses the work "hospital" it implies that
23 there's one site he's referring to, but I
24 could almost say it refers to a multitude of
25 sites where those tests might be ongoing.

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1 MS. TAYLOR:
2 Q. Do you know--and this is just because you're
3 not sure who made the comment in terms of a
4 physician you were at the middle of the pack.
5 MR. TILLEY:
6 A. Yes.
7 MS. TAYLOR:
8 Q. You don't know if it was possibly Dr. Gown who
9 may have said that?
10 MR. TILLEY:
11 A. No, not off the top, no.
12 MS. TAYLOR:
13 Q. Okay. Who was the person who told you that
14 comment?
15 MR. TILLEY:
16 A. Well, I have it in a, one of my logbooks, for
17 sure, there's a reference to a comment being
18 made about a middle of the pack. So it would
19 have been referenced to me by somebody in a
20 meeting, but I have no name assigned to it,
21 but it was being referred to one of the
22 external reviews that we had undertaken.
23 MS. TAYLOR:
24 Q. Okay. Now, if I can, Mr. Tilley, I'm going to
25 take you to the Ejeckam memos, and those would

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1 be found at P-0113, Registrar. Now, I
2 understand, Mr. Tilley, the first time you
3 actually read these memos, I say memos because
4 there's three that we've referred to.
5 MR. TILLEY:
6 A. Yes.
7 MS. TAYLOR:
8 Q. Would have been in 2007?
9 MR. TILLEY:
10 A. Yes, that's my recollection.
11 MS. TAYLOR:
12 Q. Although the memos obviously originate in
13 2003.
14 MR. TILLEY:
15 A. Right.
16 MS. TAYLOR:
17 Q. That was the first time you actually read
18 them?
19 MR. TILLEY:
20 A. Right.
21 MS. TAYLOR:
22 Q. And the Premier had referred to them in the
23 House in May of 2007.
24 MR. TILLEY:
25 A. Yes.

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1 MS. TAYLOR:
2 Q. Was it after that time that you had read them
3 or do you know?
4 MR. TILLEY:
5 A. It would have been around that time.
6 MS. TAYLOR:
7 Q. Okay. Now, when you read them, would you
8 agree that, you know, you would have been
9 aware or been cognisant of the fact that the
10 information contained in that would have been
11 important, important information about the
12 facility?
13 MR. TILLEY:
14 A. Yes.
15 MS. TAYLOR:
16 Q. And the lab. Okay. And if I can go to page
17 7, Registrar, of P-0113? Thank you. Now, I
18 should, Mr. Tilley, just so you know which one
19 that I'm referring to, because there are
20 three, this is actually, you can see here,
21 this is the memo dated June 19th, 2003.
22 MR. TILLEY:
23 A. Okay.
24 MS. TAYLOR:
25 Q. To Terry Gulliver from Dr. Ejeckam. And I'll

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1 go back now to page 7. Okay. It says here in
2 No. 6, I'll put the cursor by it, "Diagnosis
3 based on inappropriate immuno stain will
4 surely jeopardize patient care and may even
5 expose the HCCSJ to litigation," the Health
6 Care Corporation of St. John's?
7 MR. TILLEY:
8 A. Yes.
9 MS. TAYLOR:
10 Q. Okay. Now, as well, Dr. Ejeckam, you're aware
11 now, that he had halted IHC testing for about
12 six to seven weeks in 2003?
13 MR. TILLEY:
14 A. Yes.
15 MS. TAYLOR:
16 Q. Does that describe a problem of a nature that
17 you would have expected to have been brought
18 to your attention?
19 MR. TILLEY:
20 A. Well, certainly to be brought to the attention
21 of the assigned vice president.
22 MS. TAYLOR:
23 Q. But not necessarily from there to your
24 attention?
25 MR. TILLEY:

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1 A. Depending on his assessment of the situation,
2 then a determination as to whether it was
3 something that I would be involved in or not.
4 MS. TAYLOR:
5 Q. Is it something that if you were made aware of
6 it, you would normally bring to the attention
7 of the board?
8 MR. TILLEY:
9 A. It would probably be brought to the attention
10 of the board through the quality review of the
11 lab program. And I, you know, I think it's an
12 important issue. If there were implications of
13 inaccurate tests that might have a retroactive
14 application, that certainly would be something
15 that would be brought to my attention as did
16 happen in 2005.
17 MS. TAYLOR:
18 Q. Now, if we could go, Registrar, to P-0112?
19 Now, Mr. Tilley, this is an e-mail from you,
20 it appears, to the trustees -
21 MR. TILLEY:
22 A. Yes.
23 MS. TAYLOR:
24 Q. - of the board. You're familiar with that,
25 you've seen that?

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1 MR. TILLEY:
2 A. I am, yes.
3 MS. TAYLOR:
4 Q. Yes. Okay, now I'm going to take you through
5 some questions on it. Towards the bottom of
6 that page there's a paragraph that starts
7 "They".
8 MR. TILLEY:
9 A. Yes.
10 MS. TAYLOR:
11 Q. "Asked as to why it was not shared with
12 administration at the time." Now, you were--
13 if you can, just in terms of what you were
14 doing in this e-mail, you were informing the
15 board of what?
16 MR. TILLEY:
17 A. Well, there would have been some media
18 coverage about that. I just got to remind
19 myself now, did I actually have--oh, yes, so
20 we had the interviews.
21 MS. TAYLOR:
22 Q. Yeah.
23 MR. TILLEY:
24 A. And I was sharing that information with the
25 board and I usually try to do that if there

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1 was anything of a significant nature so that
2 they had some appreciation for the issue being
3 discussed.
4 MS. TAYLOR:
5 Q. And in term of the time period, obviously it's
6 dated May 31st, 2007. And in your first
7 paragraph it says that "In the House of
8 Assembly yesterday the Premier released an
9 internal memo dated June, 2003."
10 MR. TILLEY:
11 A. Yes.
12 MS. TAYLOR:
13 Q. So that's when he would have referred to it
14 and had it in the House of Assembly.
15 MR. TILLEY:
16 A. Okay.
17 MS. TAYLOR:
18 Q. Okay.
19 MR. TILLEY:
20 A. Thank you.
21 MS. TAYLOR:
22 Q. You're welcome. So at the bottom of that
23 first page, it says, "They asked as to why it
24 was not shared with administration at the
25 time." The they in that situation, they being

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1 the press, I guess?
2 MR. TILLEY:
3 A. I would think so, yes.
4 MS. TAYLOR:
5 Q. And "They asked as to why it wasn't shared
6 with the administration." It obviously it the
7 Ejeckam memo for 2003?
8 MR. TILLEY:
9 A. Yes, right.
10 MS. TAYLOR:
11 Q. And they're asking at that time, being 2003?
12 MR. TILLEY:
13 A. That's my understanding, yes.
14 MS. TAYLOR:
15 Q. The date on the memo. And then it says, "We
16 responded that it would not come to our
17 attention unless there was specific
18 recommendations flowing from it." It again,
19 obviously, is that memo that we're referring
20 to?
21 MR. TILLEY:
22 A. Yes.
23 MS. TAYLOR:
24 Q. And you're summarizing the response that was
25 given to the press at that time?

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1 MR. TILLEY:
2 A. Right.
3 MS. TAYLOR:
4 Q. Okay. With the intention, obviously, that the
5 press would rely on that?
6 MR. TILLEY:
7 A. Yes.
8 MS. TAYLOR:
9 Q. And so then in this e-mail you're repeating
10 that response to the board?
11 MR. TILLEY:
12 A. Yes.
13 MS. TAYLOR:
14 Q. Right. With the intention, obviously, that
15 the board would rely on the accuracy of the
16 response?
17 MR. TILLEY:
18 A. That's true.
19 MS. TAYLOR:
20 Q. Okay. Now, I'm going to take you through some
21 parts of the actual memo. So if we could go
22 to P-0113, please, Registrar? And if we could
23 go to page 5? Thank you. Now again, we're
24 back to the June 19th Ejeckam memo to Mr.
25 Gulliver?

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1 MR. TILLEY:
2 A. Yes.
3 MS. TAYLOR:
4 Q. And if I can just take you down through some
5 of the things that Dr. Ejeckam talks about.
6 In No. 1 in terms of the lab and just before
7 that he's talking about the General Hospital
8 Department of Laboratory Medicine and
9 Pathology.
10 MR. TILLEY:
11 A. Um-hm.
12 MS. TAYLOR:
13 Q. So in the first part, "The physical location
14 of the facility is unsatisfactory."
15 MR. TILLEY:
16 A. Um-hm.
17 MS. TAYLOR:
18 Q. That's what he was indicating. And then he
19 goes on to talk about it needing to be houses,
20 the stains, the immunohistochemical stains
21 need to be housed in a separate room and
22 humidity controlled, that's referenced?
23 MR. TILLEY:
24 A. Right.
25 MS. TAYLOR:

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1 Q. And then in paragraph 2, he talks about that
2 it's an extremely sensitive procedure and a
3 haphazard and "les affaire" approach to it is
4 not the way to go. Do you see that?
5 MR. TILLEY:
6 A. Yes, I do.
7 MS. TAYLOR:
8 Q. Okay. And then in three he talks about the,
9 in the third line, "There has to be dedicated
10 staff to take over this special procedure."
11 MR. TILLEY:
12 A. Um-hm.
13 MS. TAYLOR:
14 Q. And then he also says, actually, in that same
15 paragraph, in the last line of that paragraph,
16 and he goes through a number of things in
17 terms of what the actual designated staff
18 would do and having standby staff.
19 MR. TILLEY:
20 A. Yes.
21 MS. TAYLOR:
22 Q. But do you see where I put the cursor?
23 MR. TILLEY:
24 A. Yes, I do.
25 MS. TAYLOR:

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1 Q. "To do less, would simply become a gamble
2 where you may win or lose. This will
3 obviously spell disaster."
4 MR. TILLEY:
5 A. Uh-hm.
6 MS. TAYLOR:
7 Q. So he's indicating his thoughts on that. Then
8 paragraph 4, there's a reference in the last
9 full sentence, "Since this is the only centre
10 in the province that performs this test, there
11 is enough case to be made for identifying this
12 activity as special and unique, therefore
13 requires financing and staffing."
14 MR. TILLEY:
15 A. Uh-hm.
16 MS. TAYLOR:
17 Q. So possibly special financing and staffing
18 being arranged is something he's referring to.
19 And in paragraph 5, he's talking about--and
20 I'll put the cursor by it again, he's talking
21 about the technology, he says "some of them
22 have less than two or three years in the
23 establishment and their exit will create a
24 vacuum, another period of uncertainty for
25 immunohistochemistry." So it seems to be a

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1 warning about impending staff retirement.
2 MR. TILLEY:
3 A. Right.
4 MS. TAYLOR:
5 Q. And then it ends with a recommendation that,
6 he advises that "a hard look at the above be
7 taken, commit the necessary resources, human
8 and financial to this special all important
9 and only service in the province of
10 Newfoundland." So if I come back to P-0012,
11 please, Registrar? And when I go back to that
12 paragraph that I was referring you to earlier
13 that starts, "They ask why it was not shared
14 with administration, we responded that it
15 would not come to our attention unless there
16 were specific recommendations flowing from
17 it."
18 MR. TILLEY:
19 A. That's correct.
20 MS. TAYLOR:
21 Q. And we've just gone through a number of
22 various items, would you not agree that that
23 memo contains specific recommendations?
24 MR. TILLEY:
25 A. Yes, it certainly does; however the

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1 recommendations that I was referring to would
2 be anything that would require administrative
3 approval. Now you may recall from one of the
4 other memos that is associated with this, that
5 the service was reactivated five weeks later.
6 So at that point in time, up until that point
7 in time, there had been no executive or
8 administrative support in the decision, so the
9 recommendations were dealt with within the
10 laboratory program itself.
11 MS. TAYLOR:
12 Q. So you would view the advice that you were
13 giving to the Board at that time, as being
14 correct.
15 MR. TILLEY:
16 A. Yes, that's right.
17 MS. TAYLOR:
18 Q. But those things weren't really set out and
19 referenced in terms of what would need
20 administrative involvement or not?
21 MR. TILLEY:
22 A. No, I guess the organization is so large that
23 a lot of issues get resolved long before they
24 reach an administrative level. So we would
25 clearly see things go to administrative level

