COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

October 8, 2008

Appearances:

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Regional Integrated Health Authorities

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MR. TERRY GULLIVER, EXAMINATION BY SANDRA CHAYTOR, Q.C.
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CHAYTOR, Q.C.:
Q. Good morning, Commissioner. Good morning, Mr. Gulliver.
MR. GULLIVER:
A. Good morning, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, we've heard here about interventions that Dr. Ejeckam made in 2003. Any time prior to then had anyone raised any concern with you with respect to IHC testing and in particular ER/PR, any issues regarding fixation or any other issue that was affecting the quality of product that the technologists was producing?
MR. GULLIVER:
A. Not to my knowledge, no.
CHAYTOR, Q.C.:
Q. And given everything that's happened after that point, do you think if people had raised those issues with you, you would have a recollection of it?

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MR. GULLIVER:
A. Oh, definitely, yes.
CHAYTOR, Q.C.:
Q. So the first time you hear of any issue regarding the IHC is when Dr. Ejeckam brings it forward in 2003?
MR. GULLIVER:
A. Well, I guess the issues that he was addressing in those memos.
CHAYTOR, Q.C.:
Q. So were other issues brought to your attention?
MR. GULLIVER:
A. Well, I mean, it's a practising laboratory, you know, things are changing all the time. Obviously, I mean, if you don't perform those tests every single day, week after week, month after month, year after year and there's never an issue, it could be a simple issue, but nothing to the issues of what Dr. Ejeckam was doing.
CHAYTOR, Q.C.:
Q. Yes. So nothing that would cause you to question whether or not the tests were being done properly?

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MR. GULLIVER:
A. No, never.
CHAYTOR, Q.C.:
Q. Okay. Were you aware of tests having to be repeated prior to Dr. Ejeckam becoming involved?
MR. GULLIVER:
A. I was aware of the ER/PRs being repeated, but I was aware of that from more of a technical perspective. I know the antigen retrieval part of the procedure where you had to actually take patient slides and boil them for 20 minutes on a hotplate, just with my technical background I know that would lead quite often to the tissue just pretty well boiling or washing off the slide and therefore you'd have to repeat the procedure.
CHAYTOR, Q.C.:
Q. So what were you aware of and what time frame would that have been?
MR. GULLIVER:
A. Oh, that was sort of, I won't say common occurrence as every time a batch was run, but certainly it was frequently enough that you knew that one of the challenges was to keep

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tissue on a glass slide while you're boiling it for 20 minutes in a solution on a hotplate. And over time, you know, the vendors who provides material to perform the procedure, whether it's a reagent, whether it's a better water bath. And then they came out with newer slides, they were called, I think, HistoGrip slides that pretty well they put sort of a positive charge on the slides to kind of keep the tissue adhere to the slides.
CHAYTOR, Q.C.:
Q. So -
MR. GULLIVER:
A. We had the same thing just in the routine pathology lab. If you are staining sections, newer pathology sections, and I'm saying like brain tissue and brain tumours, just doing the routine H&Es and routine stains, that tissue could wash off the slides. It was a common occurrence in pathology labs in general.
CHAYTOR, Q.C.:
Q. So you made inquiries, I take it, at the time, to find out why that would be happening, why they were having these technical difficulties and you determined that they needed something

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different in terms of the slides that were in use?
MR. GULLIVER:
A. Well, I didn't really determine it. It was the company who came out and said, "We now have newer slides that you could use that would help keep the tissue on the slide from washing off."
CHAYTOR, Q.C.:
Q. And in terms of the tissue washing off the slides in and of itself and what would be causing that, was there any inquiry made as to what would be causing that in the first place?
MR. GULLIVER:
A. Just quite simply, you have tissue on a slide, boiling it on a hotplate, just that function -
CHAYTOR, Q.C.:
Q. So that wasn't an unexpected finding?
MR. GULLIVER:
A. No, no.
CHAYTOR, Q.C.:
Q. So other than that, so what you're saying is that the only issue that was brought to your attention was really a non-issue, something that you would expect to be happening and that

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was -

MR. GULLIVER:

A. Correct.

CHAYTOR, Q.C.:

Q. And that was taken care of by purchasing different slides?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Or different adhesive for the slides. In terms of the actual product, then, that was produced at the end of the day, the quality of the slides, was anything of that nature brought to your attention?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And the fact that what you're telling me is that at times the technologists would have to repeat their procedure because they were having difficulty keeping the material on the slide. But the fact that there may have been tests repeated after they had already gone through the technical process and been interpreted by a pathologist, the fact that

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any tests were repeated, was that brought to your attention at any time prior to Dr. Ejeckam's intervention?

MR. GULLIVER:

A. No, it wasn't. But again, I have to say, in pathology there are lots of instances where-- and it's not just for ER/PR, it could be a routine histochemical stain in the pathology lab, for some reason the pathologist may want to have a repeat. They may come in and say, "You know, you did those stains on block C. Upon review, I think I'm going to choose block F and could you repeat the stains on a different block or different part of the tissue?" You know, that's not an uncommon practice within the pathology environment.

CHAYTOR, Q.C.:

Q. And whether or not it was a concern around those repeats from a pathologist's point of view in terms of an unexpected finding or a change in results, anything along those lines ever brought to your attention?

MR. GULLIVER:

A. Never heard a thing, no.

CHAYTOR, Q.C.:

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Q. Okay. So what do you hear from Dr. Ejeckam, what's the first time that you hear that Dr. Ejeckam sees need to take certain interventions?

MR. GULLIVER:

A. I think, well, I'm pretty sure it was, actually it was Mr. Dyer, the pathology manager. He had come to me with a notice, a very short notice that Dr. Ejeckam had written, I think he addressed it to pathologists in general across the province, where he informs them for a short period of time there are certain antibodies in the laboratory that we will stop reporting on and performing that he wants to optimize or tweak the system.

CHAYTOR, Q.C.:

Q. And if we could look, please, at P-0113? I take it, Mr. Gulliver, that's the April 4th, 2003 memo?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Is that what Mr. Dyer brought to your attention, is it this document?

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MR. GULLIVER:

A. Yes. And I think Barry had seen it, maybe in the gross room posted or something like that. But I didn't get informed directly -

CHAYTOR, Q.C.:

Q. Well, it's copied to Mr. Dyer.

MR. GULLIVER:

A. - or he got it, yeah.

CHAYTOR, Q.C.:

Q. And all technical staff. But this wasn't copied to you and you didn't receive your own copy?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And so Mr. Dyer brought this to you. And what did you then do, did you make any inquires of Dr. Ejeckam as to what was the problem?

MR. GULLIVER:

A. No, I didn't. You know, Dr. Ejeckam at this point sort of, I guess, voluntarily, was interested in the IHC lab and, you know, he simply states that he's going to be doing a review of the stains, and it's a clinical thing. You know, I'm not the pathology

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manager at this point so I'm not there in the pathology lab.

CHAYTOR, Q.C.:

Q. I'm sorry, did you say it's a clinical thing?

MR. GULLIVER:

A. Well, I mean, he's a pathologist and he was going to review those particular stains. You know, it would be his decision to, you know, if he's going to optimize those stains with the technologists. So in my opinion it was being handled. I think I might have spoken to Dr. Ejeckam and maybe Dr. Cook, also, in-I mean, Dr. Ejeckam was fairly new. I think I might have just made a comment that, you know, "If you're going to do this and stop testing, you really should at least inform the clinical chief or the program director that"--we found out after he had already sent this memo out.

CHAYTOR, Q.C.:

Q. Okay, so you think you spoke to him to tell him that "Next time something like this comes up -

MR. GULLIVER:

A. Yeah, just -

CHAYTOR, Q.C.:

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Q. - at least give us a heads up."

MR. GULLIVER:

A. Yes, yeah.

CHAYTOR, Q.C.:

Q. But to ask him any questions about what do you mean by "unreliable" "erratic" and "unhelpful for diagnostic purposes," did you ask him what that meant and what his concerns were?

MR. GULLIVER:

A. At that time, no.

CHAYTOR, Q.C.:

Q. At any time?

MR. GULLIVER:

A. Well, we will talk about it later on when he puts the testing back in place.

CHAYTOR, Q.C.:

Q. Okay, so you talked to him later about it. But at the time when this happens, in April of '03, you go to him and say, "Well, the proper protocol would be, you know, come and talk to me and Dr. Cook and let us know you're going to do this." But you weren't consulted beforehand on the testing shutting down?

MR. GULLIVER:

A. No.

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CHAYTOR, Q.C.:

Q. And did you ask him why these eight stains out of the approximate 100 that we're doing, what's with these stains?

MR. GULLIVER:

A. Again, as you've heard in my testimony, you know, the medical laboratories which I'm director of, we perform 10 million tests a year, you know, it's 10 million. And through all of our divisions we have divisional chiefs, clinical leaders. You know, this is not, you know, an uncommon occurrence within medical laboratory practice that you may be reviewing certain testing, certain protocol, certain procedures that you perform to either optimize them. So this is, you know, it's not, you know, as a laboratory profession this is not something that would strike me as like, oh, this is the first time it's ever happened within labs that we're going to review some of our testing or try to put new testing in place or improve current testing.

CHAYTOR, Q.C.:

Q. So I take it the answer to my question is no, you didn't ask him why these eight stains?

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MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Okay. And you're telling me it's not uncommon for a pathologist, a fairly new pathologist, as you say, to your institution, to write a memo, shut down the testing with respect to eight stains and write that the stains have remained "unreliable, erratic, and therefore unhelpful for diagnostic purposes."

MR. GULLIVER:

A. No, not -

CHAYTOR, Q.C.:

Q. That's not an uncommon occurrence?

MR. GULLIVER:

A. Not in pathology. I'm saying this happen to be in pathology. I mean, within laboratory medicine overall.

CHAYTOR, Q.C.:

Q. So that's not an uncommon occurrence?

MR. GULLIVER:

A. Whether it's biochemistry, it could be cytology, could be genetics, it could be different parts of the lab where -

CHAYTOR, Q.C.:

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Q. So you've received similar memos? Not uncommon to receive such memos?
MR. SIMMONS:
Q. Commissioner, moments ago when answering that question initially, he didn't say that it was common to receive such memos. He said it was common throughout the laboratory for there to be instances where testing was reviewed. The questions that are being put now are as if he said something very specifically here as opposed to what Mr. Gulliver's answer actually was.
COMMISSIONER:
Q. You're saying Mr. Gulliver didn't say he got messages, he just said that these things happen?
MR. SIMMONS:
Q. Right. And I mean, he can certainly be asked, you know, what the similarities were. The questions are being put as if he had just said that he'd encountered exactly the same set of circumstances -
COMMISSIONER:
Q. Well, let's find out if he did.
MR. SIMMONS:

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Q. - and so on.
MR. GULLIVER:
A. Well, the answer would be no. I guess what I am trying to say, Ms. Chaytor, is that this is, you know, not an uncommon practice in laboratory medicine where parts of the program, in particular, could be pathology, cytology, genetics, chemistry, hematology, coagulation where you do review different kinds of tests. It doesn't necessarily mean that you get a written memo that said, "Oh, next week we're going to review our sperm testing because we're going to do" this, this, this and this. It's just sort of ongoing practice that happens in the laboratory.
CHAYTOR, Q.C.:
Q. Yes, so but to get a--so to shut things down on a temporary basis and review your testing or to do validations, for example, that would not be an uncommon thing. But to have it done and to have a written memo stipulating the reasons that Dr. Ejeckam has stipulated, that would be uncommon?
COMMISSIONER:
Q. The distinction, Mr. Gulliver, is between

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ongoing activity for test validation, etcetera, etcetera, and receiving a memo of the nature of the one you got from Dr. Ejeckam which uses language like "unreliable, erratic" etcetera, etcetera.
MR. GULLIVER:
A. Well, okay, put it this way: if Dr. Ejeckam had to write a memo to say that we are shutting down the IHC lab and all 120 or 30 or 40 antibodies that are performed in that lab, certainly, to me, that would be an absolutely huge event. But Dr. Ejeckam is saying of the 130, 140 antibodies that we offer in the IHC lab, there are several of them that I would like to review and do some testing and optimize that staining. Can you -
CHAYTOR, Q.C.:
Q. Except that's not what his memo said.
MR. GULLIVER:
A. He's saying they're "unreliable" and "erratic".
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. So as a lab person reading this here,