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1 if in fact the resources needed to be sought
2 outside of that or some other approvals that
3 were beyond their ability to approve, but in
4 this case, it obviously hadn't been.
5 MS. TAYLOR:
6 Q. With the memos overall, did you--when they
7 came to your attention and when you read them,
8 did you make any inquiries as to why you were
9 only finding out about them later and not back
10 in 2003?
11 MR. TILLEY:
12 A. I did. I think what I did learn since that
13 time is that the minutes of the surgical
14 pathology committee were in fact, or had in
15 fact been passed on to the vice-president, but
16 only that, and at that point in time it was an
17 all clear signal that things had been
18 resolved.
19 MS. TAYLOR:
20 Q. Sorry, the minutes of surgical pathology had
21 been passed on to the vice-president of
22 Medical Services?
23 MR. TILLEY:
24 A. That's my understanding, right.
25 MS. TAYLOR:

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1 Q. Would that have been Dr. Williams?
2 MR. TILLEY:
3 A. Yes.
4 MS. TAYLOR:
5 Q. Do you know when that would have, what minutes
6 you're referencing in terms of a date?
7 MR. TILLEY:
8 A. Five weeks after this date, perhaps, if that
9 was June 2003, then it would have been
10 July/August.
11 MS. TAYLOR:
12 Q. And your understanding at that point it would
13 have been that an all clear was being given.
14 MR. TILLEY:
15 A. The surgical pathology minutes indicate that
16 the service had been reactivated, that's the
17 minutes that I'm vaguely recalling.
18 MS. TAYLOR:
19 Q. Now if we can go back to P-0112.
20 REGISTRAR:
21 Q. Ms. Taylor, this is P-0112.
22 MS. TAYLOR:
23 Q. Oh I'm sorry, I apologize for that. Okay and
24 actually on the first page, here it says "The
25 questions of the media are many, including why

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1 was something not done about this in 2003."
2 And the answer that was given, I presume, at
3 least to the media and then to the Board, was
4 that "the focus at the time was about tissue
5 staining and there was no indication of a
6 results concern."
7 MR. TILLEY:
8 A. Yes.
9 MS. TAYLOR:
10 Q. Now, I can take you back to the Ejeckam memo,
11 but if you might remember the Ejeckam memo
12 stated that the diagnosis based on
13 inappropriate immuno stain will surely
14 jeopardize patient care. Do you remember that
15 from a few minutes ago?
16 MR. TILLEY:
17 A. Yes, I do.
18 MS. TAYLOR:
19 Q. So is the advice that you were giving to the
20 Board consistent with the Ejeckam memo?
21 MR. TILLEY:
22 A. Well, the information that I passed on was the
23 information that I would have gleaned from the
24 clinical chief of Laboratory Medicine to say
25 they didn't see an issue with the results, it

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1 was around the staining, the staining was a
2 problem and they believed that they had
3 corrected that problem.
4 MS. TAYLOR:
5 Q. So you were relying on Dr. Williams for
6 interpretation of any results concern -
7 MR. TILLEY:
8 A. Actually in that case, Dr. Williams had since
9 retired.
10 MS. TAYLOR:
11 Q. So Dr. Howell?
12 MR. TILLEY:
13 A. No, actually it would have been Drs. Cook and
14 Denic were available at that point in time.
15 MS. TAYLOR:
16 Q. Yes, right. So that's who you were relying on
17 for an interpretation of the concerns.
18 MR. TILLEY:
19 A. Yes.
20 MS. TAYLOR:
21 Q. And that's what you were passing on to the
22 Board?
23 MR. TILLEY:
24 A. That's correct.
25 MS. TAYLOR:

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1 Q. Your understanding after speaking with those
2 individuals?
3 MR. TILLEY:
4 A. Yes.
5 MS. TAYLOR:
6 Q. Okay, would you say that your advice to the
7 Board would suggest that there was no issue
8 with patient care in 2003?
9 MR. TILLEY:
10 A. Well that was just a referral of the
11 conclusion that had been presented to me.
12 There is always a question in my mind as to
13 whether it was bigger than that, but I had no
14 basis to assume that based upon the feedback
15 that I had gotten.
16 MS. TAYLOR:
17 Q. And in terms of your reading of the memo
18 itself and when you read "diagnosis based on
19 inappropriate immuno stain will surely
20 jeopardize patient care" that doesn't suggest
21 to you that there would have been an issue
22 with patient care, in terms of your own
23 interpretation?
24 MR. TILLEY:
25 A. Well based upon my own interpretation, it

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1 implies that unless that issue is resolved
2 there could be an issue with patient care.
3 What I was clearly hearing was that there
4 were, there was nothing that was suggesting
5 that a retroactive problem was being evident.
6 MS. TAYLOR:
7 Q. So in terms of why there was something not
8 done about this in 2003, did you question
9 whether--and putting aside there for one
10 second, did you question, you know, there's
11 retesting that's done in 2005, did you
12 question whether or not retesting might have
13 been done in 2003?
14 MR. TILLEY:
15 A. I did and the answer was, the conclusion at
16 that point in time was that there was a belief
17 that there was no need to go and retest
18 because of that.
19 MS. TAYLOR:
20 Q. Okay.
21 THE COMMISSIONER:
22 Q. Does that indicate somebody thought about it
23 and decided not to do it, or just they didn't
24 think about it or -
25 MR. TILLEY:

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1 A. Can't be specific, no.
2 THE COMMISSIONER:
3 Q. All right, thank you.
4 MS. TAYLOR:
5 Q. And if I can turn actually to P-0079? Now,
6 this is a letter that's written to Donald
7 Cook, Dr. Donald Cook and it's written by Dr.
8 Beverly Carter, dated August 2nd, 2005 and
9 this is the letter whereby she indicates that
10 she's withdrawing from the organizational role
11 in the investigation of the problems with
12 ER/PR testing.
13 MR. TILLEY:
14 A. Uh-hm.
15 MS. TAYLOR:
16 Q. You've seen this before?
17 MR. TILLEY:
18 A. I have through here, actually.
19 MS. TAYLOR:
20 Q. Right. Now you had met with Dr. Carter, as
21 well as others, on August 1st?
22 MR. TILLEY:
23 A. Yes, she was one of a number of people in a
24 meeting.
25 MS. TAYLOR:

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1 Q. And we've talked about blameless culture, that
2 was the meeting where there were some issue in
3 terms of, there was a feeling that perhaps
4 blame was being laid or that there was
5 discussion back and forth in terms of -
6 MR. TILLEY:
7 A. That's correct.
8 MS. TAYLOR:
9 Q. I don't want to put words into your mouth, so
10 you describe it for me.
11 MR. TILLEY:
12 A. No, but there were comments being made to
13 suggest that this wasn't in my camp, you know,
14 it was in somebody else's camp and so clearly
15 there was some references to people saying
16 accountability belonged to somebody else or
17 responsibility belonged to somebody else.
18 MS. TAYLOR:
19 Q. And in that letter, she actually says in the
20 third paragraph that it became clear to her
21 during that meeting that the current
22 administrator's structure within Eastern
23 Health within the laboratory allows decisions
24 regarding the development of a reliable and
25 reproducible system for assessing hormone

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1 receptor status to remain in the hands of,
2 what she calls paraprofessional staff within
3 the laboratory?
4 MR. TILLEY:
5 A. Yes.
6 MS. TAYLOR:
7 Q. She also says previous to that, the previous
8 paragraph, "The meeting with Mr. George Tilley
9 on August 1st, 2005 showed, in my opinion,
10 that Mr. Terry Gulliver and Mr. Barry Dyer, do
11 not have a good understanding of the
12 limitations of automated immunohistochemistry,
13 rigorous clinical, technical validation of
14 antibodies" and it goes on from there.
15 MR. TILLEY:
16 A. Uh-hm.
17 MS. TAYLOR:
18 Q. So basically she was indicating that the
19 meeting, to her, showed that the lab managers,
20 because those were the lab managers?
21 MR. TILLEY:
22 A. That's correct.
23 MS. TAYLOR:
24 Q. Did not have an understanding of ER/PR
25 testing.

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1 MR. TILLEY:
2 A. Well that was her opinion, I know that both or
3 all of those individuals, including Dr.
4 Carter, spoke to that issue. And with a
5 disagreement of that nature, then my
6 expectation would be the clinical chiefs got
7 to get involved to reconcile any disagreements
8 and see whether there is any appropriate
9 follow up.
10 MS. TAYLOR:
11 Q. So by that letter, she withdraws from the
12 organizational role, her organizational role
13 in the investigation of ER/PR testing.
14 MR. TILLEY:
15 A. Yes.
16 MS. TAYLOR:
17 Q. That was currently ongoing. She was a sub-
18 specialty breast pathologist, right?
19 MR. TILLEY:
20 A. That's correct.
21 MS. TAYLOR:
22 Q. The only pathologist with that sub-specialty?
23 MR. TILLEY:
24 A. That's my understanding.
25 MS. TAYLOR:

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1 Q. But you would agree that she'd be an important
2 asset to the lab and to that investigation?
3 MR. TILLEY:
4 A. Absolutely.
5 MS. TAYLOR:
6 Q. She says actually in the last paragraph, I
7 believe, of the letter, "I regret not being
8 able to participate fully in this process, but
9 I am very uncomfortable placing my
10 professional license here in the forefront of
11 this operation and risking my reputation,
12 locally, nationally and internationally as an
13 expert in breast pathology." Now, she had
14 pointed to Mr. Gulliver and Mr. Dyer as being
15 involved in and responsible for--well Dr.--Mr.
16 Gulliver would be the lab director, wouldn't
17 he?
18 MR. TILLEY:
19 A. That's correct.
20 MS. TAYLOR:
21 Q. And she had pointed to him as being
22 responsible to provide a high quality service
23 and to document that service, is that correct?
24 That he would be responsible for providing a

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1 high quality level of service, as the lab
2 director?
3 MR. TILLEY:
4 A. Yes, as well as the pathologists and all the
5 staff in fact.
6 MS. TAYLOR:
7 Q. You hadn't seen this letter though?
8 MR. TILLEY:
9 A. No.
10 MS. TAYLOR:
11 Q. Having somebody like that resign from that
12 investigation, would you describe that as a
13 serious situation?
14 MR. TILLEY:
15 A. Yes, I would. Dr. Williams and I conversed
16 about it. He understood that Dr. Cook was
17 going to follow up with her, but the end
18 result is that she chose to remain in the
19 fashion she describes here, although I believe
20 there's some reference here to being available
21 for consult, but I don't see it on this page.
22 MS. TAYLOR:
23 Q. The letter was cc'd to Dr. Williams. When did
24 you discuss the resignation?
25 MR. TILLEY:

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1 A. There's a note in one of my telephone logs
2 about Dr. Carter, so I know it's there, but I
3 can't tell you the date off the top of my
4 head.
5 MS. TAYLOR:
6 Q. And sorry, you had indicated that at that
7 point Dr. Cook was going to speak with her?
8 MR. TILLEY:
9 A. Right.
10 MS. TAYLOR:
11 Q. Now if I can take you to P-0308. Now, Mr.
12 Tilley, this is something that you may not
13 have seen. It's from Heather Predham, dated
14 October 18th, 2005. Sent to K. Laing, Dr.
15 Laing, Patricia Pilgrim, Dr. Williams and
16 Susan Bonnell. The subject is "Patient
17 Letter". Have a look at it just to see if
18 it's something that you've seen before. I'm
19 just going to reference on particular part of
20 it.
21 MR. TILLEY:
22 A. I've got to be honest with you, I've seen so
23 much these days it's all starting to appear
24 muddled, but you go ahead and reference your
25 issue and see if I can pick it up from there.