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"erratic" means that probably from week to week he's probably not seeing the same intensity of staining on these antibodies.
CHAYTOR, Q.C.:
Q. Yes. And did you ask him what he meant?
MR. GULLIVER:
A. At this point in time, no.
CHAYTOR, Q.C.:
Q. Okay. Mr. Gulliver, he also says "have remained unreliable, erratic and therefore unhelpful for diagnostic purposes." Did you ask him how long this has been a problem?
MR. GULLIVER:
A. I don't remember asking him and I don't remember him even telling me anything.
CHAYTOR, Q.C.:
Q. And did you ask him whether any investigation had been undertaken to determine how long it had been a problem?
MR. GULLIVER:
A. Well, he was, this is what he was doing right now at this point in time.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:

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A. To my knowledge there was no prior investigation.
CHAYTOR, Q.C.:
Q. And was there any investigation or any question asked as to whether an investigation may be necessary to determine whether or not tests happening prior to April, 2003 may need to be repeated?
MR. GULLIVER:
A. That was never discussed on this memo or the one following or the on in June that follows.
CHAYTOR, Q.C.:
Q. So that wasn't anything that--you didn't pose that question and nor did anyone else?
MR. GULLIVER:
A. And no one posed it back to me either, no.
CHAYTOR, Q.C.:
Q. And it's not something you thought of at the time?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Okay. So other than Mr. Dyer bringing you this and then you spoke to Dr. Ejeckam to speak about the appropriateness of informing

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you directly of such activities, when did you next hear anything about the fact that these stains had been shut down, they're being reviewed, when did you next hear anything about this?
MR. GULLIVER:
A. I guess maybe a few weeks later when they were putting them back in place.
CHAYTOR, Q.C.:
Q. And at that point in time did Dr. Ejeckam then share with you the memo that he wrote in May?
MR. GULLIVER:
A. I think he may have copied me on that one, Ms. Chaytor; I'm not sure.
CHAYTOR, Q.C.:
Q. Okay. We can look at that one then.
MR. GULLIVER:
A. And that's the one where he's giving sort of fixation protocols -
CHAYTOR, Q.C.:
Q. Yes, that's right.
MR. GULLIVER:
A. - interpretation guidelines and things?
CHAYTOR, Q.C.:
Q. That's correct.

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MR. GULLIVER:
A. I don't know if I received that one at the time.
CHAYTOR, Q.C.:
Q. Okay. So if we could look then first at P-1572, and I'll bring you back to that. Because this meeting happens in the interim. And it's April 15th, 2003. And you're not in attendance. It's the surgical pathology review committee. But if we come down through here, there's reference to the ER/PR issue. And "Dr. Ejeckam stated that ER and PR receptors are not being performed for the next six weeks due to a technical problem. If a solution cannot be found, these tests will be sent outside St. John's." Now, do you recall any discussion about the potential of having to send the tests outside of St. John's?
MR. GULLIVER:
A. No, no.
CHAYTOR, Q.C.:
Q. "He stated it is being considered to send one or two technologists to Halifax or Toronto for training." Was there any discussion with you or did you become aware of any discussion as

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to the technologists being potentially sent for additional training or for training?
MR. GULLIVER:
A. There was none, none.
CHAYTOR, Q.C.:
Q. And if we could look, please, at P-2155? And this is dated April 22nd, 2003. So again, this is happening before the stains are brought back on line. And this is written to Barry Dyer, Mary Butler. And we understand this came from DAKO. Were you aware at the time that DAKO were involved and had written this memo?
MR. GULLIVER:
A. Actually, I know when Dr. Ejeckam was reviewing those particular antibodies and Barry came over to inform me and talk about it. I think maybe it was my suggestion that said, "You know, maybe you should speak to Dan," who is the technical, our technical contact person with DAKO and, you know, "and see what DAKO thinks about the slides or the antibodies and see what they got to say."
CHAYTOR, Q.C.:
Q. And did Barry inform you that, in fact, he had

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done that? Mr. Dyer, I should say.
MR. GULLIVER:
A. I'm pretty well sure Barry told me that he had done it, but I did not receive a copy of this here. It was being dealt with by, you know, Dr. Ejeckam and the manager and technologists.
CHAYTOR, Q.C.:
Q. Okay, and -
MR. GULLIVER:
A. I've certainly seen it since.
CHAYTOR, Q.C.:
Q. Yes. When did you first see this?
MR. GULLIVER:
A. I think I first seen this maybe in 2005, you know, when the whole ER/PR issue was coming to the forefront.
CHAYTOR, Q.C.:
Q. 2005 or 2007?
MR. GULLIVER:
A. I really can't say one way or the other.
CHAYTOR, Q.C.:
Q. Okay, and the issues raised here in terms of fixation and of course, that's picked up by Dr. Ejeckam in his May memo that he sends out, but were you aware at the time that DAKO were

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suggesting certain things in terms of fixation and dealing with, for example, institutions outside of St. John's?
MR. GULLIVER:
A. No, I wasn't, no. But again, you know, in reading this here, to me this is sort of a key piece of information. The fact, you know, DAKO are saying that the control slides that have been running, it's saying that "your control tissue appears to be staining acceptably." What they're saying, the variability and erratic staining you're seeing is on the patient slides.
CHAYTOR, Q.C.:
Q. Yes, and so what--and as you say, that's a key point. So what is it that that tells you?
MR. GULLIVER:
A. Well, again, what they're recommending is to--you know, they're saying that "you are a reference lab for the province. Therefore, you are handling specimens that are fixed, prepared and grossed in other centres. You just receive"--we receive the final block to do a slide, a stain on it. I guess what they're recommending here is to do

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standardized fixation and tissue preparation protocols.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. And that may alleviate some of the variability that you're seeing from batch to batch.
CHAYTOR, Q.C.:
Q. Okay, and so DAKO, in essence, is suggesting that the variability in staining is likely due to variability in the tissue preparation?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And was that issue brought to your attention back in April of 2003?
MR. GULLIVER:
A. In 2003, no.
CHAYTOR, Q.C.:
Q. And when was that issue first brought to your attention?
MR. GULLIVER:
A. Again, I don't know if it was like 2005 or, as you said, '06 or '07, but since, you know, we've started the whole ER/PR retesting and

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been dealing with this issue, at some point during that time frame, certainly long after 2003.
CHAYTOR, Q.C.:
Q. So you've spoken then again with Barry and suggested that he get in touch with DAKO. Did you then get any further feedback on how things were going or how they were progressing, and what, if any, involvement did you have in terms of keeping an eye on things while Dr. Ejeckam is undergoing the review?
MR. GULLIVER:
A. I had no involvement.
CHAYTOR, Q.C.:
Q. If we could look then, please, back to P-0113? And if I just take you here to page two, it's the May 2nd, 2003 memo, and this is sent to pathologists, St. Clare's and out of --HSC, St. Clare's and out-of-town hospitals, from Dr. Ejeckam, May 2nd, 2003, and it's copied to the site chief at the Health Science and St. Clare's and Barry Dyer and all technical staff. So do you know whether or not you received this memo?
MR. GULLIVER:

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A. I think Barry probably showed it to me at the time.
CHAYTOR, Q.C.:
Q. So you became aware through the memo that the staining, at least for ER/PR, had been -
MR. GULLIVER:
A. Well, yes, I knew it was put back in place, yes.
CHAYTOR, Q.C.:
Q. So you knew this was--it had been put back in place?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And Mr. Dyer informed you of that?
MR. GULLIVER:
A. And I think it was Barry, yeah.
CHAYTOR, Q.C.:
Q. And in terms of the content of the memo, you knew the staining was put back in place, but did you--were you told at the time, the issues that had been identified by Dr. Ejeckam such as, in paragraph one, the issue regarding fixation, the mention of internal controls, which reporting of ER/PR, different formula in

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the literature. This section here in paragraph five -
MR. GULLIVER:
A. Well, he's really giving the pathologists some guidelines on interpretations and guidelines on, you know, sort of pitfalls or watch out for this or watch out for that.
CHAYTOR, Q.C.:
Q. Yes, and that certain tumours would be expected to be ER positive. So the content itself, were you aware of that or was it just the testing has resumed?
MR. GULLIVER:
A. Just testing has resumed, you know. I'm not a pathologist so that wouldn't--most of this would not be directly related to me in practising.
CHAYTOR, Q.C.:
Q. Did you, at the time--when did you become aware about the other--these are two of the stains. What about the other six stains? Did you become aware whether or not they in fact had resumed?
MR. GULLIVER:
A. I was just made aware that whatever Dr.

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Ejeckam had stopped was back in place again.
CHAYTOR, Q.C.:
Q. And who would have informed you of that?
MR. GULLIVER:
A. I think it was Barry.
CHAYTOR, Q.C.:
Q. And after learning from Mr. Dyer that the ER/PR had come back on, did you have any further follow up with Dr. Ejeckam to ask him about what he had discovered, if there was anything else that needed to happen?
MR. GULLIVER:
A. Well, Dr. Ejeckam certainly never came to tell me directly what he had discovered or what they did. It was only through, you know, getting information back from the manager, as you've just--as I just outlined there. At some point though, I just informally, I ran into Dr. Ejeckam like over in the pathology corridor, in the hall, because I mean, the pathology lab physically, you know, it's not that far away from where my office is, and you know, I had said to Dr. Ejeckam, "look, you know, if you're reviewing the lab, you did some of these stains, is there anything else

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in that part of the lab that you think that we need to do for IHC lab?" and then you're going to see the next June something memo.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Where, you know, he puts in a list of things that he thinks could help overall improvement in the IHC part of our lab.
CHAYTOR, Q.C.:
Q. Okay. So you ran into Dr. Ejeckam in the corridor and had an informal conversation with him after the testing had come back online and asked him if there was anything else that he felt was needed?
MR. GULLIVER:
A. That's pretty well it.
CHAYTOR, Q.C.:
Q. Okay, and that was followed shortly thereafter by the June 19th memo or letter to you, I should say?
MR. GULLIVER:
A. Well, it was a week later or two weeks later or I'm not really sure, but I mean, you know, at some point after Dr. Ejeckam does come over

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with, you know, with that memo and he and I and Barry would sit in my office and we'd just, you know, pretty well just chat about it.

CHAYTOR, Q.C.:

Q. Yes, and I'll take you to that in a minute. I'm just wondering about at this point in time then, what discussions or follow up you had with him. The identification of fixation as a potential issue or potential factor on the results of the immunostains, was that the first time that anyone had raised with you any concern about fixation?

MR. GULLIVER:

A. No, certainly not.

CHAYTOR, Q.C.:

Q. And so in what other context had the issue of fixation been raised as a concern?

MR. GULLIVER:

A. You mean just at this point in time or you mean in general in pathology?

CHAYTOR, Q.C.:

Q. Prior, prior to--no, prior to Dr. Ejeckam sending out this memo and his intervention, had anyone raised with you that there was a

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problem or a perceived problem or any potential problem with fixation of your specimens?

MR. GULLIVER:

A. I mean, certainly. I mean, it's a large volume pathology lab where you have multiple pathologists practising, you know. I've been there, I worked in pathology as a technologist from 1980 to '87 and I was the manager from '87 to 2001. Certainly I've had issues of fixation come to me before from the technologist. You seen yesterday, you know, a lecture that I would give and at times, other senior techs would give the new pathology residents, talking about the importance of fixation and a lot of the times, the issue wasn't that specimens were not put in fixative. Don't get that wrong. The specimens were put in fixative and either they weren't left long enough or they were left too long. Most importantly, at the gross bench, that when the pathologists were grossing, they really were not cutting their sections thin enough to allow for the full penetration of the formalin fixation.

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CHAYTOR, Q.C.:

Q. Okay, so those -

MR. GULLIVER:

A. And that was an issue on different occasions multiple times.

CHAYTOR, Q.C.:

Q. Okay, and so what prior to Dr. Ejeckam sending out his memo then, on May 2nd, 2003, what on those prior occasions happened to prevent that from being an ongoing issue?