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1 MS. TAYLOR:
2 Q. All right. I'll just summarize it first for
3 you, there would have been a draft letter
4 attached, then she's going down through, in
5 terms of some considerations I would think
6 with respect to disclosure or the sending of
7 the letter.
8 MR. TILLEY:
9 A. Uh-hm.
10 MS. TAYLOR:
11 Q. But then where it says here, "Finally, I think
12 we should be aware that we will not be able to
13 notify everyone. Several on the list have
14 moved and we have no other contact
15 information."
16 MR. TILLEY:
17 A. Uh-hm.
18 MS. TAYLOR:
19 Q. So I understand that Ms. Predham was and her
20 department was pretty involved in the
21 disclosure aspect of this issue?
22 MR. TILLEY:
23 A. Yes.
24 MS. TAYLOR:
25 Q. And she is saying there and stating as a fact

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1 that she thinks we should be aware that "we
2 will not be able to notify everyone".
3 MR. TILLEY:
4 A. Uh-hm.
5 MS. TAYLOR:
6 Q. So were you aware in October of 2005 that
7 Eastern Health or certainly individuals at
8 Eastern Health felt that the organization
9 would not be able to notify everyone?
10 MR. TILLEY:
11 A. I do recall a reference to having difficulties
12 with current--sorry, with old contact
13 information and that was presenting quite a
14 challenge for them. My expectation beyond
15 that is that they would keep looking until
16 they found those people.
17 MS. TAYLOR:
18 Q. In terms of a time period on when you
19 understood that this old contact information
20 was an issue, can you recall? Would that have
21 been around the same time?
22 MR. TILLEY:
23 A. I would expect so, yes. I know when they
24 started the process, they were relying on
25 information that had been in the--that

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1 addresses that would have been submitted at
2 the time the tests were actually performed, so
3 some of those people had obviously moved, but
4 that was, I guess in many ways to be expected
5 when the information was, in some cases,
6 several years old.
7 MS. TAYLOR:
8 Q. So it's fair to say that Eastern Health or
9 certainly individuals within Eastern Health
10 knew that it would not be able to note
11 everyone from a time period of October 2005,
12 that that was going to be an issue?
13 MR. TILLEY:
14 A. Well it certainly was going to be an issue and
15 a challenge to keep tracking those people
16 down.
17 MS. TAYLOR:
18 Q. Up to May of 2007, however, Eastern Health
19 stated publicly that everyone was notified.
20 MR. TILLEY:
21 A. Yes.
22 MS. TAYLOR:
23 Q. And the Minister of Health had been told that
24 everyone had been notified.
25 MR. TILLEY:

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1 A. Yes.
2 MS. TAYLOR:
3 Q. And actually various ministers throughout that
4 time period, yet some in Eastern Health were
5 advised as a fact, from October of 2005, that
6 not everybody would be able to be notified.
7 MR. TILLEY:
8 A. Yes.
9 MS. TAYLOR:
10 Q. Now that was given to Dr. Laing, Ms. Pilgrim,
11 Dr. Williams and Ms. Bonnell. Was--you're
12 saying that that information was given to you
13 as well, but in terms of exactly when--would
14 you have known that when the other information
15 was being put out by Eastern Health that, you
16 know, saying that everybody was contacted?
17 MR. TILLEY:
18 A. Right. I certainly knew in the fall of 2005
19 that they were having difficulties with names
20 and the expectation that I had from there is
21 that it was going to require more effort in
22 terms of tracking those people down. The
23 assumption that we went forward with after
24 that is that over time we were able to pick up
25 those and move on.

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1 MS. TAYLOR:
2 Q. That you were able to identify them.
3 MR. TILLEY:
4 A. Right.
5 MS. TAYLOR:
6 Q. Okay, so that was your understanding that
7 somewhere along the way people on the list
8 that had moved and you had no contact
9 information, that that had been tracked down.
10 MR. TILLEY:
11 A. Yes.
12 MS. TAYLOR:
13 Q. Now if I could, Mr. Tilley, I'm going to get
14 the Registrar to take us to P-0056. Now these
15 are pages from the administrative policy
16 manual.
17 MR. TILLEY:
18 A. Okay.
19 MS. TAYLOR:
20 Q. And I'm not going to go into great deal of
21 detail because some of this has been covered.
22 When I look at page--sorry, just bear with me
23 for a second here, when I look at page 8. Now
24 this is dated 1999-09-30, revised 2002-06-20
25 and the second is quality title "Critical

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1 occurrence incident review, issuing authority
2 VP Quality Planning" and signed, there the
3 signature is Pamela Elliott. And her role
4 again was what?
5 MR. TILLEY:
6 A. Would have been vice-president of quality and
7 planning.
8 MS. TAYLOR:
9 Q. Now this would have been the policy that would
10 have governed occurrences in 2003?
11 MR. TILLEY:
12 A. Yes.
13 MS. TAYLOR:
14 Q. Okay, and I think that you said earlier when
15 Ms. Newbury was asking you questions that the
16 Ejeckam incident, did you classify that as an
17 occurrence?
18 MR. TILLEY:
19 A. There's a form that might be able to help my
20 thinking here, but it required or it outlined
21 a list of those things that would normally be
22 expected to have a, to be documented on. But
23 off the top of my head, I would think that
24 that type of a situation would be an
25 appropriate one to document.

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1 MS. TAYLOR:
2 Q. Well -
3 MR. TILLEY:
4 A. I'm going to scroll down if that's okay.
5 MS. TAYLOR:
6 Q. Yes, go ahead.
7 MR. TILLEY:
8 A. There's a broad list there but it's not
9 conclusive enough to -
10 MS. TAYLOR:
11 Q. Well just to go up a little bit further, under
12 policy where it says "A critical occurrence
13 incident review is any situation that because
14 of its nature may be a significant risk to the
15 client staff reputation or finances of the
16 Health Care Corporation of St. John's."
17 Looking at the Ejeckam memos and the
18 circumstances at that time, and looking at
19 that definition of occurrence which I would
20 suggest is very broad -
21 MR. TILLEY:
22 A. Yes.
23 MS. TAYLOR:
24 Q. Now testing was suspended for five to six
25 weeks in 2003 for what was described as

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1 unreliable, erratic, unhelpful stains,
2 unhelpful for diagnostic purposes. Would you
3 say that that fits within the definition that
4 we've just read?
5 MR. TILLEY:
6 A. Yes, I would like to have seen that in an
7 occurrence support (sic).
8 MS. TAYLOR:
9 Q. And according to page 4--oh, I'm sorry, I have
10 my pages out of order here. Who would
11 normally--who would that be reported to?
12 MR. TILLEY:
13 A. All the occurrence reports would be submitted
14 to the Quality Department.
15 MS. TAYLOR:
16 Q. Okay, would they be then reported to the
17 applicable vice-president?
18 MR. TILLEY:
19 A. If in fact it was an active issue, yes.
20 MS. TAYLOR:
21 Q. And at that time the applicable vice-president
22 in 2003 would have been whom?
23 MR. TILLEY:
24 A. For the lab, it would have been Dr. Williams
25 and of course, for the quality, it would be

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1 Mrs. Elliott.
2 MS. TAYLOR:
3 Q. And I thought that you had indicated in your
4 testimony that your understanding was Dr.
5 Williams wasn't informed of the testing
6 suspension occurrence until 2005?
7 MR. TILLEY:
8 A. That's correct.
9 MS. TAYLOR:
10 Q. Which is two years later?
11 MR. TILLEY:
12 A. That's correct.
13 MS. TAYLOR:
14 Q. That would seem to be a breach of the policy
15 that we're just reading through, if he hadn't
16 been informed at that time?
17 MR. TILLEY:
18 A. It implies that either there was no occurrence
19 report filed or that it was filed and not
20 referred on to him, but I can't answer which.
21 MS. TAYLOR:
22 Q. Right, but you would have expected to see an
23 occurrence report?
24 MR. TILLEY:
25 A. I think that would have been a significant

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1 event, yes.
2 MS. TAYLOR:
3 Q. And then if I can turn to page 18 of that same
4 document, Registrar? Now this is from the
5 Administrative Policy Manual and the date on
6 it is 2004-09-09, Guidelines on Disclosure of
7 Adverse Events. Would this have been the
8 policy that would have been in place for
9 disclosure of adverse events in 2005?
10 MR. TILLEY:
11 A. Yes, I would think so.
12 MS. TAYLOR:
13 Q. Okay, and in terms of that, I know you've
14 already been asked questions on it today, I
15 think that what you had indicated was that the
16 magnitude of the ER/PR issue, you weren't sure
17 if it would have fit within the occurrence
18 reporting form, as would be outlined in this
19 policy?
20 MR. TILLEY:
21 A. That's true.
22 MS. TAYLOR:
23 Q. I haven't seen anything, perhaps you can tell
24 me if you have, I haven't seen anything that,
25 to show a documented consideration of these

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1 disclosure guidelines and how they might apply
2 to the ER/PR issue?
3 MR. TILLEY:
4 A. I don't recall any documented issue either,
5 other than to say that there were lots of
6 discussions about how do you apply it in the
7 context of the number of individuals impacted
8 here.
9 MS. TAYLOR:
10 Q. Okay, and I think you had said in your
11 testimony that in terms of an adverse event
12 that you would identify an adverse event in
13 the ER/PR context of one where there was a
14 change in result, is that what you had
15 indicated?
16 MR. TILLEY:
17 A. That may not be, there may be any number of
18 reasons for a change in a result that might
19 not have resulted from an error.
20 MS. TAYLOR:
21 Q. Okay, if I can find the reference -
22 THE COMMISSIONER:
23 Q. Ms. Taylor, it is about the time for the
24 afternoon break. Would you like me to do the
25 break now and you can find that?

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1 MS. TAYLOR:
2 Q. Yes, I think so, because I don't want to take
3 up too much time and I can find the reference
4 and put it to you.
5 THE COMMISSIONER:
6 Q. Okay, we'll take fifteen.
7 (RECESS)
8 THE COMMISSIONER:
9 Q. Please be seated. Ms. Taylor.
10 MS. TAYLOR:
11 Q. Thank you, Commissioner. Registrar, if I
12 could, I'd ask you under the transcripts of
13 the evidence, April 17th, page 117, if you
14 could go to that please? Can you pull up
15 transcripts?
16 THE COMMISSIONER:
17 Q. If you go to our website.
18 MS. TAYLOR:
19 Q. If not, I can -
20 THE COMMISSIONER:
21 Q. Can you show the witness the excerpt? I think
22 that would be a quicker way. Well why don't
23 you show the witness the excerpt while we're
24 trying to pull it up and that way, he's had a
25 chance to have a read of it before we--now

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1 what page -
2 REGISTRAR:
3 Q. What was the page number Ms. Taylor?
4 MS. TAYLOR:
5 Q. 117 is the start, that's the page number at
6 the top and it's P-0056, that's what that
7 refers to and I was going to take you down to
8 where it is.
9 MR. TILLEY:
10 A. Okay, you've got it all ready, I think.
11 THE COMMISSIONER:
12 Q. No, it's the part that was getting down there.
13 MR. TILLEY:
14 A. I'm sorry.
15 THE COMMISSIONER:
16 Q. Here we go.
17 MS. TAYLOR:
18 Q. You were being asked about an adverse event.
19 MR. TILLEY:
20 A. I think I know what you're saying now.
21 MS. TAYLOR:
22 Q. I can read it out because it's just two
23 sections.
24 THE COMMISSIONER:
25 Q. Is that what's on the screen now?