MR. GULLIVER:

A. What would happen at the time, at the time when there--if there was an issue and generally, you know, in your routine processes in pathology, once your tissue has been, you know, fixed and grossed, go through the processing cycle, the next day when the technologist are doing the paraffin embedding and the cutting of the slides and the routine staining of the slides, that's where a fair bit of time you would notice if the specimen had not been fixed properly, the technologist would pick it up and they would go directly back to the submitting pathologist, you know, and say to them, "look, we're having

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difficulty even cutting H & E's on this case because it's not fixed properly."

CHAYTOR, Q.C.:

Q. Was there ever any discussion to bring in any kind of policy procedure or protocol to standardize fixation?

MR. GULLIVER:

A. I don't know if there was a policy to standardize fixation. There was certainly a lot of discussion, even when I was there as manager, which you know, predates 2001, discussion about trying to standardize grossing practices. Again, you know, I'm going to go back to even that small presentation I gave to all new residents in talking about the importance of fixation and proper fixation, proper thickness of tissues. It's not something that people were not informed of, and when issues arose, it was brought back to the particular pathologist who had prepared that sample.

CHAYTOR, Q.C.:

Q. Yes, and was that a presentation that you gave every time a new batch of residents came in?

MR. GULLIVER:

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A. It went on for--yeah, for a long time.
CHAYTOR, Q.C.:
Q. Went on -
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And was it ever changed or is it just that one version that we have there?
MR. GULLIVER:
A. You know, it's pretty well that one version, but you know, it's--like the foundation of pathology is the specimen that comes in, most importantly, it is fixed properly, because everything else you do from that specimen, it's critical to make sure the specimen is preserved in as lifelike manner as possible and is preserved properly.
CHAYTOR, Q.C.:
Q. Yes, and that's critical, as you say?
MR. GULLIVER:
A. And that's just basic pathology foundation.
CHAYTOR, Q.C.:
Q. But no--even though this was discussed and the importance and it being critical was acknowledged, there was no standardized

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protocol procedure or policy put in place to ensure that it was in fact happening?
MR. GULLIVER:
A. Not to my knowledge, no.
CHAYTOR, Q.C.:
Q. And how about the standardization of the grossing? Was there anything ever put in place to ensure that that was going to happen?
MR. GULLIVER:
A. No. I mean, obviously it's happening now with our pathology assistants who are trained and doing the grossing. You know, I know at various times, I remember myself and Mr. Dyer, we met with the pathologists as a group, along with Dr. Cook, talking about, you know, doing that kinds of things, standardizing our grossing templates, standardizing grossing protocols, but you know, it just didn't really--it just didn't get off the ground.
CHAYTOR, Q.C.:
Q. And Mr. Gulliver, by May of 2003 then, the tests are brought back. Did you ask Dr. Ejeckam what he had done to rectify the problem?
MR. GULLIVER:

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A. I don't think I asked him and I don't think he even came and offered up anything.
CHAYTOR, Q.C.:
Q. And did you, at this point in time, then inquire of him as to whether or not the problems he had discovered could have impacted upon the tests that had been done in the past?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And why not?
MR. GULLIVER:
A. Why would I ask him has it impacted in the past?
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Rightly or wrongly, I would assume that he's a physician, a pathologist, every slide that came out of that lab is reviewed and signed out by a pathologist, so if they had issues, then I'm assuming I would have heard about it long before this, and if he had issues or concerns, I would expect that he would express them. You can see Dr. Ejeckam, the way he

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operates, whether it's a minor issue or it could be a major issue, you know, he expresses himself and he puts things in writing. So I'm assuming if he had a concern with tests that were performed prior to this, he would have informed Dr. Cook or informed myself, but it just didn't happen.
CHAYTOR, Q.C.:
Q. And what did you understand--you said from a technologist reading the earlier memo what you would have read into erratic staining, what did you understand erratic staining might mean?
MR. GULLIVER:
A. Oh, erratic to me is something that this week everything looks good and this week, it doesn't look as good as the week before.
CHAYTOR, Q.C.:
Q. And how does it not look good?
MR. GULLIVER:
A. Well, I would interpret it to mean that the staining intensity could vary from week to week. So one week you have a really good nice, strong positive result and the next week, you've got a positive--it could be a

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positive result, but it's weak, it stained weaker.

CHAYTOR, Q.C.:

Q. And what effect might weak staining have on a patient who is a low expressor?

MR. GULLIVER:

A. I'm really not qualified to answer that.

CHAYTOR, Q.C.:

Q. So if the staining is erratic, wouldn't you think there might be slides that are not staining at all that should perhaps be staining because the person is a low expressor?

MR. GULLIVER:

A. I guess it could be possible.

CHAYTOR, Q.C.:

Q. Okay, but that didn't cross your mind at the time?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Okay, and it wasn't discussed with anyone within -

MR. GULLIVER:

A. I mean, we're talking 2003. At that time, I

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would have no idea what a low expressor is.

CHAYTOR, Q.C.:

Q. And if we could look then, please, continuing on with actually this exhibit, and it's page-- well, perhaps I can do this, page five of the exhibit. So this is June 19th, 2003. So Mr. Gulliver, you're saying that between the May memo and the letter to you or memo to you of June 19th, 2003, you had somewhat of a casual conversation with Dr. Ejeckam and asked him if there is anything else that may be required?

MR. GULLIVER:

A. Pretty well, yeah.

CHAYTOR, Q.C.:

Q. And is that what you understand to be the reason why then you received this memo dated June 19th?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay, and if I could just take you through this. So is it a situation where you actually invited this from Dr. Ejeckam?

MR. GULLIVER:

A. Well, I can't say I invited it from him. You

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know, I had a casual conversation with him. I pretty well said to Dr. Ejeckam, like you know, he hadn't been here a long time, that for example, in our--in that part of our pathology lab at the time, the IHC testing was still being performed sort of the back bench of pathology. You know, we were--had for a long time planned--needed physical space freed up, needed some renovations from facilities management to move IHC into its own lab. I talked to him about, you know, the senior techs that were doing the testing at one point in time. The pathologists wanted those technologists trained to do the gross bench, the small specimens. So I just pretty well gave him some of the history of what had gone on in our IHC part of our lab and you know, said you know, if you got anything that you'd like to put--to come talk to me about or put in writing, you know, just do it.

CHAYTOR, Q.C.:

Q. Okay. So you suggested that to him, if there's anything else, you could put it in writing?

MR. GULLIVER:

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A. Yeah.

CHAYTOR, Q.C.:

Q. And why would you want that? Why would you want him to put something in writing to you?

MR. GULLIVER:

A. Because in writing, you can follow it step by step and what's there and what you can do to respond to it. I also put it--I asked him, I think, you know, at the time, in my mind would be if it's something in writing and it's coming from a doctor, you know, it may lend a bit more weight to things that he may request or things he may suggest for that part of our laboratory.

CHAYTOR, Q.C.:

Q. So it would make it easier for you to go forward to your superiors to try and get put in place whatever it was that Dr. Ejeckam may be requesting?

MR. GULLIVER:

A. Well, and not necessarily for me to go forward, but it could be, if it's a clinical thing, Dr. Cook to go forward with.

CHAYTOR, Q.C.:

Q. Yes. If you have it committed to writing,

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then you were thinking that this might have a little, as you say, a little more weight and would give you something of substance to take forward, should it be something you need to take forward or Dr. Cook, whoever in the laboratory medicine program needed to go forward with it. Okay, and is that what-- that's what you had in mind when you suggested to Dr. Ejeckam that he could put this in writing?

MR. GULLIVER:

A. That certainly was in the back of it, yes.

CHAYTOR, Q.C.:

Q. Okay, and then having received it, Mr. Gulliver, who did you share this with?

MR. GULLIVER:

A. You know, what I remember, I think Dr. Ejeckam just walked over to my office and brought it in and gave it to me, and Barry came over and the three of us sat down and we just kind of reviewed it and, you know, we just went through the pieces of it that we felt that we could address, myself and Mr. Dyer.

CHAYTOR, Q.C.:

Q. Okay. So you're saying that Dr. Ejeckam

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walked in and handed it to you?

MR. GULLIVER:

A. That's what I remember.

CHAYTOR, Q.C.:

Q. And then the three of you sat down, you and Dr. Ejeckam and Barry Dyer?

MR. GULLIVER:

A. And Barry, yeah.

CHAYTOR, Q.C.:

Q. Sat down and went through his memo?

MR. GULLIVER:

A. We went through, you know, the basic things, went through it. For example, the physical location of the facility is unsatisfactory. Well, that's not telling me anything new.

CHAYTOR, Q.C.:

Q. And if Dr. Ejeckam has told the Commissioner that he wrote this letter to you, stopped you afterwards to find out whether or not you had in fact received it, had a chat with you in the corridor to see whether or not you had even received it, was told that you would be responding to him and then never heard anything else from you on it, no response?

MR. GULLIVER:

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A. Well, I didn't hear Dr. Ejeckam's testimony. I'm just telling you what I remember. I can clearly remember myself, him, and Barry, in my office, I have a small table, the three of us sitting there informally talking about this letter and myself and Barry going through with him and pretty well saying, yeah, we know about the facility, the physical space location is unsatisfactory.

CHAYTOR, Q.C.:

Q. So that's paragraph one.

MR. GULLIVER:

A. We have been working on trying to get dedicated space for the IHC part of pathology. We talked about workload and volumes. I had told Dr. Ejeckam at the time that I had recently been to a large conference where I had seen that vendors were coming out with new automated technology for IHC testing, i.e. this is how I first seen the Ventana System. He talked about at the time--I think at the time Mary, and I think Peggy may be still there, and Ken is new into the lab. You know, he wanted them to be full time working in IHC.

CHAYTOR, Q.C.:

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Q. By June, I think--by this point in time, I think Peggy would have moved on?

MR. GULLIVER:

A. I think Peggy is gone.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And, you know, Ken was still fairly new, only had been there probably a year in IHC lab, and Les Simms has just moved over from St. Clare's. So he was saying that, you know, those staff needed to be dedicated to IHC to give them time to learn, give them time to read articles and read journals. Therefore, we kind of--those were the senior techs that were doing the grossing that the main body of the pathologists had asked for a couple of years prior without pathology assistants. So we had to put in processes to skill up or retrain other technologists to take over that biopsy grossing function in order to do this. So these are the kinds of things that we talked about, the kinds of things that we could do.

CHAYTOR, Q.C.:

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Q. Okay, so first of all, it's the physical space, the physical location of this facility is unsatisfactory. "Immunohistochemical stains need to be housed in a separate room with proper humidity control. This is lacking in the corner of an open laboratory where procedures are carried out at the moment". So what was done in response to that particular concern?

MR. GULLIVER:

A. Well, shortly afterwards there--adjacent, and you've been in to, you've physically seen our lab when you came in for your tour. Physically adjacent to the pathology lab, there was other lab testing taking place, and I moved those staff out and moved them over to the main biochemistry lab. We had been waiting on with the Janeway moving and reopening, additional space was being renovated over in that part of the lab in order to move these people out, and then we started moving the IHC stuff into that part of the lab.

CHAYTOR, Q.C.:

Q. And when did that actually happen, when did

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that physical move happen?

MR. GULLIVER:

A. It happened, I think, by the end of '03. By the time we did--by late summer/fall of '03, you know, we do a tender where we're going to acquire the Ventana System. By the time the Ventana System comes into the physical plant, that new system is being set up in the dedicated space for IHC lab.

CHAYTOR, Q.C.:

Q. So was that spurred then--the change in the physical location brought on by Dr. Ejeckam's concerns back in June or was that brought on by the fact that you had acquired new technology and in December, 2003, then the move happens?

MR. GULLIVER:

A. It was brought on by neither.

CHAYTOR, Q.C.:

Q. Sorry?

MR. GULLIVER:

A. It wasn't brought on by Dr. Ejeckam and it wasn't brought on by Ventana. It's something that even I as the manager two years prior to this had wanted, however, we were waiting on

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facilities management to get things done.

CHAYTOR, Q.C.:

Q. So your response to Dr. Ejeckam was this is something I'm already working on and we'll get it done when we can?

MR. GULLIVER:

A. Well, working on, and frustrated with.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. That we've been trying to get this done for a couple of years.

CHAYTOR, Q.C.:

Q. And what was it--sorry, Mr Gulliver, what was it you needed to have happen in order--if it's something you're frustrated with and something you've been trying to do for a while, what was it you needed for that to be able to happen?

MR. GULLIVER:

A. We needed renovations to take place in other parts of our laboratory program.

CHAYTOR, Q.C.:

Q. And what was the slow up in that happening? Was it a resource issue?

MR. GULLIVER:

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A. It was facilities management, and prioritizing what needs to be done within the health care system. Before the Grace closed and Janeway closed, we're going back to 1999, the main pathology lab at the Health Sciences, we had done up detailed plans to renovate and upgrade the current space at the Health Sciences. We had also done detailed plans to upgrade our microbiology services at the Health Sciences to consolidate for one lab.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And here it is, 2008, and it still isn't done.

CHAYTOR, Q.C.:

Q. So did you -

MR. GULLIVER:

A. So when I'm talking about this here with Dr. Ejeckam, it's like it's so frustrating that maybe with a doctor putting this in writing, we might get some response.

CHAYTOR, Q.C.:

Q. Right. Okay, so now you've got your doctor has put it in writing. What do you do with it?

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MR. GULLIVER:
A. Well, what happened was we're able to get space finished over in the extension of our chemistry lab.
CHAYTOR, Q.C.:
Q. So who did you go with this memo--armed with this memo, who did you take it to to make things happen?
MR. GULLIVER:
A. I didn't take this memo--no, I didn't take this memo to facilities management and say here.
CHAYTOR, Q.C.:
Q. Did you take it to Dr. Williams?
MR. GULLIVER:
A. I don't think I did. I addressed the parts in this here as the administrative director and I would have assumed if there was any clinical issues that Dr. Cook would have taken this up with Dr. Ejeckam and with Dr. Williams.
CHAYTOR, Q.C.:
Q. You report directly to Dr. Williams as well, though?
MR. GULLIVER:
A. Yes.

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CHAYTOR, Q.C.:
Q. So you now have something committed in writing, you've been frustrated trying to have this happen yourself. So, how does having this put in writing by Dr. Ejeckam, what do you do, how do you use that to make it happen faster?
MR. GULLIVER:
A. Well, I think--it could be by coincidence. I think around this same time we knew that the renovations over in chemistry would be completed in the next few months, so we could move hormone chemistry testing out of the space adjacent to pathology, over with the main biochemistry, and then that space would be vacated and we could move the IHC testing into that part of our laboratory.
CHAYTOR, Q.C.:
Q. And how physically then does the move happen, who makes the move happen?
MR. GULLIVER:
A. Pretty well mostly Barry and the techs do it themselves.
CHAYTOR, Q.C.:
Q. Okay. So they actually go in and move things,

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move the equipment, and it's Barry Dyer and his technologists?
MR. GULLIVER:
A. They went in and moved out parts of benches and made things a bit more ergonomic, as best they could, and put different tables in there.
CHAYTOR, Q.C.:
Q. And the idea that it be a separate room with proper humidity control, do you currently have that, do you have a separate room with proper humidity control?
MR. GULLIVER:
A. Well, it is a separate room, and proper humidity control now, I don't think is an issue because the Ventana System is the closed system. So the slides are on a closed system, they're not exposed to sitting in the bench in a petri dish or even the old DAKO autostainer, what the autostainer did was provide the humidity chamber for the slides during the incubation time. So, I mean, this is back in 2003 before we got the Ventana System.
CHAYTOR, Q.C.:
Q. Yes, and up until, I guess, then December of '03, from June of '03 to December '03, you

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continued on with the DAKO System?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. The next paragraph talks about the stain is not just another special stain, "It's affected by far more numerous factors than apply in other special stains. It is extremely sensitive procedure, therefore, haphazard and laissez-faire approach to it is not the way to go". Would that have been any new information for you, Mr. Gulliver, or would you have been well aware of that?
MR. GULLIVER:
A. Well aware.
CHAYTOR, Q.C.:
Q. And then he talks about the staff arrangement in paragraph three, "As it now stands, is grossly inadequate and unacceptable for problem free or minimal problem operations. There has to be a dedicated staff to take over this special procedure. The staff is expected to read wide on the subject and understand the theory and practical aspects of immunohistochemistry. The staff should be a

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problem shooter and that can only materialize through thorough understanding of the subject". So just let me ask you about that piece, what happened in response to his concern here about the dedicated staff and need for dedicated staff?

MR. GULLIVER:

A. Well, I think Mr. Dyer started the process then of--there wasn't enough workload in the IHC part of pathology to justify or warrant those numbers of staff doing this testing every single day. What Dr. Ejeckam was saying was I understand that, however, we have new staff there--Les and Ken had just--Les was just there a few months and Ken a year, and they need to have time freed up to be able to sit down, read journals, and if Dr. Ejeckam wants to give them some lectures and those kinds of things, those staff were the senior pathology technologists and they were the staff that were doing the small biopsy grossing to help with the pathologists front end workload. So Barry had to take other technologists in the pathology lab and then skill them up to a certain level to take over

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the grossing function. Therefore, Les and Mary and Ken could then be freed up, more time to spend in the IHC part of the lab.

CHAYTOR, Q.C.:

Q. And when did that happen?

MR. GULLIVER:

A. It may have taken four or six months before it finally happened.

CHAYTOR, Q.C.:

Q. The idea that the staff were expected to be quite knowledgeable with respect to immunohistochemistry and should be reading upon it and should be able to problem shoot, what if any measures were taken to ensure that that was the case?

MR. GULLIVER:

A. Nothing that I took. You know, he's pretty well saying that the staff who are performing this testing should be able to understand the testing, and if he's the director of the IHC lab--I think Dr. Ejeckam also gave some basic lectures at the time to the new staff.

CHAYTOR, Q.C.:

Q. And he uses some strange language at the end of this paragraph where he's talking about the

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dedicated staff should cut and stain all cases while the assistant standby staff does that twice a week. "The designated staff uses this valuable time for housekeeping jobs in immuno. This will include dealing with order and titrating new antibodies. This ensures that the standby staff is in tune with the procedure and can produce acceptable results when the need arises. To do less would simply become a gamble where you may win or lose. This obviously will spell disaster". When you read that, Mr. Gulliver, and as you say you sat down and discussed this with Dr. Ejeckam, that's fairly strong language, did you understand what he meant by that, "how it could spell disaster"?

MR. GULLIVER:

A. Again he's not telling me anything new. He's talking about laboratory testing, you know. I could sit down and speak to the biochemist and he can come and say to me, you know, if we don't have this, this, and this, you realize it could be disaster for this particular testing or the outcome for the patient, it' just basic understanding, and this is the way

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Dr. Ejeckam spoke. You know, he put--the way he's writing here is the way he expressed himself. He never brought it as a major concern to me and I read this here to say, yeah, I mean, it's just -

CHAYTOR, Q.C.:

Q. So that doesn't--that's not bringing to you a major concern?

MR. GULLIVER:

A. He's not saying that we're gambling, he's not saying the staff aren't trained, he's not staying the staff are not qualified.

CHAYTOR, Q.C.:

Q. But to do less -

MR. GULLIVER:

A. He's just saying that we need to ensure that the staff have got enough time to be able to read and learn on the job.

CHAYTOR, Q.C.:

Q. And enough knowledge--enough time and enough knowledge to be able to do these things?

MR. GULLIVER:

A. Yes, and he never once said to me our staff did not have the knowledge or could not perform the testing.

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CHAYTOR, Q.C.:
Q. So when you -
MR. GULLIVER:
A. I think if you'll scroll down, I think he actually says the reason why we have good quality stains now is because of our technologists.
CHAYTOR, Q.C.:
Q. It's a credit them.
MR. GULLIVER:
A. Somewhere there, yeah.
CHAYTOR, Q.C.:
Q. We'll come to that, but in terms of them being able to be problem shooters and to knowledge, I'm just wondering when you read this and when you discussed it with Dr. Ejeckam, did you take from this that he had any concern that up to this point in time they perhaps did not have sufficient knowledge?
MR. GULLIVER:
A. He never said--no, he didn't say. As a matter of fact, he--well, I can't say that, I can't-- I was going to say, I mean, I think he kind of praised the technologists that they're good technologists, but I can't really swear that

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he said that, but that was generally the conversation.
CHAYTOR, Q.C.:
Q. And you didn't take away from this that there was any concern about their current level of expertise?
MR. GULLIVER:
A. No, I didn't, no.
CHAYTOR, Q.C.:
Q. And he talks then in paragraph four about the volume of immunohistochemical procedures continuing to increase, every day more diagnostic antibodies are added.
MR. GULLIVER:
A. And again, you know, he's saying every day more diagnostic antibodies are being added. We may have added an antibody every few months, a new one.
CHAYTOR, Q.C.:
Q. "And each new antibody", he says, "poses its own special problems that needs to be mastered before reliable, reproducible, and consistent results can be obtained. Since this is the only centre in the province that performs this test, there is enough case to be made for

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identifying the activity is special and unique, therefore, requires financing and staffing", and Mr. Gulliver, if it requires financing and staffing, who would be responsible for that?
MR. GULLIVER:
A. Well, it would be my main function.
CHAYTOR, Q.C.:
Q. And if you needed financing or other resources to be able to carry out what Dr. Ejeckam is seeking here, where would you have to go?
MR. GULLIVER:
A. Well, there's two avenues. We operate under program management. There are times where there were financial resources freed up for various reasons in other parts of the lab that I could actually move that money over to the pathology budget, and other cases that required a direct ASP (phonetic) through the budget process, you know, within the Health Care Corporation, but what he's saying here is he's just reinforcing the fact, the staffing, that we've got three staff who are trained in immuno, so let's just keep them dedicated in immuno. That means the staffing issue here is

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I need to get other technologists to backfill the grossing function that those three techs were doing in immuno. The financing piece of it was pretty well saying that when we add new antibodies to our arsenal, it will increase the operating cost for the IHC part of our lab, and never once to my knowledge in all the years have we not ever purchased a new antibody that a pathologist suggested that should be in our protocols.
CHAYTOR, Q.C.:
Q. Did anything that you did in response to Dr. Ejeckam's memo require extra resources?
MR. GULLIVER:
A. I'm thinking at the time and I don't know if, like we put a fulltime tech to them. We used to have, like Mary and Peggy and Ken would do a weekly rotation at the gross bench and Barry took one of the next senior technologists and trained them in to do the grossing. And I don't know if I sort of took money from biochemistry hematology division and put it over to pathology to fund that position, or we just went right ahead and put that position in place and I dealt with the budget deficit for

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that. But we put the fulltime -
CHAYTOR, Q.C.:
Q. So there was an actual position created, whether you reassigned within the program -
MR. GULLIVER:
A. Right, at this time, I don't think we got the position created, but it does come in the next year or so through the budget cycle.
CHAYTOR, Q.C.:
Q. So it's a year or so down the road through the next budget?
MR. GULLIVER:
A. But we do have a physical person who is now fulltime doing all the small biopsy grossing.
CHAYTOR, Q.C.:
Q. Right.
MR. GULLIVER:
A. A Technologist II.
CHAYTOR, Q.C.:
Q. And when was that put in place?
MR. GULLIVER:
A. Again, I don't know the exact date, you know.
CHAYTOR, Q.C.:
Q. Around the same time the space moved, the end of '03?