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1 MR. TILLEY:
2 A. Yes.
3 MS. TAYLOR:
4 Q. What I had been asking you about is how you
5 saw an adverse event underneath, in the
6 context of the policy that we were talking
7 about.
8 MR. TILLEY:
9 A. Yes, okay.
10 MS. TAYLOR:
11 Q. And what I showed you was starting on the page
12 P-0117 towards the bottom you can see that
13 what you were being asked about was--the same
14 exhibit. I think I've just lost the reference
15 to it. Yes, you were being asked about P-0056
16 and page 18 was referred to. And then you
17 were being asked about your view of an adverse
18 event.
19 MR. TILLEY:
20 A. Right.
21 MS. TAYLOR:
22 Q. The Commissioner had actually asked you in
23 terms of clarifying, that's page 119, okay,
24 and the Commissioner had asked you "I'm
25 understanding the witness to say that looking

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1 at this, it is still your view that in order
2 for it to be an adverse event, you'd have to
3 have a change in result." And then your
4 answer is there.
5 MR. TILLEY:
6 A. "Particularly those that may cause risk to a
7 patient and the issue of "may", I interpreted
8 that as, you know, if the results changes, it
9 may or may not be a risk to the patient, but
10 that would be obviously a factor." So I guess
11 the change in result as to whether it presents
12 a risk to the patient.
13 MS. TAYLOR:
14 Q. So adverse event, if you don't have a change
15 in result, then you don't have an adverse
16 event in the context of ER/PR, do I have that
17 straight?
18 MR. TILLEY:
19 A. I'm a little rusty on the policy, I confess
20 that. But sometimes it's not only actually
21 events, it's near misses that we try to
22 capture at the same time, but without looking
23 at the policy, what I said here relates to
24 making a connection between the result change
25 and whether there's a particular risk to the

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1 patient.
2 MS. TAYLOR:
3 Q. Well let's go back to the policy.
4 MR. TILLEY:
5 A. Okay.
6 MS. TAYLOR:
7 Q. P-0056, page 18. This is the same policy that
8 was being referred to and if I could, I would
9 ask you to look at that. There's three pages
10 to this policy. And my question is that when
11 I read it, I don't see anything that
12 distinguishes, you know, in terms of an
13 adverse event, between people who have changes
14 in test results or people who don't, so I
15 guess what I'm trying to get at is, is that
16 your interpretation or is there something
17 specific in here which addresses that?
18 MR. TILLEY:
19 A. So what you're saying is that it doesn't refer
20 to situations where patients--or that there's
21 a distinguishing factor between patients whose
22 results change and those whose results don't
23 change, or is it the treatment change and not
24 change?
25 MS. TAYLOR:

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1 Q. It said a change in result according to your
2 evidence.
3 MR. TILLEY:
4 A. Right.
5 MS. TAYLOR:
6 Q. So what I'm wondering about is what triggers
7 this policy having an effect? What's an
8 adverse event?
9 MR. TILLEY:
10 A. Right.
11 MS. TAYLOR:
12 Q. If your evidence was that you need a change in
13 result for it to be an adverse event -
14 MR. TILLEY:
15 A. Right.
16 MS. TAYLOR:
17 Q. Can you point me to something in the policy
18 which -
19 MR. TILLEY:
20 A. No. No, I'm sorry. Thank you. No, I can't.
21 I mean, really adverse events are intended to
22 identify those issues that may cause a risk to
23 a patient. I guess that's the overriding
24 factor.
25 MS. TAYLOR:

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1 Q. So it's your interpretation, not necessarily
2 how it's specifically written in the policy?
3 MR. TILLEY:
4 A. That's correct.
5 MS. TAYLOR:
6 Q. Okay. Now if we can go to P-0779? Now if I
7 can go towards the middle of the page, you'll
8 see here that there's an e-mail from Rick
9 Singleton, dated May 19th 2006, to a number of
10 individuals, Robert Williams, Louise Jones,
11 Heather Predham, Dr. Kara Laing, N. Denic, Dr.
12 Denic I would presume.
13 MR. TILLEY:
14 A. Yes.
15 MS. TAYLOR:
16 Q. And D. Pullman. Now who is Rick Singleton?
17 MR. TILLEY:
18 A. Rick Singleton would be the director of
19 pastoral care and ethics.
20 MS. TAYLOR:
21 Q. And according to this, he had been asked--"I
22 have been asked to organize an ethics consult
23 to discuss the ethical issues regarding
24 disclosure of information ER/PR results to
25 families of deceased patients."

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1 MR. TILLEY:
2 A. Yes.
3 MS. TAYLOR:
4 Q. And just for completeness, at the top is just
5 a response back from Dr. Laing saying that she
6 was out of the province during a period of
7 time. Those are the things on that page.
8 Now, in terms of, Mr. Tilley, medical ethics,
9 that's a recognized area of specialized
10 knowledge. You would agree with that
11 statement?
12 MR. TILLEY:
13 A. It is certainly recognized, not well
14 developed, but Eastern Health, I think, has
15 been fortunate to make some advances there and
16 D. Pullman is Darryl Pullman, who's an
17 ethicist that works at Memorial but spends a
18 lot of time making himself available to
19 Eastern Health and its predecessors.
20 MS. TAYLOR:
21 Q. So the ethics consult was being sought around
22 May of 2006, and who instigated that?
23 MR. TILLEY:
24 A. I'm not sure who initiated it. I guess it
25 could have been either Dr. Williams or Ms.

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1 Jones, recognizing that she has oversight for
2 that dimension of the organization.
3 MS. TAYLOR:
4 Q. And again, it was on the issue of disclosure
5 of retesting with respect to the results of
6 deceased patients.
7 MR. TILLEY:
8 A. Yes.
9 MS. TAYLOR:
10 Q. And would you say that disclosure is primarily
11 an ethical matter or certainly has a strong
12 element of ethics in the consideration of what
13 would be correct disclosure?
14 MR. TILLEY:
15 A. I've come to the conclusion that there's a lot
16 of things in the health side that certainly
17 could use the benefit of an ethical dimension
18 or analysis.
19 MS. TAYLOR:
20 Q. You'd see the consult as having value?
21 MR. TILLEY:
22 A. Yes.
23 MS. TAYLOR:
24 Q. And then an opinion was actually provided by
25 Rick Singleton and that can be found at P-

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1 0481. Now before I get into the specifics of
2 it, while it's being pulled up, Mr. Tilley did
3 you give any consideration to obtaining an
4 ethics consult when the issue first arose, the
5 ER/PR issue first arose?
6 MR. TILLEY:
7 A. I don't recall any discussions of that nature
8 back then.
9 MS. TAYLOR:
10 Q. Have you given any thought to it since?
11 Because my next question is going to be, in
12 retrospect, would you view it as a mistake not
13 to obtain an ethics consult at that time?
14 MR. TILLEY:
15 A. Well, I'm not sure I'd coin it as a mistake,
16 but clearly we were dealing with a very
17 complex issue. We had a lot of very highly
18 trained individuals around the table talking
19 about it. I don't think it would have
20 detracted from our issue, and you know, I'd
21 certainly think there might have been an
22 element--if there was a potential element of
23 helping us see through this, we certainly
24 would have wanted it to be a part of the
25 analysis, yes.

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1 MS. TAYLOR:
2 Q. So an ethics consult earlier than when it was
3 performed in 2006 would have been helpful?
4 MR. TILLEY:
5 A. Yeah, at that point in time, of course, it's
6 only referring to the deceased patients. I
7 guess the question that one would have to
8 raise, what is the issue that we're actually
9 seeking ethical input on. Is it the public
10 disclosure piece? Is it who we should contact
11 in the end? Like that question would have to
12 be analyzed first and I'm not familiar with it
13 enough to be able to frame it out, so I'd
14 leave it to somebody else's expertise to help
15 do that before I would make a decision on it.
16 MS. TAYLOR:
17 Q. Well, I need to go back for one second -
18 MR. TILLEY:
19 A. Okay.
20 MS. TAYLOR:
21 Q. - to P-0779, Registrar, and back to that same
22 e-mail and I put the cursor by where I am.
23 MR. TILLEY:
24 A. Okay.
25 MS. TAYLOR:

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1 Q. You'll see here that Mr. Singleton is saying
2 "for this discussion, we need Dr. Pullman, the
3 ethicist, Dr. Cook, Dr. Denic, Dr. Laing. We
4 will recruit others as needed," and then it
5 goes on to talk about timing and that may be a
6 challenge.
7 MR. TILLEY:
8 A. Okay.
9 MS. TAYLOR:
10 Q. So if we can now go to P-0481? It's, I'm
11 saying, two pages in length, but that's
12 because the first page just says ethics review
13 on it, so the substance of it starts, I
14 believe, on the second page.
15 MR. TILLEY:
16 A. Um-hm.
17 MS. TAYLOR:
18 Q. So this is Pastoral Care and Ethics
19 Department, Eastern Health, May 29th 2006, and
20 it goes to Dr. Robert Williams from Rick
21 Singleton, and it's "re: ethics consult,
22 ER/PR." Have you seen this before?
23 MR. TILLEY:
24 A. I hadn't seen the report. I did get briefed
25 about it on a telephone call.

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1 MS. TAYLOR:
2 Q. Okay, I'm going to actually ask you about the
3 report in particular. When I look at the
4 people that are listed as being in attendance,
5 okay -
6 MR. TILLEY:
7 A. Yeah.
8 MS. TAYLOR:
9 Q. - see there, present?
10 MR. TILLEY:
11 A. I do.
12 MS. TAYLOR:
13 Q. It lists off the people, Dan Boone, lawyer,
14 Heather Predham, risk management, Dr. Joy
15 McCarthy, Dr. Cook, Dr. Denic, Dr. Natalie
16 Bandeau, and Rick Singleton. Now just in
17 terms of context, you stated previously in
18 your evidence that the lawyer who was giving
19 advice through Ms. Predham worked for HIROC?
20 MR. TILLEY:
21 A. Yes.
22 MS. TAYLOR:
23 Q. And that lawyer was whom?
24 MR. TILLEY:
25 A. Dan Boone.

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1 MS. TAYLOR:
2 Q. Okay. Had it occurred to you, and I've seen
3 it in your evidence that you made a
4 distinction between Mr. Boone being HIROC's
5 lawyer versus Eastern Health's lawyer?
6 MR. TILLEY:
7 A. That's correct.
8 MS. TAYLOR:
9 Q. And in this situation, we see that Mr. Boone
10 is in attendance at this meeting. Did it
11 occur to you that you should get legal counsel
12 from a lawyer who worked for Eastern Health?
13 MR. TILLEY:
14 A. Well, I confess, I wasn't involved in the
15 selection of people here, and I can't tell you
16 who would have invited Mr. Boone into this
17 discussion, so looking back at your earlier
18 memo, I don't think his name was on the list,
19 so it must have been a decision made after the
20 fact.
21 MS. TAYLOR:
22 Q. But you didn't have involvement in that?
23 MR. TILLEY:
24 A. In the selection of it, no.
25 MS. TAYLOR:

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1 Q. Okay. So the report is addressed to Dr.
2 Williams, and then it records who's present.
3 It looks like the report also sort of--saying
4 present seems to indicate that perhaps there
5 was a committee meeting and that's summarizing
6 who was present at it, and then the author at
7 the end, Rick Singleton, he's identified as a
8 facilitator. Now if you need a chance to look
9 at it, the opinion seems to be a consensus of
10 those attending.
11 MR. TILLEY:
12 A. Okay.
13 MS. TAYLOR:
14 Q. Did you want to have a look just to see?
15 MR. TILLEY:
16 A. No, that's fine. I'll let you go ahead.
17 MS. TAYLOR:
18 Q. Okay, and again, as I've indicated, one of the
19 people in attendance would have been the
20 insurance lawyer. Are you able to--just from
21 your own perspective, as CEO of the
22 organization, are you able to state--CEO at
23 the time--what benefit there'd be in having
24 the lawyer for the insurance company present
25 at an ethics meeting on disclosure issues?