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MR. GULLIVER:
A. It could be around that time, early 2004 or, you know, I mean, it took time to get all this work through and meanwhile, I remember when Dr. Ejeckam and I and Barry talked about this stuff, it was like we're right in the beginning of summer vacation where staff were now getting all their holidays and we had pretty well said, well now, Dr. Ejeckam, there's not much going to happen over the summer, you know, until staff get their vacation and everything over with.
CHAYTOR, Q.C.:
Q. So in paragraph five then, he talks about "the present staff performing this procedure are doing the best they can, but with myriads of other duties that take them away from the immunostain fairly regularly, it is virtually impossible for them to devote the time required to master the intricacies of this procedure. A fairly good stain we have now is a credit to them, but they do not have enough time to spare. It is my understanding too that some of them have less than two or three years in the establishment"--and he's concerned then

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with succession planning, that there will be a vacuum and another period of uncertainty. Sorry?
MR. GULLIVER:
A. No, I'm just reading this now, you know, again for--I haven't read it for awhile, but -
CHAYTOR, Q.C.:
Q. Was there something there though that you wanted to comment on?
MR. GULLIVER:
A. Well I just, you know, when he talks about this succession planning for the technologists, and yes, we were well aware that the staff who had left, like Peggy had left and you know, it wasn't an expected decision for Peggy to move to Nova Scotia for, other than her reasons.
CHAYTOR, Q.C.:
Q. I think she's gone, though, by this point in time.
MR. GULLIVER:
A. I know, but then the backfill of that, you know, we expected Peggy--she's still working in Nova Scotia, you know, I expected Peggy would be in the IHC lab until she decided to

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retire, which is still a fair number of years away. And the backfill of Peggy, again, was a senior technologist, Les Simms, who was already retired. And he only moved to this part of the lab only in 2003 and Les just retired. I guess the part that strikes me here is that he's talking about, you know, we need to put in succession planning for the technologists, but he doesn't talk about succession planning for the pathologists.
CHAYTOR, Q.C.:
Q. Well that's probably because he's writing it to you, though, I guess.
MR. GULLIVER:
A. And we know that when Dr. Ejeckam decided to leave that, you know, it left a vacuum in our lab.
CHAYTOR, Q.C.:
Q. So what you're saying is this is an issue on both sides of your program -
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Clinical and technical, okay. Then his issue here in terms of them doing the best they can

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but they have numerous other duties, and what you're saying is that there was an extra position created sometime within the next year.

MR. GULLIVER:

A. No, before a year, it started, I think by the fall, once the summer holidays were over, I think Barry started training someone else to start doing all the grossing.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. I think he might have trained two people.

CHAYTOR, Q.C.:

Q. And his last numbered paragraph, number six, "Finally it is pertinent to mention that results of immunostains are extremely important in histopathological diagnosis, especially where classification of lymphomas and determination of benign or malignancy on certain lesions. For example, in the prostate biopsies depend on crisp reliable and reproducible staining results. Diagnosis based on inappropriate immunostain will surely jeopardize patient care and may even expose

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the Health Care Corporation of St. John's to litigation. Therefore, it will be ill advised to operate an unreliable and erratic immunohistochemical procedures in our laboratory." And Mr. Gulliver, when you read this paragraph, and again there's fairly strong language used, did this cause you any concern and did you take this up with Dr. Ejeckam?

MR. GULLIVER:

A. No, you know, to me he's just, he's simply stating the facts and this is laboratory medicine, this is the practice and this happens to be potential outcomes, I guess if something were to go wrong in that part of the laboratory. But for him saying to me that this is important diagnostic testing and it's important for lymphomas, it's important for prostates, it's important for every pretty well cancer I know the pathologists use it for, I mean, he's not telling me something new.

CHAYTOR, Q.C.:

Q. And again, though, I take it happened -

MR. GULLIVER:

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A. But we never ever discussed nothing like litigation and suing and, you know, that kind of stuff.

CHAYTOR, Q.C.:

Q. That wasn't discussed?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And to be told something like that in writing, how common would that be?

MR. GULLIVER:

A. More common in the last two or three years.

CHAYTOR, Q.C.:

Q. How about up to this point in time?

MR. GULLIVER:

A. Up to this point in time? Fairly uncommon.

CHAYTOR, Q.C.:

Q. But it wasn't the subject of anything that you and he discussed in your sit down after you received this?

MR. GULLIVER:

A. No, no.

CHAYTOR, Q.C.:

Q. And was it something that you--did you ask him, well Dr. Ejeckam, what about right now,

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you know, what are you telling me, is this something that I should be concerned about right now?

MR. GULLIVER:

A. I have to say I didn't ask him, Ms. Chaytor and you know, neither did Dr. Ejeckam, you know, say to me that, you know, we have erratic staining, he didn't say that we have poor staining, he complimented the staff, you know, and as you said in the one before he says, "we do have a good lab and we've got good staining there" and this is just a way Dr. Ejeckam spoke and did things. And I guess the thing that I would say, this is in 2003 and Dr. Ejeckam, you know, eventually retires in 2006 and for the next three years, I don't hear one thing from him, either in writing or even verbally with any issue in the IHC part of our laboratory.

CHAYTOR, Q.C.:

Q. So he didn't come forward with any other requests once you took the measures that you took in response by the end of 2003, early 2004.

MR. GULLIVER:

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A. Yeah, I think he was very pleased that we were able to finally get things set up in a dedicated part of the laboratory, we were able to get some new refrigerators and things to keep all the reagents together. I think he was pleased that we were able to acquire through an operational lease -

CHAYTOR, Q.C.:

Q. Did he tell you that? Did he tell you that he was pleased with the response?

MR. GULLIVER:

A. Well, I don't know. But I'm thinking if he was displeased, he would have told me.

CHAYTOR, Q.C.:

Q. Was there anything--then he finishes by saying that, he advised that "you kindly take a hard look at the above and then commit the necessary resources, human and financial to this special all important and only service in the province." And you've indicated that one of the reasons that you had asked him or invited him to put this in writing is that it would, in essence, provide you with extra ammunition if it's coming from a physician and a physician feels strongly enough to dedicate

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it to writing. If you need additional resources, human and financial to have this happen, wouldn't you have to take it to Dr. Williams?

MR. GULLIVER:

A. It all depends on the magnitude of the additional resources. When myself and Dr. Ejeckam and Barry kind of reviewed this stuff, you know, the kinds of things that he was sort of suggesting here certainly were not new to us and like we knew that we were going to get our own space, we knew that was going to happen, it was just the timing and how long it was going to take. So that didn't require additional resources, it required the time to get that set up and we were--at the time in June '03, it wasn't until Barry did the tender to the marketplace looking for new equipment and new reagent contract with a vendor, it could have been DAKO, it could have been Ventana, it could have been Vision, there were several companies out there who provided automation and, you know, your antibodies and solutions to go with it. And luckily enough, the volumes of dollars that we were spending

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in our current budget when the tender quotes came in, we pretty well had the dollars already in our operating budget to be able to do a five-year contract with Ventana for the new automation. So that did not require me to go to Dr. Williams for additional resources for the automation or equipment and really the only additional resources here would be the ongoing purchase of new antibodies, which would be sort of a one-time cost, it could be a couple of thousand dollars and on a budget in pathology, I mean, that was something you just absorbed in your operating budget regardless. Really the only new resource here that we needed to respond to this, was a dedicated technologist to do the grossing to backfill the IHC techs, to let them be dedicated down to IHC part of our lab. And as you've seen for many years, I run a budget deficit year after year after year, and pretty well I just felt like this was important enough that either, if I could find the money somewhere else in our program, like another staff position that was freed up somewhere else and reassign the money to pathology and

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if I couldn't do that, either way we just put a staff person in place and just ran a deficit. I felt like as long as I could justify it at the end of the budget year why I was over budget in all our divisions, I felt comfortable enough in being able to do that.

CHAYTOR, Q.C.:

Q. And the other piece, though, in terms of the additional training for the staff and the staff--what about that, in terms of any monies expended on that?

MR. GULLIVER:

A. At the time I don't think there was any money spent directly on it, but there were two things, you know, I assumed Dr. Ejeckam, he seemed to be very enthusiastic and by this time, you know, he was pretty well in the lab with the technologists, working with them. I think the staff certainly appreciated his guidance and so did I. I think Dr. Ejeckam had indicated that, you know, he would be able to bring some books into the lab, some new textbooks or new materials coming out, so I thought Dr. Ejeckam would provide some of that training to the staff if he felt they needed

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it.
CHAYTOR, Q.C.:
Q. And the idea that we saw in the meeting, the surgical pathology meeting in April of sending perhaps one or -
MR. GULLIVER:
A. He never ever--I never seen that, Ms. Chaytor -
CHAYTOR, Q.C.:
Q. And that didn't come up in the context of this?
MR. GULLIVER:
A. And he never ever brought it up, no. But then something else happened though, that in our-- when we went to the marketplace in the fall for the tender for IHC lab, and you know, we spend upwards of $200,000 a year -
CHAYTOR, Q.C.:
Q. And why did you do that, because I mean, that wasn't something that Dr. Ejeckam was looking for? Why did you see the need to do that?
MR. GULLIVER:
A. Oh, he's talking about workload of volume increases and at about six months prior, I had seen at a trade show where laboratory vendors

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go and show their new chemistry equipment and hematology equipment and pathology equipment -
CHAYTOR, Q.C.:
Q. Where was that?
MR. GULLIVER:
A. That was in New Orleans. It was at the CMLA conference, which is a clinical lab managers association for North America and I had seen this company, there was two actually, Ventana where they had their protocol of new technology that would be coming to the marketplace and there was a company from Australia called Vision, and they had a similar kind of automated platform coming out that would replace just the basic DAKO autostainer that was just pretty well a fluid dispenser. So by this time, we know that Ventana is coming out with a much more automated system and it helps with workload and volumes and those things, and we had said to Dr. Ejeckam that, you know, and I'm kind of thinking that we spent enough money through that part of our lab, if we kind of pooled all of those dollars, we could probably be able to afford an operational lease that included new

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equipment and, you know, reagents all inclusive type of thing. But in that contract, we wrote and I had done contracts similar to this much much larger, now, mind you, like in biochemistry, we'd have like a three million dollar a year reagent lease with a large vendor that supplies both the equipment and service and reagents. So I was applying the same kind of theory that we used in biochemistry to this part of our pathology lab and in the Ventana contract, in the other contracts I always write in and ask for is there any staff education you can provide also because we're going to give you all this business, and Ventana came back and they said that they would co-support one technologist per year to attend the national histology conference in the United States. So that would be sort of a part--I would have a resource for some dedicated funding to send one of our IHC techs to that conference annually.
CHAYTOR, Q.C.:
Q. So after, in essence, inviting Dr. Ejeckam to state any issues that he had to put it in

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writing, you didn't--are you saying you didn't go to Dr. Williams and raise these concerns with him and use it for anyone in authority for the purpose that you thought you would need to use it originally?
MR. GULLIVER:
A. No, because what Dr. Ejeckam put in this letter were pretty well most of the things we had either already agreed upon, it was just the timing to get things done and most of the things that we needed for, if it was new resources, we pretty well could find it within the program and we could find them for the new leasing for the new automated equipment.
CHAYTOR, Q.C.:
Q. Even if it meant further, running further deficit?
MR. GULLIVER:
A. I didn't go to Dr. Williams ever time we thought we were going to run a deficit in a particular division. It's no different--I use the same philosophy, for example, I mean, even back in 2003 I think most of my budget deficit was we didn't have--we don't have enough staff to keep up with the daily outpatient blood

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collection demands. At St. Clare's we were seeing 300 patients a day and I gave the manager the approval to add two new lab assistants to improve the waiting time.

CHAYTOR, Q.C.:

Q. And, Mr. Gulliver, that's not my point, my point was -

MR. GULLIVER:

A. No, but it's the same philosophy.

CHAYTOR, Q.C.:

Q. But you asked for this because you thought this might give you something, some ammunition that you could go and say, well these are things I've been frustrated with for awhile, put it in writing, I've got a physician saying it and perhaps now this will make a difference, so in terms of then using the memo for the purpose for which you originally envisioned it, you didn't do that?

MR. GULLIVER:

A. Well I asked Dr. Ejeckam to put his concerns in writing. I had no idea what concerns he was going to put in writing, but the concerns he put in writing, we were able to address most of his concerns within the Laboratory

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Medicine Leadership Program. If Dr. Ejeckam had to put concerns in here that would involve, well I think we need to have four new additional staff for IHC lab, if he had to put in concerns here we need to have three pathology assistants for the lab, those things I would have had to have brought forward to Dr. Williams because we're talking about a large amount of new additional resources, and not either reallocating resources within the program.

CHAYTOR, Q.C.:

Q. And his concerns that the potential, his wording that "It will be ill advised to operate an unreliable and erratic immunohistochemical procedure in our laboratory" and his concerns for a potential litigation, were they anything that you thought needed to be brought forward?

MR. GULLIVER:

A. Again, I mean, he's telling me stuff that I already know, it's basic lab practice. It would be ill advisable to run a bad lab, yes. And if there was a clinical issue, I would assume Dr. Ejeckam would have brought that

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directly to Dr. Cook.

CHAYTOR, Q.C.:

Q. And do you know whether or not then your superior, Dr. Williams, would have been aware of the nature of Dr. Ejeckam's concerns?

MR. GULLIVER:

A. I don't think he was, no.

CHAYTOR, Q.C.:

Q. So you didn't tell him, you didn't bring it forward?

MR. GULLIVER:

A. No. And Dr. Ejeckam didn't ask to bring it forward. He never expressed any concern whatsoever to bring it forward to Dr. Williams.

CHAYTOR, Q.C.:

Q. So was there anything at all in his letter to you that you took issue with?

MR. GULLIVER:

A. You mean that I didn't support?

CHAYTOR, Q.C.:

Q. Anything that you--from what I'm hearing you say and correct me if I'm wrong, that for the most part, these were things that you were working on, anything in terms of his concerns

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as to what might be the outcome of doing things in less than an ideal way, all that was nothing new to you, so I'm wondering is there anything there that you did take issue with?

MR. GULLIVER:

A. I don't remember taking issue with anything in it, no.

CHAYTOR, Q.C.:

Q. Was there any reason that you didn't want Dr. Williams to see this memo?

MR. GULLIVER:

A. None whatsoever. It was an issue that was, in my opinion, was being handled very well by Dr. Ejeckam. He was the director of IHC lab and if he had any other major concerns, I would assume he would have brought it up to the clinical side of the program.

CHAYTOR, Q.C.:

Q. Now the memo or letter is copied to a number of other people, Dr. Robb, Dr. Cook, Dr. Parai and Mr. Dyer and you've told us about your discussions with Mr. Dyer. Did you discuss the memo with any of the physicians named?

MR. GULLIVER:

A. I think I didn't--I don't know if I discussed

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the memo with Dr. Cook, but I know myself and Don talked about it and pretty well just to give Don an update on, look, in the next few months, once the summer is over, here are the things that I think that we can do, you know, like moving the staff, setting the new lab up, we're going to go to tender and look for some new automation, we're going to retrain another senior tech to take over the grossing function, like those basic things to make sure that Don knew, was aware. But Dr. Cook and I never ever sat down and went through this memo, like paragraph by paragraph or line by line.

THE COMMISSIONER:

Q. And Drs. Parai and Robb, did you hear from them?

MR. GULLIVER:

A. I never heard anything from either one of them, no.

CHAYTOR, Q.C.:

Q. And I take it there was no written response to Dr. Ejeckam?

MR. GULLIVER:

A. No, we just pretty well went ahead and did

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what we said we were going to do.

CHAYTOR, Q.C.:

Q. Okay, and if we could have, please, the transcript of Dr. Ejeckam's evidence, June 3rd, 2008. And, Registrar, it's page 286. And Mr. Coffey was asking Dr. Ejeckam the questions about your June 19th memo and he says "By the time you came to write the June 19th memo, one, the immediate problem of the eight stains was addressed? Yes. Did anyone ask you to write this? No. Okay, so it was your idea? Yes. Having written it, did you ever get any feedback or anybody ever ask you about it, any response? Not in terms of written feedback, but I remember after some days when I didn't get any reply, I ran into Dr. Robb in the corridor and I asked him if he got the letter. He said yes, I got it and I think it was a good letter and that he was going to have a meeting. Unfortunately he was ill and went off for January for surgery and didn't make it back. And then also the same process with Terry. I saw him in the lab and said did you get a letter? He said, yes, and he told me I am going to reply to you and that

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was the follow up that I had and that was all the response that I got from this. So you spoke to Dr. Robb and as you pointed out, he was going to get back to you. Dr. Robb unfortunately was ill and got iller and I gather died shortly thereafter? Yeah. And you also spoke to Mr. Gulliver? Yes. And he said he expected to act upon it and he would get back to you? Yes. And that was the last you heard from him about it? Yes. Did you ever hear from anybody else about it? No, well I know, I think Dr. Don Cook may have discussed it, but not written communication." So, Mr. Gulliver, I'm just wondering in terms of Dr. Ejeckam's recollection of your response, he's saying that--you're saying that you sat down with him and Mr. Dyer and discussed and went through his memo line for line or paragraph for paragraph?

MR. GULLIVER:

A. Pretty well paragraph by paragraph, yeah, and I mean, I don't know--well, you know, Ms. Chaytor, this inquiry has been ongoing for months and obviously I'm director of the program, one of the key witnesses, and I

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really don't follow other people's testimony and I've been prodded by people in Eastern Health to say, well I should be watching it and following it. Well I've got all to much work to do and my -

CHAYTOR, Q.C.:

Q. I just wanted to offer you an opportunity to respond if you haven't seen this -

MR. GULLIVER:

A. I know, but my response has been I don't want for me to read other people's testimony, so that would influence my testimony.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And I'm saying to you -

CHAYTOR, Q.C.:

Q. That's why I'm offering you an opportunity when I see a situation where your evidence is not the same as what we've heard from others, so I'm offering you an opportunity to respond.

MR. GULLIVER:

A. And when you read this here, he says he spoke to Dr. Robb in January. The memo was written in June and he's saying he spoke to Dr. Robb,

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but he went off on surgery in January. You see this right here?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. You know, so is he saying he spoke to Dr. Robb six months after he wrote the memo. I guess, my point to you is that I clearly remember speaking to Dr. Ejeckam and Barry in my office, and, you know, that's--I can't say anything different. Whether Dr. Ejeckam remembers that or not, I don't know. I clearly remember speaking to him about this memo, going through it, and clearly indicating to him the things I can do within my own authority as director of the program to respond to some of those concerns in his memo.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, who was prodding you to follow the evidence and what's the purpose in doing that?

MR. GULLIVER:

A. Oh, not prodding me to follow evidence. It's just that obviously you can understand within Eastern Health that this is webcast live all

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day long, and people have it on their computers, they have it on their computer screens. I'm not someone--I have never yet put it on my computer screen. Even though key witnesses have come here to testify that could have an impact on the laboratory, I still don't feel I want to watch their testimony directly unless it's been staff--you've seen me here in the back of the room when my manager and staff have been here. I felt to be here for support for them, but I don't want to read people's transcripts because I want to make sure what's in my mind is what's in my mind and what my memory is, what my belief is, and I'm afraid if I read someone else's testimony, it would be like, oh, I should change what I'm going to say and I don't want to do that.

CHAYTOR, Q.C.:

Q. So have you been an attendee at meetings at Eastern Health for the purpose of the inquiry?

MR. GULLIVER:

A. For the purpose of reading evidence or the testimony?

CHAYTOR, Q.C.:

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Q. No, for talking about the inquiry.

MR. GULLIVER:

A. I generally don't go to those either.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. I know there was a session set up for staff who are coming to the inquiry as more of support. I think it's more of a psychological support and group support. I've gone to several of those, but nothing is discussed about coming up at the inquiry, none of the details of the inquiry. It's more of as a support group mechanism.

CHAYTOR, Q.C.:

Q. And in terms of the manner in which you would give your evidence or things that you -

MR. GULLIVER:

A. Nothing whatsoever, no.

CHAYTOR, Q.C.:

Q. If we could have, please, P-2406. Before we leave that then, Mr. Gulliver, is there anything else around Dr. Ejeckam and his memos that you recall that would be important for us to know about?

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MR. GULLIVER:

A. Again I mention to you that, you know, you can see the way Dr. Ejeckam writes and he spoke the same way, that he remained as director of our lab for three more years, he never ever wrote another concern, never wrote another concern to my level about the IHC lab, and as a matter of fact, I think it may have been last summer--as you know, Dr. Ejeckam retired in June of '06, and last summer he came back to Newfoundland and spent the summer as a locum in, I think, Gander or Grand Falls, and he sent all of his IHC tests in to the Health Sciences to get done while he was practising as a pathologist out in Gander or Grand Falls. So I take that to mean that he was pretty well happy with the service.

CHAYTOR, Q.C.:

Q. Well, would he have had any choice as a locum pathologist as to where his samples went?

MR. GULLIVER:

A. He could send them out to Toronto or send them anywhere. It's their decision.

THE COMMISSIONER:

Q. Could we go back to 113 or--yes, 113, for just

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a moment, page one. Mr. Gulliver, you've on two or three occasions during your testimony regarding this series of communications, referred to Dr. Ejeckam's way of speaking, and as an outsider when I read phrases like "have remained unreliable, erratic, and, therefore, unhelpful for diagnostic purposes", my reaction is that's serious stuff. You seem to say that's--what Dr. Ejeckam is talking about is nothing more than the normal adjustments one does in IHC, and you add that's the way he talks. Now are you suggesting that Dr. Ejeckam is apt to exaggerate?

MR. GULLIVER:

A. I don't think exaggerate is the correct term.

THE COMMISSIONER:

Q. Okay, do I discount what Dr. Ejeckam says because he speaks in a particular way that others don't? I'm not quite sure I'm understanding your response when you say, well, that's the way Dr. Ejeckam talks?

MR. GULLIVER:

A. Well, it is the way Dr. Ejeckam talks, however, it is a serious issue he's bringing forward here. Now in this memo, he's pretty

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well direct.

THE COMMISSIONER:

Q. Uh-hm.

MR. GULLIVER:

A. However, what he's saying here, Judge Cameron, is something that would not be uncommon practise in medical laboratories, that a part of your laboratory, a clinical physician, whether it's a pathologist, a biochemist, or microbiologist, they may decide to review some of the current testing and practises and put changes in place.

THE COMMISSIONER:

Q. I'm not having difficulty with the concept that my suspicion is it would be good practise to from time to time ensure that your practises are properly being followed, if there are variations that you note in your process, make sure that you are rigidly adhering to the proper protocols, determining whether, in fact, protocols should be changed for some reason or another because of perhaps a variable having changed that was not there when you originally determined your protocol. That to me is science. I really don't have

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any difficulty with the idea that in a laboratory sciences would from time to time make adjustments, check, double check, triple check, that's what they do, but the language used by Dr. Ejeckam of unreliable, erratic, and, therefore, unhelpful for diagnostic purposes, to somebody who does not live in that scientific world, causes me some concern and what I need to know from you is whether you have a similar view of this language, or are you telling me that in the world of science, when they use "unreliable, erratic, and, therefore, unhelpful for diagnostic purposes", that's just the normal day?

MR. GULLIVER:

A. And somewhere in between. You know, I -

THE COMMISSIONER:

Q. Well, see, I need to know two things; whether that's really normal, or you're telling me it was a normal situation and Dr. Ejeckam has a tendency to up the level of the language, and don't worry about it, or should I be concerned that Dr. Ejeckam, who everybody has come here has indicated is a person who had an interest in IHC, had a knowledge that was greater than

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other people in the general area at the time, took great pains to deal with the subject within the lab, communicated very well with the technologists--I got the impression from the technologists who came through here that they were most appreciative of the opportunity to learn side by side with him, and he says, "unreliable, erratic, and, therefore, unhelpful for diagnostic purposes", so I'm wondering what's the situation? There seems to be a disconnect between what I, as an outside person would view that statement as being, and how you see it, and I need to understand why you don't see it the same way I would.

MR. GULLIVER:

A. I don't know if it's because of my 28 years in laboratory, whether it's--you know, anything in the laboratory could be unreliable or erratic, you know, that could happen. I guess my main point would be when this came across--well, it didn't come across my desk, I was informed from Barry, and all the pathologists, no one raised any red flags to say, hold on here, what are you saying to us, Dr. Ejeckam,

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do we have to stop practice, do we have to go back and review what we did five years ago. So it's--within the lab environment, this was not a red flag that was raised where you had to stop everything you were doing and focus all of your attention, all your resources, on this particular issue. It was something that Dr. Ejeckam was saying to you, that you realize that if we have unreliable and erratic staining, it could lead to, and would be unhelpful for diagnostic purposes, and he's saying something to me that I know as a medical lab technologist, and as the former manager, that if these stains or any IHC stains are unreliable and erratic, it's not going to help the pathologist render a diagnosis or help them with their interpretations.