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1 MR. TILLEY:
2 A. No, I can't.
3 MS. TAYLOR:
4 Q. You don't have any comment on that?
5 MR. TILLEY:
6 A. No.
7 MS. TAYLOR:
8 Q. Now if we can go to P-0304? Now this is a
9 memo to you from Susan Bonnell dated July
10 21st, 2005. You've seen this before?
11 MR. TILLEY:
12 A. I have.
13 MS. TAYLOR:
14 Q. And you've had a chance to read through it and
15 you've been referred to it, I believe, in your
16 testimony.
17 MR. TILLEY:
18 A. Yes.
19 MS. TAYLOR:
20 Q. Okay. So it was sent to you from your
21 director of corporate communications, is that-
22 -Susan Bonnell?
23 MR. TILLEY:
24 A. Yes.
25 MS. TAYLOR:

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1 Q. Had you requested the memo?
2 MR. TILLEY:
3 A. There was one memo I had requested, but if I
4 can just--sorry, scroll over to make sure.
5 No, it's not the one that I was--I had
6 requested a memo which really outlined sort of
7 the pros and cons of different approaches or a
8 public announcement versus a letter versus
9 individual contacts. So this one would have
10 been Susan reflecting on the situation to date
11 and just giving her opinion to me in writing
12 with regards to her thoughts.
13 MS. TAYLOR:
14 Q. Okay. When I look at it, it has the
15 appearance of what I'd consider a fairly
16 substantial work product in the sense that
17 obviously time went into it, in terms of
18 consideration of different issues. Do you
19 have any comment on that?
20 MR. TILLEY:
21 A. Well, I can't say for sure. She was certainly
22 a good person at putting her thoughts on
23 paper.
24 MS. TAYLOR:
25 Q. In terms of what it recommends, it seems to

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1 recommend what she at least feels is in the
2 best interest of the public when she's talking
3 about public disclosure in the first paragraph
4 and she's looking at here "while I'm a strong
5 advocate for public disclosure, certainly one
6 of the first voices out there when we thought
7 this was our error saying that we needed to
8 disclose ASAP, I'm not convinced that we can
9 serve 'the greater good' and still maintain
10 the reputation of the lab, which in my opinion
11 is in the best interest of the public to
12 maintain." So she's looking at what she sees
13 to be in the best interest of the public.
14 Now the reason for non-disclosure at this
15 time, I believe that there's a reference to
16 there's a risk of upsetting and confusing
17 patients. Sorry, I had it in--I apologize, I
18 thought I had it highlighted in mine. It's on
19 the second page, and it says here, right here,
20 "I'm also concerned that the public approach
21 (a) will open up a Pandora's box and will
22 cause unnecessary and undue stress on cancer
23 patients, their families and the families of
24 cancer victims."
25 MR. TILLEY:

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1 A. Yes.
2 MS. TAYLOR:
3 Q. There is also a reference in the first part to
4 "in terms of maintaining the quality and
5 professional reputation of our laboratory, it
6 would be better, in one way, if we could focus
7 on issues with this one test rather than
8 looking at it with respect to retesting
9 everyone because the technology has improved,"
10 and she's talking about then "we have to
11 protect the integrity of the system at large."
12 So it seems that, you know, she's balancing,
13 in her view, non-disclosure in terms of risk
14 of upsetting patients, issues in terms of
15 calling into question professionalism of the
16 lab or reputation of the lab. Would you agree
17 with that?
18 MR. TILLEY:
19 A. I think there was clearly, in the first bullet
20 you referenced, a sincere interest which
21 talked about the patient and my sense was that
22 her recommendation was that a blanket-wide
23 public disclosure was going to be something
24 that would negatively impact on them, and of
25 course, that subsequently became a position

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1 that was taken by the oncologists, as you will
2 recount. The issue with regards to--going
3 back to the other page, I'm sorry, about the
4 test, I know there was some reference very
5 early in the game, and I suspect it was around
6 this time, that this was a technology issue
7 and an improvement in a technology issue, and
8 if we were going to go out and say that and
9 here we were going to retest everybody, then
10 why wouldn't you do that for every piece of
11 technology that we brought in the
12 organization. So I think that was her
13 reference there.
14 Now the other thing that you just
15 referenced was protecting the integrity of the
16 system, was it?
17 MS. TAYLOR:
18 Q. Yes, it's on the first page.
19 MR. TILLEY:
20 A. Can I just go back?
21 MS. TAYLOR:
22 Q. Sure. Do you want control or I can put it
23 back?
24 MR. TILLEY:
25 A. No, I'll leave it to you. I'm just trying to

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1 get my head around that piece now. "We have
2 to protect the integrity of the system at
3 large." I think her point here was that we
4 needed to focus in on the test in question,
5 rather than suggest in any way that this was
6 an issue that affected every test that was
7 being performed in the lab.
8 MS. TAYLOR:
9 Q. So was that a factor in terms of non-
10 disclosure at that time? Is that how you read
11 it?
12 MR. TILLEY:
13 A. No. Well, that didn't become the factor in
14 terms of disclosure. As you probably know,
15 again, the oncologists were very persuasive in
16 their opinions and that's what drove the
17 approach. I don't think, at any point in
18 time, did that issue become a factor of the
19 integrity of the system at large.
20 MS. TAYLOR:
21 Q. Any decision in terms of preserving any public
22 confidence in competence of the lab, that
23 wouldn't have factored into it?
24 MR. TILLEY:
25 A. No. In fact, I said before that in discussing

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1 this with Dr. Williams I had said that we're
2 doing the right thing because we're following
3 up on this and that we were going to have to
4 deal with the impact of it, and I think I used
5 the words warts and all, so.
6 MS. TAYLOR:
7 Q. You'll be happy to know I'm on my last area of
8 questioning. Now, Mr. Tilley, one of the
9 people that testified and actually the first
10 person who testified was Beverly Green, she's
11 a cancer patient who testified on the first
12 day of the Inquiry. And there were some
13 things that she had indicated in terms of the-
14 -her view of how authorities handled
15 communication. Now, it's probably best if I
16 do ask that it be pulled up again? I don't
17 mean to delay things, but it's March 19th,
18 2008, transcript of Beverly Green, page 78.
19 Okay. Now, at line 10 she was asked, "Ms.
20 Green, as a breast cancer patient what is your
21 view on how the responsible authorities
22 handled the communication of this issue and
23 their response to this issue?" And then she
24 says in terms of her answer starting at 16,
25 "Well, I think it was totally, you know, the

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1 way it was handled was very unprofessional,
2 very sneaky, deceiving, just everything that
3 builds even more resentment and more doubts
4 and I think it could just have been done a lot
5 better." Then on page 79, and if there's
6 anything in between once I refer to particular
7 areas that you want to look at -
8 MR. TILLEY:
9 A. Okay.
10 MS. TAYLOR:
11 Q. - that's fine. Page 79, she's going on, she's
12 still talking about that and she's saying at
13 line 3, "But the way this was handled, it was
14 just unforgivable." She goes on then page 79,
15 line 19, she says, "I think if we had been,
16 you know, approached on an individual basis
17 and things were admitted to us," basically
18 she's saying there she thought patients should
19 be approached on an individual basis.
20 MR. TILLEY:
21 A. Yes.
22 MS. TAYLOR:
23 Q. Things admitted. And then line 22 she goes on
24 from there, "Everyone makes mistakes and we,
25 and you know, sometimes we're much more

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1 forgiving when we're told straight out than
2 when we are lead to be mislead or deceived."
3 She goes on to say then at line--at page 80,
4 line 6, "I probably wouldn't even have become
5 part of the suit." And again, if you need to
6 look at anything from when I started on page
7 78 to line 80, but that's, I'd suggest,
8 summary of when she was asked about her view
9 on how the authorities handled disclosure. Do
10 you want me to give you a minute before I ask
11 the question?
12 MR. TILLEY:
13 A. No, no, go ahead.
14 MS. TAYLOR:
15 Q. The question is, looking at that, and that's
16 here perspective, is there anything that you'd
17 like to say in response to that, to that
18 particular individual?
19 MR. TILLEY:
20 A. It is devastating when you hear a patient talk
21 about the organization in that way. The
22 references I know are sincere. At no time did
23 I feel the organization was trying to be
24 deceiving. But obviously one of the issues
25 that's important to the organization is the

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1 patients and it was the driving factor in
2 terms of how we were following up on this. As
3 it turned out, in our attempts to achieve that
4 objective, we ran into more obstacles than I
5 could ever imagine that we could have run into
6 if I had to anticipate what the problems were.
7 And I can empathize with this patient's
8 position. I know that there were individuals
9 who felt that we were calling them too early
10 because we didn't have the information
11 available, but my belief is there were many
12 others that felt, tell us up front.
13 MS. TAYLOR:
14 Q. Um-hm.
15 MR. TILLEY:
16 A. I think you'll find many examples of
17 individual adverse events in and around
18 Eastern Health where that, in fact, was the
19 process. The challenge that we all now have
20 to struggle with is how do we deal with
21 situations that are literally in the hundreds
22 rather than in the single digits. Because I
23 think in the ideal world we would have wanted
24 a person to be able to look the patient into
25 the eye directly, be able to give them all the

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1 time they needed to be able to understand the
2 complexity of the issue, share their concerns,
3 share the emotions, provide whatever
4 assistance that could be had. So it's
5 unfortunate that it turned out that way. And
6 I accept the criticism, but it certainly
7 wasn't designed to be that way. And because I
8 was head of the organization at that time, I
9 take responsibility for that. And it is
10 something I think that I think everyone in the
11 organization feels that wish it had not turned
12 out that way.
13 MS. TAYLOR:
14 Q. Thank you, Mr. Tilley. That's all the
15 questions that I have.
16 COMMISSIONER:
17 Q. Thank you.
18 MS. TAYLOR:
19 Q. Thank you, Commissioner.
20 COMMISSIONER:
21 Q. Mr. Pike?
22 MR. PIKE:
23 Q. No questions for Mr. Tilley.
24 COMMISSIONER:
25 Q. Mr. Simmons.

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1 MR. GEORGE TILLEY, CROSS-EXAMINATION BY MR. DANIEL
2 SIMMONS
3 MR. SIMMONS:
4 Q. Mr. Tilley, you've given a lot of evidence
5 over many days here at the Commission and
6 there are a wide range of things that I could
7 now ask you about and follow up on based upon
8 the evidence you've already given. But there
9 will be many other witnesses who will be
10 coming to the Inquiry who will be in the
11 position to speak to many of those, so I am
12 going to do my darnest to get you out of here
13 today and consequently I'm going to limit the
14 number of things that I'm going to ask you
15 about. A question about ethics. You've just
16 been asked about the ethics review that was
17 done concerning the deceased patients, and
18 that was a formal ethics consult for which
19 there was a procedure and a practice in place
20 within Eastern Health and before that at the
21 Health Care Corporation of St. John's,
22 correct?
23 MR. TILLEY:
24 A. Yes.
25 MR. SIMMONS:

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1 Q. Was that the only way that ethical
2 considerations were taken into account when
3 decisions were made in those two
4 organizations?
5 MR. TILLEY:
6 A. The only way in terms of how it was referred
7 to them or the source?
8 MR. SIMMONS:
9 Q. The only, was that the only time at which
10 ethical, ethics would come into play, when
11 people working in Health Care Corporation or
12 Eastern Health would make decisions, by having
13 a formal ethics consult?
14 MR. TILLEY:
15 A. No. Of course, ethics was an issue that
16 everybody decided and whether you consulted
17 with a professional or not would have depended
18 on the severity of the situation.
19 MR. SIMMONS:
20 Q. Um-hm.
21 MR. TILLEY:
22 A. We would have shared with staff various
23 educational opportunities around the ethical
24 dimensions of health care, so in many ways
25 there were attempts to bring that dimension

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1 into everybody's thinking.
2 MR. SIMMONS:
3 Q. Okay. And in the Health Care Corporation were
4 there any measures that were taken in that
5 organization itself to promote the use of
6 ethical considerations and the understanding
7 of ethical considerations among those people
8 who were in the position to make decisions
9 about patient care?
10 MR. TILLEY:
11 A. Yes, there would have been, again, ongoing
12 educational opportunities. But in particular
13 I recall that there was even a ethical
14 framework developed that was used as a guide
15 for making resource allocations, so it was
16 reaching in the organization in many ways.
17 MR. SIMMONS:
18 Q. Okay. When decisions were made throughout the
19 ER/PR retesting and communication process,
20 from--at one point there was a formal ethics
21 consultation that was concerning what to do
22 about results that were available for a number
23 of deceased patients. Can you say that
24 whether or not ethical considerations would
25 have been brought to bear at other points in

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1 that process by those people that were
2 involved in making decisions?
3 MR. TILLEY:
4 A. I'm not aware of any formal process that had
5 resulted in documented minutes. But I know
6 that there would always be opportunities to
7 consult on an informal basis with either Dr.
8 Singleton or the ethicists themselves.
9 MR. SIMMONS:
10 Q. Okay. And a number of the people involved in
11 that decision making were themselves
12 physicians?
13 MR. TILLEY:
14 A. Yes.
15 MR. SIMMONS:
16 Q. And do ethical considerations form, to your
17 knowledge, any part of the education of
18 physicians and of the practice of their
19 profession?
20 MR. TILLEY:
21 A. I believe so.
22 MR. SIMMONS:
23 Q. Would you expect them to bring those ethical
24 considerations to bear when they were involved
25 in decisions such as the ones in this ER/PR

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1 retesting process?
2 MR. TILLEY:
3 A. Yes, they would.
4 MR. SIMMONS:
5 Q. Okay. You were asked a number of questions a
6 few moments ago, as well, when you were shown
7 the adverse event policies from the Health
8 Care Corporation which I believe were the ones
9 that would have been carried over and into
10 effect in summer of 2005 when the ER/PR
11 situation first came up. Now, from your chair
12 as chief executive officer of the corporation,
13 would you be conversant on a day-to-day basis
14 with understanding the interpretation and
15 application of those policies?
16 MR. TILLEY:
17 A. No, I would just want to make sure that there
18 was a policy and a process in place to deal
19 with that, but the actual interpretation and
20 its application would be left to those who
21 would deal with it on a day-to-day basis.
22 MR. SIMMONS:
23 Q. Right. So were you, in this case, actually
24 involved in any analysis yourself of whether
25 there were events which fit within the

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1 definitions of those policies or whether the
2 policies applied or how they would be used in
3 these circumstances?
4 MR. TILLEY:
5 A. No, I had not been involved in that
6 discussion.
7 MR. SIMMONS:
8 Q. Okay. And if you were to be involved in those
9 discussions, would you, yourself, be the
10 person to make decisions about that or would
11 you look to others in the organization?
12 MR. TILLEY:
13 A. Well, the health care system does have its
14 amount of hierarchy in it.
15 MR. SIMMONS:
16 Q. Yes.
17 MR. TILLEY:
18 A. But the actual way that the system works is
19 very much on a consultative team basis. And
20 if the belief from those who were closest
21 involved, hence, the reason why the
22 oncologists' opinion was a major influence in
23 the day in terms of how we contacted patients,
24 but if in any particular issue those closer to
25 it had a better understanding, there would

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1 have to be compelling evidence to the contrary
2 to go against their decision or
3 recommendation.
4 MR. SIMMONS:
5 Q. Right. You had some questions earlier today
6 concerning the blameless or blame-free culture
7 and the promotion of that within Eastern
8 Health. And I had heard you a couple of times
9 to say that the blameless culture is an aspect
10 of patient safety?
11 MR. TILLEY:
12 A. Yes.
13 MR. SIMMONS:
14 Q. What other--and if I understood from evidence
15 from yourself and from others earlier, that
16 patient safety is a relatively new term in use
17 in health care in Canada over the last five or
18 six years or so?
19 MR. TILLEY:
20 A. Um-hm.
21 MR. SIMMONS:
22 Q. Correct? And that there is now the Patient
23 Safety Institute, which is a national
24 organization that you have spoken of, correct?
25 What other aspects are there of the patient

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1 safety movement aside from encouraging the
2 blame-free culture in health care?
3 MR. TILLEY:
4 A. Well, there's a certain amount of education,
5 there's information sharing. In the Patient
6 Safety Institute there is initiatives such as
7 Safer Health Care Now, which are programs that
8 have been developed in recognition of them
9 being areas where adverse events tend to occur
10 more regularly than others, so there have been
11 programs like that implemented in various
12 organizations throughout the country. The
13 issue that we talked about earlier about the
14 different ways of analysis of problems, those
15 are all things that have been coming out of
16 the patient safety movement. The culture is
17 the one that I was greatly focusing on because
18 I would speak to it. I positioned myself on
19 the corporate quality committee because
20 sometimes the importance that the staff
21 attract to an issue is where the CEO chooses
22 to participate, so I positioned myself to be
23 on that. So we were taking the findings of
24 the Baker Norton Study that there were adverse
25 events happening in the hospitals very

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1 seriously and looking to find ways of
2 educating our staff in the name of prevention,
3 and if there were situations of adverse events
4 occuring, that we were looking to be sure that
5 we followed up on them appropriately.
6 MR. SIMMONS:
7 Q. In a very generalized way, am I correct in
8 understanding that the concept of a patients,
9 promotion of patient safety came out of a
10 growing recognition that in the delivery of
11 health care, there was also potential to cause
12 harm in the way health care was delivered and
13 that that needed to be recognized and
14 identified and then the potential for that
15 harm to be caused to be minimized.
16 MR. TILLEY:
17 A. Right.
18 MR. SIMMONS:
19 Q. And that the Baker-Norton study was one of the
20 key studies which brought to light the extent
21 to which there was potential for patients for
22 suffer harm as a result of the delivery of
23 their health care services.
24 MR. TILLEY:
25 A. There is some similarities to the

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1 circumstances we have here.
2 MR. SIMMONS:
3 Q. Yes.
4 MR. TILLEY:
5 A. In Europe and in the United States there was a
6 lot of discussion with regards to adverse
7 events occurring in health care organizations.
8 As a consequence, ten national bodies took it
9 upon themselves to initiate this study by
10 Baker-Norton. And from that, the Canadian
11 Health system, while it had always been
12 focused in on quality, took a renewed interest
13 in getting more focused in on those
14 particulars areas where we're vulnerable. So,
15 it really did become a common theme and a
16 guideline for how business was to be
17 performed.
18 MR. SIMMONS:
19 Q. Okay. And was the idea then of encouraging
20 the blameless culture within health care, was
21 that idea one way of promoting the objectives
22 of improving the safety for patients who were
23 receiving health care in the system?
24 MR. TILLEY:
25 A. Very much so. In fact, the feedback I'd

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1 gotten from staff is that that's how they had
2 interpreted it. And when I heard that then I
3 felt that we were making some headway with
4 this.
5 MR. SIMMONS:
6 Q. Right. Now, did it require any kind of formal
7 resolution to adopt a blameless culture for
8 the organization and one day you don't have a
9 blameless culture and then next day you do.
10 Was it as black and white as that? Or was it
11 more of a way of thinking and a philosophy or
12 an approach to the way you'd organize -
13 MR. TILLEY:
14 A. It certainly was a way of thinking and a
15 philosophy that we had talked about many times
16 within the organization and that we were
17 starting to implement.
18 MR. SIMMONS:
19 Q. Okay. Eastern Health was created as a new
20 regional entity in April of 2005. Did the
21 creation of that organization give you and
22 others who were involved in it an opportunity
23 to do things differently than they'd been done
24 before.
25 MR. TILLEY:

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1 A. Well, you had seven organizations coming
2 together. It necessitated some major change.
3 What we often did was looked at whatever
4 programs might have been in place in all seven
5 organizations and tried to pick the best
6 elements out of them. So, it clearly was an
7 opportunity to make things different. And we
8 were a very different organization than I had
9 been involved in with the Health Care
10 Corporation of St. John's.
11 MR. SIMMONS:
12 Q. Was it an opportunity as well to institute
13 this kind of cultural change that you spoke
14 of?
15 MR. TILLEY:
16 A. There was a number of things that the team sat
17 down and talked about and yes, the idea of a
18 change at the organizational level, a new
19 organization was coinciding with the patient
20 safety push and the blameless culture.
21 MR. SIMMONS:
22 Q. How much did that way of thinking affect your
23 approach to your involvement in the ER/PR
24 issue over the coming couple of years.
25 MR. TILLEY:

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1 A. Well, the focus became on the recommendations
2 and how we improve the organization. The
3 focus was less on tell me the cause, even
4 though one had to obviously look at and
5 surmise what the causes might be. But for me,
6 it was to be dealing with this on an
7 optimistic way to make improvements in the
8 system so that the oncologists could have
9 confidence in the work of the laboratory
10 medicine program. The risk of going in
11 another direction which is to start digging
12 and finding fault, the system depends
13 significantly on one another. And any key
14 piece that may be weakened will weaken the
15 whole system. So, from my perspective, it was
16 trying to deal with this in the most
17 constructive way that I could come up with.
18 MR. SIMMONS:
19 Q. When the -
20 THE COMMISSIONER:
21 Q. I either ask this question now or later and
22 while we're on the topic -
23 MR. SIMMONS:
24 Q. Yes.
25 THE COMMISSIONER:

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1 Q. - please allow me to jump in just for a
2 minute. I've heard this a couple of times
3 now, the business of not focusing on the
4 cause. And maybe you and I see case
5 differently because I'm thinking, how do you
6 know that you don't have a problem if you
7 haven't figured out what the cause of the
8 problem was.
9 MR. TILLEY:
10 A. Right. Well, what I was referring to is that
11 I focused in on the recommendations and I also
12 mentioned a moment ago that in order to get
13 the recommendations, one has to look at the
14 causes. So, it's not a matter of ignoring
15 what potentially may be the source of a
16 problem. But the culture that I was trying to
17 implement was one of constructive
18 relationships, always excelling, looking for
19 opportunities to improve. I didn't turn the
20 organization around and start saying, whose
21 fault was that?
22 THE COMMISSIONER:
23 Q. But I see that different than what caused it.
24 So, maybe it's just a language thing.
25 MR. TILLEY:

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1 A. Okay.
2 THE COMMISSIONER:
3 Q. Because you said that a couple of times in
4 your testimony and others have said it as well
5 with the focus or the organization on fixing
6 things and I couldn't figure out how you had
7 any confidence you were fixing things unless
8 you figured out what went wrong in the first
9 place.
10 MR. TILLEY:
11 A. I'm glad you asked the point because really
12 what we're focusing on is whether we hold
13 somebody to blame for that.
14 THE COMMISSIONER:
15 Q. Ah, well that's a different thing in my mind.
16 MR. TILLEY:
17 A. Yes, okay.
18 THE COMMISSIONER:
19 Q. So, I'm glad we raised it.
20 MR. TILLEY:
21 A. Okay, thank you for asking it.
22 MR. SIMMONS:
23 Q. Just to follow up on that, it is late in the
24 day and if I might just suggest a couple of
25 propositions to you in relation to that. And

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1 one is that in 2005 when this was being
2 investigate, I take from what you said in your
3 days of testimony earlier that two of the
4 primary objectives were first, to identify
5 those women and men who could benefit from a
6 change in treatment and that meant retesting
7 their results. Right?
8 MR. TILLEY:
9 A. That's correct.
10 MR. SIMMONS:
11 Q. And a second was to ensure that the current
12 testing of people who need tests done is done
13 in a reliable and accurate manner, whether
14 that be at Eastern Health or by referring it
15 out somewhere else, like Mount Sinai.
16 MR. TILLEY:
17 A. Correct.
18 MR. SIMMONS:
19 Q. And if testing was going to continue--well, on
20 the first of those objectives which is
21 identify that patients who could benefit from
22 a change of treatment, did you have to answer
23 the question of what was the cause of a
24 problem with their original result in order to
25 achieve that objective?