THE COMMISSIONER:

Q. Uh-hm.

MR. GULLIVER:

A. I don't know if I'm answering you correctly.

THE COMMISSIONER:

Q. Can I read what you're saying this way, Dr. Ejeckam was a person who spoke directly and

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plainly, and he was being honest and not exaggerating when he said his view was that these were unreliable, erratic, and, therefore, unhelpful for diagnostic purposes, but your perspective is that within a laboratory setting, that's life, that happens from time to time?

MR. GULLIVER:

A. It does.

THE COMMISSIONER:

Q. You deal with it.

MR. GULLIVER:

A. It does happen from time to time.

THE COMMISSIONER:

Q. And unless somebody like Dr. Ejeckam raised with you that this was a particularly unusual circumstances, you would read that as being normal adjustment being done within a particular division of the lab?

MR. GULLIVER:

A. I would have to say yes, yeah.

THE COMMISSIONER:

Q. All right, thank you.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner.

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THE COMMISSIONER:

Q. Now you wanted 2406.

CHAYTOR, Q.C.:

Q. Yes. Just before, though, we leave this, the ER and PR, we understand that is for prognostic purposes as opposed to diagnostic purposes. Did that make any difference to you, Mr. Gulliver, in your interpretation of what's being said here?

MR. GULLIVER:

A. It did not, no.

CHAYTOR, Q.C.:

Q. If we could have, please, 2406, and this is a division of anatomical pathologist meeting, September 1, 2004, and I'm thinking that's not the right number. Let's try 2404. Yes, this is the one, sorry about that. This is quality assurance document, Division of Anatomic Pathology, Health Care Corporation of St. John's, and it's, we understand, a draft document at that time, quality assurance in anatomic pathology, and if we just go through the document here, do you know anything about this, Mr. Gulliver, this document, and whether or not it was finalized?

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MR. GULLIVER:

A. It's not something that I had seen.

CHAYTOR, Q.C.:

Q. So you're not involved in this?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. If we could have 1867, please, page 50. This is another quality initiatives report. You'll recall I took you to one yesterday, and this one is for the time period, April 1st, 2003 through March 31st, '04, submitted by yourself as program director, and if we look at your challenges that you've identified in your report on page 52, and then your achievements, when I look down through the challenges, you indicate, "Ongoing renovations of laboratory at General site, providing high quality laboratory services within existing resources", and dealing again with labour management issues, keeping abreast with new technology equipment, and implementation of the HAY operational report. When I look down through in terms of the fact that Dr. Ejeckam had to shut down the stains, those eight

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stains for that period of time, and the response that you had to make in this calendar year to that, or in this fiscal year to that, I don't see any indication of that under your challenges. Is there any reason for that?

MR. GULLIVER:

A. Well, actually, I think we were told we had to keep four or five bullets for challenges and achievements and I had to submit this for the laboratory medicine program, pathology being about ten percent of the program. Ninety percent of the program is not in pathology. And I guess at the time I don't think it was a major challenge to move the staff into a new space for IHC. We're able to operationalize the new reagent lease for the Ventana equipment without getting any new funding. So, I mean, it wasn't like it was a--we did it within our program. A lot of these things here are put on here for major challenge are things that would probably require outside the program and issues that are more than just the laboratory.

CHAYTOR, Q.C.:

Q. Okay. So you didn't see it as being something

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that would make your list here at the end of the year?

MR. GULLIVER:

A. Obviously it didn't.

CHAYTOR, Q.C.:

Q. And achievements, "Increase workload by five percent; increase productivity; maintain cause/workload unit; ranked in top quartile for productivity; provide professional development for staff." You "improved technology equipment through capital purchases and/or negotiated reagent leases; increase laboratory revenue." Those were some of the achievements for the year?

MR. GULLIVER:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And then your "Key Directive," "Key Directives/Objectives. Continue to improve operational efficiencies within the program: Consolidate technical Pathology services." So that's still under way. "Meet budget targets for 2004/05. Maintain HAY productivity benchmarks. Standardize specimen collection services within Health Care Corporation of St.

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John's." Again, in terms of setting up a separate IHC lab to address the concerns and having that become a dedicated space with dedicated staff, you wouldn't see that as something you would outline in your quality initiatives report?

MR. GULLIVER:

A. No, because if you go back here earlier where I said I set up a system where I met with each division manager to outline their goals, objectives, probably we discussed that at the manager's level and the accomplishments that were done within each--with each division or with each manager. And again, for example, we're currently, in this year, we are going to open up a new blood collection centre at Major's Path and we're moving our fertility testing lab to Major's Path. That will probably be under my list of achievements because it's a significant thing to move your service outside your building. In the pathology lab we moved IHC testing from the back bench right here, you open the door and walk into a separate room. It wasn't like a significant thing to have to go through and do

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that. It was like saying "Ms. Chaytor, you're going to go and question me over on the other side of the room this afternoon." You know, it's adjacent to each other. So I guess it wasn't significant enough to put it underneath the achievements for the lab program for that year. But again, if we had to move that to a brand new lab with new construction and new spaced, new square footage and new benches and all that stuff, it would probably be on our list of achievements.

CHAYTOR, Q.C.:

Q. And the directive for to ultimately become more than just a physical move a few feet away and to have it become an IHC lab with dedicated staff, that again is not seen as under you key objectives or directives?

MR. GULLIVER:

A. Um-um. And the staff, you're talking about dedicated staffing, the staff were always dedicated for IHC. We only had two or three staff who were trained for IHC testing, therefore we had dedicated staff for IHC testing. The issue was to take the other duties away from those staff so they're

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fulltime in IHC lab.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, why isn't your quest for a quality manager listed as a key directive or objective at this point in time?
MR. GULLIVER:
A. In 2004? I think by this time we're--looking at the consolidate pathology technical services and, you know, redesigning St. Clare's lab to a core function, you know, addressing our out-patient collection issues, which we still have today. Look, and I just mention to you, we're now getting a new adult walk-in collection centre. This is 2004. This is 2004. "Present a formal proposal for consolidated adult walk-in specimen collection to a new off-site centre." and 2009 it's going to happen.
CHAYTOR, Q.C.:
Q. Yes. Well, my question is why isn't on your list here the quality manager position?
MR. GULLIVER:
A. I don't know why it's on the list. I'm saying to you -
CHAYTOR, Q.C.:

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Q. Why it's not on the list.
MR. GULLIVER:
A. The directives there are big picture stuff that -
CHAYTOR, Q.C.:
Q. And you didn't see that as a big picture item?
MR. GULLIVER:
A. Well, we had already been denied that before.
CHAYTOR, Q.C.:
Q. If we could have, then, please, 1891? And this is your annual report then for the laboratory medicine program from April 1st, 2003 through March 31st, '04. And it's you and Dr. Cook and Dr. Williams is the VP. And again, when I look down through here, there's a list of goals. And then you have a list of highlights for the year. Opportunities to acquire new technology; to offer new services; improve specimen collection; continue the implementation of your three-year strategic plan. This is going on then into '04, '05. And challenges, you had limited financial resources; dependency on facilities management. And your workload increase is identified coming up for the challenges of

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'04, '05. And outcome measures. And when I look through that document and I couldn't see any reference there, either, to the issues regarding IHC and the need for IHC staff and any measures that had been taken to address that in terms of it becoming more of a dedicated lab. And also couldn't see any reference to looking to have a quality management position. So is that also for the same reasons that we didn't see it in the quality initiatives report?
MR. GULLIVER:
A. Um-hm, I guess so. I mean, but if you look at this comprehensive report, there are a lot of things in there. And there's probably lots of other things you could put in there.
CHAYTOR, Q.C.:
Q. And if we could look, please, at 0912?
MR. GULLIVER:
A. You know, if Mr. Dyer had to submit a quality report for pathology division, you'd probably see that in there. As program director, you know, having to report up for the whole laboratory medicine program, you know, there's only so many things you can put in a report.

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CHAYTOR, Q.C.:
Q. Okay. And these are your own goals, objectives, performance goals and objectives for 2003/'04 for the program director. And your goals and objectives, number one, "To be benchmarked in the top quartile for productivity within Canada; to provide the Health Care Corporation and/or the province with a comprehensive lab service and also expand the test menu to provide in-province testing." And then there's a list of things including under "Pathology" "To expand HER2/neu; to off FISH; and develop extensive gross training program for senior technologists; to make available the most up-to-date laboratory technology, ensuring that the Health Care Corporation lab program is a leader in Canada." And under "Pathology" in terms of that, you have listed here, "New technology for immunopathology: digital cameras; two microscopes; multi-headed microscope; other microscopes; an autopsy; and water baths; autopsy"--"ensure there is proper number of qualified staff, correct skill mix of staff and to utilize human resources in an

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efficient manner." And under "Pathology" again you have "Consolidation of the technical staff to the Health Sciences Centre; develop canned text for transcription." And then "Meet your budget targets," number five. Number six is "Utilization issues." And number seven, "Continue the development of the laboratory management team philosophy." And number eight, "Plan, design, monitor laboratory renovations." So those were your goals and objectives for that year?

MR. GULLIVER:

A. Well, this is the program's, not just mine.

CHAYTOR, Q.C.:

Q. Okay, so how would these be developed, then? This is not just something you submit. Who would sit down and who would come up with those?

MR. GULLIVER:

A. Well, as I mentioned to you, we had sort of a final planning day exercise around, I think it was March of '03. But for about three or four months leading up to that exercise I sat down with the division managers, division chiefs, we talked about, you know, the next three

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years for lab services for St. John's. It's post the Grace closing, post Janeway closing, it's post HAY report. And I felt that this is the way I operate, I like to have things that are, you know, like a clear-cut plan. But pretty well in talking to each division was to, this is not a wish list, these are things that we think we could accomplish. You know, it was like don't put things on a list that you think you're not going to be able to do. Let's be realistic and see what can we do in the next three years within your division and within the lab medicine program. So everyone was for months working on their vision or goals for each division and then our planning day was really more of bringing all the leadership team in lab medicine, division chiefs, division managers, and each division had an opportunity to present to the whole team. For example, in cytology Patsy Francis (phonetic) and Dan Fontaine did a presentation and it would be here's where we see cytology moving in the next three years. The same thing would happen for biochemistry, for pathology, for client services, for genetics.

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And that was a full-day exercise and we had it facilitated with, I think, one of our, I think Janet Laidley was our facilitator internally. But it was a lot of work went into preparing this. From that three-year plan I then developed a sort of a template like this where on a quarterly or, a quarterly basis I would sit down with Dr. Williams and say for the first year of our plan here are the things within our divisions that we are going to work towards and hopefully achieve. We did the same thing for year two, year three. I then sat down and made a same template. I would meet with my managers every six months and say, "Okay, you're goals for your division this year, where are we? what are you doing? Give me an update. And is there some reason why we're not meeting this target or achieving this target?" So that's--does that give you enough background on it?

CHAYTOR, Q.C.:

Q. Yes, to how they're developed, yes. Thank you. Now, under the goals for pathology, we saw back here the intent to acquire new technology for immunopathology. Is that the -

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MR. GULLIVER:

A. That would be, I guess, the Ventana.

CHAYTOR, Q.C.:

Q. The Ventana machine.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay. And also the issue then of the consolidation. Come down here under number four, "Consolidation of technical staff to the Health Sciences Centre." And I take it that's something that had long been a goal for you?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. But you're saying that was actually having it articulated here, it was that's a program goal, that's something everybody by 2003 and '04, for that year, everybody has agreed upon?

MR. GULLIVER:

A. Oh, not saying everyone is in agreement upon. I'm saying that the general consensus is this is a goal within that division.

CHAYTOR, Q.C.:

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Q. And during this calendar--or this, I should say, fiscal year, then as you move forward, is there--and beyond there in terms of trying to achieve that goal, do you take part in meetings regarding the consolidation of the technical services?