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1 MR. TILLEY:
2 A. No.
3 MR. SIMMONS:
4 Q. And the second objective then which would be
5 to ensure that you were delivering accurate
6 and reliable tests to people who nee them now.
7 In the short run that could be met by sending
8 the tests out to Mount Sinai which was
9 recognized as being a gold standard lab.
10 MR. TILLEY:
11 A. That's correct.
12 MR. SIMMONS:
13 Q. In the longer run, you would have to ensure
14 that Eastern Health was going to be able to do
15 the tests to that standard itself.
16 MR. TILLEY:
17 A. And hence the importance of the
18 recommendations and the follow up on those.
19 MR. SIMMONS:
20 Q. Now, so would it be correct to say that in
21 meeting that second objective, there would
22 have to be enough investigation of cause done
23 to find out all the potential causes so that
24 each potential cause could be addressed before
25 testing was started again?

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1 MR. TILLEY:
2 A. That's accurate and there I suggest, refer to
3 the swiss cheese again. You're looking for
4 all the holes in the cheese and the way I
5 looked at the recommendations is that they
6 were looking for all the potential holes that
7 could be followed up on.
8 MR. SIMMONS:
9 Q. Right. And if the objective had been to find
10 those responsible for the holes being there,
11 you would then have had to take the
12 investigation further to identify which holes
13 lined up--in other words, which were the
14 actual causes at any particular time through
15 this eight year period of the results not
16 being accurate.
17 MR. TILLEY:
18 A. That's correct.
19 MR. SIMMONS:
20 Q. And that's the road that you didn't go down?
21 MR. TILLEY:
22 A. No, I did not.
23 THE COMMISSIONER:
24 Q. Well, the distinction looking for all the
25 holes in the swiss cheese and not just the

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1 ones that line up. Is that what we're talking
2 about?
3 MR. SIMMONS:
4 Q. I think exactly, Commissioner. A few short
5 questions on the concept of decision making in
6 an organization like Eastern Health and Health
7 Care Corporation. We've seen the
8 organizational charts which have an hierarchy,
9 people's positions in boxes and lines drawn
10 and it's one that suggests that the people at
11 the top are able to give orders to the people
12 farther down the line and people farther down
13 the line, take orders from people on top. But
14 in practice in an organization like Eastern
15 Health, particularly among the senior levels
16 of CEO, executive and senior managers, how did
17 decision making actually happen? How is it
18 preferred that decision making happen?
19 MR. TILLEY:
20 A. We certainly weren't into an environment where
21 we would operate in a very autocratic way.
22 You'll find the term "interdisciplinary teams"
23 being common language spoken in health care.
24 It's not expected that the physician will work
25 independently of the other health providers

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1 and in many ways, that was the theme behind
2 the program based model whereby the physician
3 and the program director were expected to work
4 as a team. But in many ways the part of the
5 organization that, any part of the
6 organization that may have been impacted by a
7 particular decision, there was always an
8 attempt to involve them in some way and in
9 fact, I had this invisible poster on my wall
10 that used to say "who have I not consulted
11 with".
12 MR. SIMMONS:
13 Q. Uh-hm.
14 MR. TILLEY:
15 A. Often you made decisions without consultation
16 at your peril. There was always somebody
17 would come back and say I can add another
18 dimension to this, so if there was a
19 particular leaning, it was an environment of
20 being very consultative and I think that's
21 proven in many circles to be the best way in
22 running an organization that has so many
23 professional groups in it.
24 MR. SIMMONS:
25 Q. Okay. Through the summer of 2005, there are a

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1 number of decisions made around ER/PR
2 retesting and communication to patients.
3 There was the decision to retest, there were
4 decisions about how extensively to retest and
5 that was determined to be to go back to the
6 beginning of ER/PR testing by the
7 immunohistochemical method and bring it right
8 up to the point that testing was suspended in
9 '05. There was the decision to retest at
10 Mount Sinai instead of locally, using the
11 newer technology in St. John's. There was the
12 decision to wait and not immediately notify
13 patients that their samples would be retested,
14 not to make a public announcement, believing
15 that results would be available in a certain
16 period of time and that patients could be
17 notified of the changed results. Around all
18 of those decisions, what kind of decision-
19 making process was used through that summer?
20 MR. TILLEY:
21 A. Well, again, we involve a number of people and
22 I guess one of the greatest decisions that
23 impacted the outcome here is the one we relied
24 on when we consulted the oncologists.
25 MR. SIMMONS:

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1 Q. Uh-hm.
2 MR. TILLEY:
3 A. Now I look at the people who have the direct
4 involvement with the patient and in
5 particular, the oncologists who are dealing
6 with a very difficult disease, a very
7 emotional disease and from my perspective,
8 their opinion weighed significantly in the
9 overall process. You would have seen in my
10 notes numerous examples to consultations with
11 various individuals, some that I was involved
12 in, some that had others. So I did not at any
13 point reach a point in time where I felt that
14 I had to ignore the advice that had been
15 emanating from those discussions and override
16 them.
17 MR. SIMMONS:
18 Q. Around the issues of communication to patients
19 and the public, the manner of it, the timing
20 of it during that summer, was there debate and
21 were there differing views expressed by
22 different people who were involved?
23 MR. TILLEY:
24 A. Yes, there were multiple opinions put on the
25 table, but in the end, the consensus was along

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1 the lines of the route that we chose.
2 MR. SIMMONS:
3 Q. Right, okay. In October then of 2005, the
4 knowledge became public through a story in the
5 media that Eastern Health was retesting old ER
6 and PR samples. There then, in the time
7 period following that, had to be decisions
8 made about how to respond and whether to
9 contact patients and how to do it. What can
10 you tell me about that decision-making
11 process, how it was carried out? I'm not
12 looking for the blow-by-blow detail of what
13 happened, but what the approach to it was and
14 whether it was arrived at by consensus in the
15 end.
16 MR. TILLEY:
17 A. Well it was a similar process that we went
18 through, we did have people at our disposal,
19 either amongst the executive team in
20 communications, in quality, the lab, oncology,
21 in fact, I remember seeing one reference in
22 the documentation over the past few days that
23 I've been here, an expression by somebody that
24 we needed to be sure to talk to the
25 oncologists about that. So again, the change

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1 in direction was one that we developed on a
2 consensus approach.
3 MR. SIMMONS:
4 Q. Okay. When retest results became available
5 from Mount Sinai, there was a process adopted
6 of having certain of those referred to a
7 physician panel and there had to be a plan
8 worked out about how patients were going to be
9 notified of the results of the retests and
10 generally we've heard that those patients who
11 had no change in results were notified by
12 direct telephone contact from personnel in the
13 Quality Department.
14 MR. TILLEY:
15 A. That's right.
16 MR. SIMMONS:
17 Q. And other patients who had a change in result
18 would be notified by written correspondence to
19 the most responsible physician, who would be
20 then expected to deal with the patient.
21 MR. TILLEY:
22 A. Uh-hm.
23 MR. SIMMONS:
24 Q. What can you tell me about the process used to
25 arrive at the decisions around approaching

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1 patient communication that way?
2 MR. TILLEY:
3 A. Well, the panel was developed and it was felt
4 that the most appropriate person to be making
5 any contact with the patient where there were
6 implications for the patient's treatment,
7 would be the most appropriate attending
8 physician. So that would always be the case
9 and it was followed through here.
10 MR. SIMMONS:
11 Q. Just as an aside, do you know how lab test
12 results are normally communicated to patients
13 in the normal circumstance?
14 MR. TILLEY:
15 A. Well through the attending physician who would
16 have ordered the tests.
17 MR. SIMMONS:
18 Q. Is it normal practice at all to communicate
19 test results directly to patients, other than
20 through their physicians?
21 MR. TILLEY:
22 A. No, that would be an exceptional circumstance.
23 MR. SIMMONS:
24 Q. Now in December of 2006, there was the media
25 briefing and there were decisions made about

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1 how much information to release publicly at
2 that point about the statistics, the retest
3 results statistics, and you've told us about
4 the extent of your involvement in that, but
5 how much can you tell me about how the
6 decisions came to be made around what
7 information would be released and not released
8 in the sense of were multiple people involved,
9 was there debate, was there discussion.
10 MR. TILLEY:
11 A. Right.
12 MR. SIMMONS:
13 Q. How did it get brought to a head and decisions
14 get made, as much as you know?
15 MR. TILLEY:
16 A. Well I know that I was sent a copy of the
17 documents that were going to be used in that
18 press release by e-mail. My recollection that
19 that e-mail had referred to a number of people
20 being involved in the discussion as to how
21 that was going to unfold. I know at the
22 executive team we did talk about the
23 importance of getting out there and speaking
24 to this, because it was a matter of public
25 trust and we wanted to err on that side. But

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1 there were certainly several individuals who
2 would have participated in the content of that
3 technical debriefing.
4 MR. SIMMONS:
5 Q. Okay, so you weren't actually part yourself to
6 the decision making about what information was
7 going to be released and not released, you
8 were informed -
9 MR. TILLEY:
10 A. Right.
11 MR. SIMMONS:
12 Q. And had some opportunity to review it.
13 MR. TILLEY:
14 A. That's correct.
15 MR. SIMMONS:
16 Q. But you weren't part of the discussion that
17 led to that?
18 MR. TILLEY:
19 A. Right.
20 MR. SIMMONS:
21 Q. Okay. There's been a considerable number of
22 questions asked to you about whether all
23 patients were notified of their test results
24 and the understanding by a number of people
25 that all patients had been contacted and some

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1 public communications around that. And first
2 of all, just to make it clear, was there ever
3 any intention that you're aware of on the part
4 of anyone involved in this process to not
5 contact a patient -
6 MR. TILLEY:
7 A. No.
8 MR. SIMMONS:
9 Q. - with any results. And you have stated that
10 there was a belief that affected patients had
11 been notified through the process.
12 MR. TILLEY:
13 A. That's correct.
14 MR. SIMMONS:
15 Q. Okay. Now, I would like to show you one
16 document and that is the "Globe and Mail"
17 article by Mr. Picard that you referred to, I
18 believe, yesterday and it's a new exhibit, not
19 entered yet, and I believe it's going to be
20 699.
21 THE COMMISSIONER:
22 Q. Entered.
23 EXHIBIT ENTERED AND MARKED P-0699
24 MR. SIMMONS:
25 Q. And I'm watching the clock.

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1 MR. TILLEY:
2 A. That's okay.
3 MR. SIMMONS:
4 Q. You probably recognize this as being a
5 clipping from the "Globe and Mail" with that
6 particular article.
7 MR. TILLEY:
8 A. I do.
9 MR. SIMMONS:
10 Q. And I'm going to go down to the second page of
11 it and I'm going to go to the fourth column
12 and begin reading here where it says, "Eastern
13 Health officials suspected in early 2004 when
14 they purchased new equipment and knew
15 definitely in 2005 that there was serious
16 problems with hormone receptor tests. Yet
17 breast cancer patients and the public were
18 told nothing". Do you remember reading that
19 article?
20 MR. TILLEY:
21 A. Yes, I do.
22 MR. SIMMONS:
23 Q. And what was your reaction when you read that?
24 MR. TILLEY:
25 A. This, I think, followed the press conference

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1 that we had had where we had reviewed the
2 process to date and of course, it went against
3 everything that we had put in place with the
4 intentions of following up with individual
5 patients. The implication that was being left
6 here and was being left nationally is that we
7 were choosing not to tell the patients about
8 this. So, it was devastating, to say the
9 least. We, in turn, made a decision to write
10 a letter to the editor. Unfortunately, not
11 all of that letter was actually published, but
12 it did, sort of, bring an element of
13 frustration to all this and disappointment, to
14 say the least.
15 MR. SIMMONS:
16 Q. Now, two things that followed the publication
17 of this story in May of 2007 were writing the
18 letter to the editor of the "Globe and Mail"
19 that you referred to. And as well, there was
20 a notice published in newspapers in
21 Newfoundland and you were shown -
22 MR. TILLEY:
23 A. That's right.
24 MR. SIMMONS:
25 Q. - that in your evidence earlier.

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1 MR. TILLEY:
2 A. Yes.
3 MR. SIMMONS:
4 Q. And that's a notice that said all patients
5 have been contacted.
6 MR. TILLEY:
7 A. Yes.
8 MR. SIMMONS:
9 Q. The reason for taking those courses of action,
10 publishing that notice and writing to the
11 "Globe and Mail", was it because there was an
12 issue as to whether every single patient had
13 bene contacted or was it because of this
14 article which said that no patients had been
15 contacted?
16 MR. TILLEY:
17 A. Well, I got to confess, this was a major
18 driver in terms of getting that notice out
19 there because we were fighting now a credible
20 reporter who was suggesting otherwise.
21 THE COMMISSIONER:
22 Q. Has your question been answered?
23 MR. SIMMONS:
24 Q. When drafting the letter to the "Globe and
25 Mail" and approving it, and approving the

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1 advertisement, which way was your mind
2 directed about what the issue was that you
3 were addressing?
4 MR. TILLEY:
5 A. The issue that we were trying to deal with was
6 the fact that they were alleging we didn't
7 contact any patients.
8 MR. SIMMONS:
9 Q. That you didn't contact anybody, that there
10 had been no patient contact.
11 MR. TILLEY:
12 A. Right.
13 MR. SIMMONS:
14 Q. As opposed to an issue of whether every
15 patient had been tracked down and contacted?
16 MR. TILLEY:
17 A. Right, yes.
18 MR. SIMMONS:
19 Q. Okay.
20 THE COMMISSIONER:
21 Q. That was the thing that most disturbed you
22 about the article.
23 MR. TILLEY:
24 A. Yes.
25 MR. SIMMONS:

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1 Q. At the same time here, in the middle of May,
2 after the CBC news story which had taken
3 information from the affidavit that had been
4 filed and you held your news conference then
5 on May 18th, you said in your evidence that
6 there was a reluctance then to discuss some
7 aspects of this publicly at this time because
8 there was litigation outstanding.
9 MR. TILLEY:
10 A. Yes.
11 MR. SIMMONS:
12 Q. And was there anything in particular happening
13 around that time in relation to the litigation
14 that may have affected that consideration?
15 MR. TILLEY:
16 A. Well of course certification hearings were
17 about to occur, like my recollection is they
18 were probably within weeks of being scheduled.
19 MR. SIMMONS:
20 Q. Yes. To what extent did that play as a factor
21 at that time, in the middle of May?
22 MR. TILLEY:
23 A. Well certainly the general feeling that we had
24 was that it was inappropriate for us to be
25 talking about this issue with that so

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1 imminent, it would be inappropriate from
2 trying to influence whatever decisions were
3 being or going to have to be made or what
4 arguments are going to be made. And secondly,
5 if we were talking about this, I think this
6 issue is much more complex than can be dealt
7 with in one story. I think this inquiry is
8 getting a sense as to how complex this issue
9 is, so we had made a conscious decision that
10 we weren't going to be addressing each media
11 call that was coming at us.
12 MR. SIMMONS:
13 Q. Okay, one final question, you had in your
14 wrap-up comments after Mr. Coffey finished
15 questioning you and he asked you if you had
16 anything else to say, you did say that you
17 would not expect that this particular
18 confluence of circumstances would come
19 together again, and in particular, the large
20 scale retesting problem at the same time that
21 there was a major restructuring happening
22 within your organization.
23 MR. TILLEY:
24 A. Yes.
25 MR. SIMMONS:

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1 Q. And my question is can you elaborate a little
2 more on what the--what the impact of being at
3 the outset of that restructuring process had
4 on this whole ER/PR process?
5 MR. TILLEY:
6 A. Hmm, well when you're building a new
7 organization, you got to create a level of
8 excitement and enthusiasm and willingness for
9 people to roll up their sleeves and make
10 massive change happen. Going hand in hand
11 with that in bringing the organizations
12 together, you're obviously impacting a lot of
13 people. So there was a whole recruitment
14 process. Jobs were being advertised and
15 people were unsure as to what new role they
16 might have had and I know that some of the
17 individuals who were affected here, changed
18 roles during that process. So what I was
19 getting at there is that here we were taking
20 on this massive challenge that happens so
21 infrequently in this country to take on
22 something of this magnitude and here we were
23 facing one of the most significant issues that
24 I've heard any health care organization in
25 this country have to deal with. So it was a

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1 coming together of major events which
2 certainly added to the pressure that we were
3 under at the time. And of course, each of the
4 organizations that we were bringing together
5 in and of themselves had issues that were very
6 significant that had to be dealt with.
7 MR. SIMMONS:
8 Q. Thank you, very much, Mr. Tilley, I don't have
9 any other questions for you.
10 MR. TILLEY:
11 A. Thank you.
12 COMMISSIONER:
13 Q. Mr. Coffey?
14 COFFEY, Q.C.:
15 Q. I have some (inaudible).
16 MR. GEORGE TILLEY, RE-EXAMINATION-IN-CHIEF BY BERNARD
17 COFFEY, Q.C.
18 COFFEY, Q.C.:
19 Q. Mr. Tilley, you were asked about Dr.
20 Ejeckam's June 19th, 2003 memo.
21 MR. TILLEY:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. By Ms. Taylor, I believe. And I gather then
25 in responding, because she was asking you

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1 about, well, the recommendations and your
2 understanding whether the recommendations
3 there, because if they were operational in
4 nature, they might very well get up as high
5 the administration?
6 MR. TILLEY:
7 A. Right.
8 COFFEY, Q.C.:
9 Q. And you understood that that had not been
10 necessary in 2003 because the recommendations
11 had been implemented before the ER/PR testing
12 was resumed in '03?
13 MR. TILLEY:
14 A. Well, my understanding was the surgical
15 pathology committee recommended that it had
16 been reinstated, the tests had been reinstated
17 that had been stopped for five weeks.
18 COFFEY, Q.C.:
19 Q. Yes.
20 MR. TILLEY:
21 A. And that as part of that recommendation or
22 that decision, then the recommendations had
23 obviously been followed up appropriately by
24 Dr., according to Dr. Ejeckam.
25 COFFEY, Q.C.:

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1 Q. Who gave you that understanding?
2 MR. TILLEY:
3 A. Well, that would have been the clinical chief
4 at the time, would have been Dr. Cook or the
5 previous clinical chief.
6 COFFEY, Q.C.:
7 Q. And well, this would be--but you only
8 discussed this, I take it, in '07?
9 MR. TILLEY:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. So that would be Drs. Denic or Cook?
13 MR. TILLEY:
14 A. That's correct.
15 COFFEY, Q.C.:
16 Q. Okay. Because there are a list of
17 recommendations there such as a separate room
18 for the IHC service, dedicated IHC
19 technologists and they didn't occur until,
20 even if they've occurred to this day?
21 MR. TILLEY:
22 A. Right.
23 COFFEY, Q.C.:
24 Q. In terms of the room, until 2006 or '07?
25 MR. TILLEY:

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1 A. Yeah.
2 COFFEY, Q.C.:
3 Q. So the recommendations that he has there, not
4 all of them could have been done before ER/PR
5 resumed in '03?
6 MR. TILLEY:
7 A. I understand.
8 COFFEY, Q.C.:
9 Q. Okay. So you were never under any
10 misapprehension -
11 MR. TILLEY:
12 A. No, other than the fact that Dr. Ejeckam had
13 reactivated the service or felt comfortable
14 that whatever recommendations were critical
15 were being done.
16 COFFEY, Q.C.:
17 Q. Okay. So I just wanted to be clear on that.
18 And one final point, and it's taking up on a
19 response t a question that Mr. Simmons gave,
20 asked you, and an exchange involving the
21 Commissioner just then where you were talking
22 again about Swiss cheese.
23 MR. TILLEY:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. And -
2 COMMISSIONER:
3 Q. I may never eat another piece.
4 COFFEY, Q.C.:
5 Q. I never have, Commissioner, and I'll leave it
6 at that. No offence to the Swiss. I would
7 say but just on that point, Mr. Tilley, is it
8 your understanding that the following is true,
9 Eastern Health had hired the two external
10 reviewers to identify the reasons for all
11 those holes?
12 MR. TILLEY:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. Okay. By early 2007 Eastern Health resumed
16 ER/PR?
17 MR. TILLEY:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And was it your understanding then that
21 Eastern Health at that point felt that each--
22 the reason for each hole had been identified
23 and filled?
24 MR. TILLEY:
25 A. That my understanding was that the

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1 recommendations from the external reviews had
2 reached such a level in terms of follow up
3 that it was a decision to reactivate the
4 service.
5 COFFEY, Q.C.:
6 Q. You certainly, I gather, at that point, if you
7 weren't explicitly told, you certainly
8 assumed, based upon the fact that they were
9 resuming the service, that they were doing so
10 because it was safe to do so?
11 MR. TILLEY:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. In other words, there weren't going to be any,
15 as best as humanly possible, no more holes?
16 MR. TILLEY:
17 A. Right.
18 COFFEY, Q.C.:
19 Q. Okay.
20 MR. TILLEY:
21 A. Because my--sorry.
22 COFFEY, Q.C.:
23 Q. So if that's so, you must have felt or did you
24 feel that the two external reviewers had in
25 their reports identified the reason for each

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1 hole or each potential hole?
2 MR. TILLEY:
3 A. I can't say yes to that. I mean, obviously
4 they had done a thorough analysis and the
5 recommendations was where I was getting people
6 to focus.
7 COFFEY, Q.C.:
8 Q. But you told the Commissioner in order to make
9 a recommendation you have to have--it has to
10 be addressing a reason?
11 MR. TILLEY:
12 A. That's -
13 COFFEY, Q.C.:
14 Q. A, what's the word?
15 MR. TILLEY:
16 A. A cause.
17 COFFEY, Q.C.:
18 Q. A cause, an inadequacy, perhaps?
19 MR. TILLEY:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Or perceived inadequacy. So then if that's
23 so, now anyone in Eastern Health who read
24 those reports, both of those reports in 2005,
25 although they might not have known the precise

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1 reason for a problem in any one individual
2 patient's original test.
3 MR. TILLEY:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. There's no suggestion one would have.
7 Yourself and those of your staff who read
8 those reports must have believed that all the
9 reasons for all those holes could be found
10 somewhere in those 2005 reports?
11 MR. TILLEY:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. So any one individual patient's know, you'd
15 have to go and examine that individual
16 patient's slide as you pointed out or slides?
17 MR. TILLEY:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. But you could read the reports and ascertain
21 what the causes were, not for any one
22 individual patient -
23 MR. TILLEY:
24 A. Right.
25 COFFEY, Q.C.:

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1 Q. - but the overall causes?
2 MR. TILLEY:
3 A. Right. And the question for me was some of
4 those were obviously assessing us against
5 Mount Sinai who had become a gold standard.
6 COFFEY, Q.C.:
7 Q. Um-hm.
8 MR. TILLEY:
9 A. And that's clearly what we were looking for.
10 So when he talks about having a director to
11 service, those were things that I think would
12 position the organization to achieve that.
13 The extent to which some of those things were
14 in place or not in place in organizations
15 throughout the country I really can only use
16 the fact about where we were left with the
17 impression that we were somewhere in the
18 middle of the pack.
19 COFFEY, Q.C.:
20 Q. And they're the questions I have,
21 Commissioner. Thank you.
22 COMMISSIONER:
23 Q. Thank you, Mr. Coffey. Mr. Tilley, thank you
24 very much for your patience.
25 MR. TILLEY:

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1 A. Thank you, Commissioner.
2 COMMISSIONER:
3 Q. And for the information you've provided. I
4 can only tell you that like you I hope at the
5 end of the day this process will be of help to
6 the -
7 MR. TILLEY:
8 A. I'm confident it will be.
9 COMMISSIONER:
10 Q. - to the system and to improving patient
11 safety, as we say.
12 MR. TILLEY:
13 A. That's right, that's everybody's objective
14 here.
15 COMMISSIONER:
16 Q. Thank you, very much. Tomorrow morning, 9:30.
17 Upon conclusion at 4:57 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 13th day of May, A.D., 2008 before the
6 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 13th day of May, A.D., 2008
13 Judy Moss

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