MR. GULLIVER:

A. I do, yes.

CHAYTOR, Q.C.:

Q. Okay. And did you have--did you run into any particular challenges or obstacles in trying to achieve that goal?

MR. GULLIVER:

A. Well, as you can see there, well, first of all, for my three-year plan some of these things were goals that each division could attain within their own division. It may be change practice, change procedure or do something differently. Some of these objectives were big objectives, like the off-site blood collection centre for adult walk-in for St. John's. This is, I'm saying this is 2003 and five years later we're going to move to Major's Path. The -

CHAYTOR, Q.C.:

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Q. But in terms of the pathology -

MR. GULLIVER:

A. The actually moving pathology from St. Clare's to Health Sciences was a bigger issue than within the pathology division. So some of these goals had to go to executive team for approval or not approval. For example, the off-site blood collection centre had to go to executive team to give us permission to work towards that goal. The pathology consolidation was one of those issues that also went up to executive team.

CHAYTOR, Q.C.:

Q. And did you, in fact, have any--and I guess in terms of it having to go up to the executive team, why would certain things have to go to the executive team as opposed to the program itself working it out?

MR. GULLIVER:

A. It could be either/or, it could be -

CHAYTOR, Q.C.:

Q. Well, what about in this case, for pathology consolidation?

MR. GULLIVER:

A. For example, the off-site blood collection would cost significant new dollars.

CHAYTOR, Q.C.:

Q. Right. But what about -

MR. GULLIVER:

A. This one here, the program leadership team didn't agree upon the goal, so because we didn't have agreement within the program, then that would go to Dr. Williams, which he brought to executive.

CHAYTOR, Q.C.:

Q. So that's you and Dr. Cook didn't agree on this particular goal and objective, to consolidate the pathology services to Health Sciences?

MR. GULLIVER:

A. Pretty well.

CHAYTOR, Q.C.:

Q. Okay. And so Dr. Williams then became involved. And so what happened after that, did you have meetings with Dr. Williams on the issue?

MR. GULLIVER:

A. We talked about it several times, I think, in our monthly leadership meetings, and I think what eventually happened was, I guess within

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the pathology division, also Ms. Chaytor, there was, I guess, apprehension about, you know, consolidating pathologist services. While there was a fair bit of agreement to it, again, there was still some resistance to it, and what happened was myself and Dr. Cook, Dr. Williams invited myself and him to Mr. Tilley's office and we had a discussion with Mr. Tilley and Dr. Williams, myself, Dr. Cook, about this particular goal objective.

CHAYTOR, Q.C.:

Q. Okay. So with Mr. Tilley. What came out of that?

MR. GULLIVER:

A. Well, at -

CHAYTOR, Q.C.:

Q. Or what happened at the meeting I should ask you first?

MR. GULLIVER:

A. Well, at the meeting, it was, I guess, Mr. Tilley wanted to find out firsthand, you know, why am I in favour and why is Dr. Cook not in favour, and we both--you know, we both did sort of a presentation to George and Dr. Williams pros and cons and went through that,

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you know, by this time, with Mr. Tilley, you know, we had had an assessment from our risk management department to ensure that there was no risk management issues with transporting specimens from St. Clare's to Health Sciences and vice versa, if we consolidated. We had already done consolidation with microbiology specimens from St. Clare's to Health Sciences and that had been working fine for about a year by this time. We had management engineering engaged to look at sort of the processes and efficiencies of having one lab operating as opposed to two lab operating doing the same similar functions. So those are the kinds of things that I was bringing forward to Dr. Williams and Mr. Tilley.

Of course, Dr. Cook's concerns were--and I had mentioned this yesterday, you know, I really believe Dr. Cook's big concern was the viability of St. Clare's Hospital and not so much as the fact that pathology itself was moving. Obviously that's his love and that's his life is pathology, but again, to put this in perspective, you know, the Grace closed, Janeway closed. There was still all kinds of

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rumours that St. Clare's may close post Hay, and I really believe Dr. Cook was more arguing for, not against the pathology consolidation per se, even though he wasn't, you know, 100 percent in favour of it, I really believe he was more supporting St. Clare's, the St. Clare's Hospital, and keeping services there and keeping St. Clare's more as a viable operating hospital and not turning it into just a routine ambulatory care hospital.

CHAYTOR, Q.C.:

Q. So you had a situation with respect to the consolidation of pathology services where the program director, yourself, and the clinical chief, Dr. Cook, had starkly different views as to what should happen. That gets brought to the VP Medical and ultimately you're sat down with the CEO of the Health Care Corporation. You each, from what you're saying, put forward your position, the pros and the cons, as you say, of doing this or not doing it. What happens? Did Dr. Williams and Dr. (sic) Tilley offer any advice or guidance as to where you go from there?

MR. GULLIVER:

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A. Well, actually, at this time, I think by this time, Ms. Chaytor, it's probably--I'm thinking it was May of 2004 when I met with Mr. Tilley and Dr. Williams and Dr. Cook, and by this time, Mr. Tilley actually says to us, as a group, I mean, obviously he's connected in much higher places than I would be as director of the program, you know, he says now there's rumblings and talks about the new government is probably going to form a new health boards, and you know, the Health Care Corporation of St. John's would be gone and there could be much larger region that we're dealing with, and he suggested that, you know, if the new health board does materialize, these are the kinds of issues we're probably going to have to look at on a regional basis. So we're talking about consolidating pathology from St. Clare's to Health Sciences, making one lab for the City, and he's saying, you know, maybe in the next six months or a year, you could be here talking about doing something like this for the region, and what Mr. Tilley pretty well said is that he was not going to force a decision upon us. He took our advice and he

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said that because the leadership team is not in favour of this objective, he thinks we're probably best advised to let this issue--don't make a decision. Let's wait and see what's going to happen with a new health authority and what would happen on a regional basis.

CHAYTOR, Q.C.:

Q. And what did you do following that?

MR. GULLIVER:

A. Well, at the meeting, because what we're talking about, even it says technical staff, we were talking about, you know, moving pathology services into one lab and what happened from that there is that we actually moved some of the technical staff out of St. Clare's and some of the technical processes and did that consolidation. We did not go through and do a full consolidation and move pathologists and the whole thing.

CHAYTOR, Q.C.:

Q. And why did you do that? Why did you move technical staff out of St. Clare's?

MR. GULLIVER:

A. Well, you know, like St. Clare's were doing tissue processing, embedding, cutting,

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staining. The staff were doing the same functions, to a lesser degree, at St. Clare's. We also found, you know, the St. Clare's pathology lab, while it had been operating for a long time, it was just--it was a general pathology lab. They didn't do any specialized kind of testing, and by this time, staff from St. Clare's, our senior staff, that had been there since like the late '70s, early '80s, like Les Simms and Ken Green and Catherine Parnell and they were the senior candidates in taking positions at the Health Sciences pathology lab, like tech twos and tech threes, that these people really had no big, no wide background in. So we felt that it was also important for the skill training to have all of our technical staff operating in the one lab and give them an opportunity to learn other parts of pathology than just routine pathology. We're talking about muscle histochemistry. We're talking about doing the grossing, the IHC part of pathology, immuno fluorescent staining, doing the frozen sections. So there were things that the functions didn't take place at St. Clare's

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pathology.

CHAYTOR, Q.C.:

Q. Did you have any concern that you wanted, by doing this, to move staff and move the technical staff over to the Health Science, were you trying to achieve standardized processing and grossing?

MR. GULLIVER:

A. I really can't say standardized grossing, no.

CHAYTOR, Q.C.:

Q. What about the processing?

MR. GULLIVER:

A. But certainly tissue processing then would be more standardized.

CHAYTOR, Q.C.:

Q. Okay, and -

MR. GULLIVER:

A. At this time, the grossing is still being performed by the pathologists.

CHAYTOR, Q.C.:

Q. Are you then, in terms of standardizing the processing, I just want to understand your reasons why this was so important to you to have the technical consolidation?

MR. GULLIVER:

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A. Well, see, it's not--well, actually, you're not showing the full scope. It's not just staff. It's also the equipment. At St. Clare's, they were probably doing a couple 100 slides a day. The Health Sciences were doing 7-800-900 slides a day, and we had similar equipment. So they had a slide stainer, slide cover slippers at St. Clare's. The same equipment was over at the Health Sciences. The Health Sciences' volume warranted more than one piece of equipment. So we actually took the slide stainers and slide cover slippers and embedders from St. Clare's that were being under utilized and moved them to Health Sciences to make them better utilized and help with the volumes at the Health Sciences. So it's not just the technical staff that was important. The staff had to come with that in order to do it.

CHAYTOR, Q.C.:

Q. Yes, and was Dr. Cook consulted on that, and was he in agreement?

MR. GULLIVER:

A. I don't know if myself and Dr. Cook had a sort of dedicated meeting to talk about the

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technical side, but obviously at some point, Dr. Cook was okay with the technical piece moving to St. Clare's--from St. Clare's to Health Sciences.

CHAYTOR, Q.C.:

Q. So whether or not you discussed that with him beforehand or not?

MR. GULLIVER:

A. Oh, I know we discussed it. I don't know if we discussed it in a separate dedicated meeting, but we obviously had discussions over it. I think Dr. Cook was fine as long as he knew that St. Clare's still had support staff on site to respond for frozen sections, that there was technical staff on site to assist the pathologists in the gross bench. I think Dr. Cook's concerns were alleviated by that.

CHAYTOR, Q.C.:

Q. In terms of standardizing the processing, Barry Dyer is manager of both sites, Health Science -

MR. GULLIVER:

A. By this time, yes.

CHAYTOR, Q.C.:

Q. - yes, and St. Clare's, and why--and had been

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for a couple of years. Why wouldn't--if you have the same manager, why couldn't you have the same standardized processing happening at both sites?

MR. GULLIVER:

A. Well, and you could ask Barry that question, but I'm pretty sure that the processing cycle that was being operated on for each tissue processor at Health Sciences and St. Clare's was probably the same kind of schedule. However, there's more than just, you know, the processing cycle. You want to make sure that all the fluids on the tissue processor are being changed on a routine schedule, you know, those kinds of things that also go into maintaining the tissue processors.

CHAYTOR, Q.C.:

Q. But can't that be done through your standard operating procedures?

MR. GULLIVER:

A. I guess it could, yes.

THE COMMISSIONER:

Q. Ms. Chaytor, it's past the time when we normally take the break.

CHAYTOR, Q.C.:

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Q. Sorry.

THE COMMISSIONER:

Q. So I suggest we do that.

CHAYTOR, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. Thank you. Take 15 minutes.

(BREAK)

THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Mr. Gulliver, we were talking about the consolidation of the technical services. Your meeting that you had with Mr. Tilley and Dr. Williams regarding that, did Dr. Williams express his view as to on the issue of consolidation?

MR. GULLIVER:

A. I don't remember Dr. Williams being either in favour or against. I think he was also, you know, listening to Mr. Tilley's assessment and I would assume that he agreed with that position.

CHAYTOR, Q.C.:

Q. And at any point prior to that meeting, this

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had been an issue back and forth between yourself and Dr. Cook within the program for some time, at any point in time, did Dr. Williams express his view?

MR. GULLIVER:

A. His view was that the leadership team should be in favour of it, and he never ever viewed that he was completely in favour or he was against. He was sort of on the fence.

CHAYTOR, Q.C.:

Q. But it was his view that the leadership team should be in favour of it?

MR. GULLIVER:

A. To do the full pathology consolidation, yeah.

CHAYTOR, Q.C.:

Q. So he was encouraging the consolidation to happen?

MR. GULLIVER:

A. I would have to say yes, yeah.

THE COMMISSIONER:

Q. Sorry, I'm confused now. Are you saying that Dr. Williams wanted you and Dr. Cook to be of the same view before it moved?

MR. GULLIVER:

A. Yes.

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THE COMMISSIONER:

Q. It really didn't much matter what he thought, he just wanted the two of you to be in agreement? Is that it?

MR. GULLIVER:

A. He wanted the two of us to be in agreement. However, I don't think Dr. Williams would have wanted to make a decision one way or the other if both Dr. Cook and I were not in full agreement.

THE COMMISSIONER:

Q. Okay.

MR. GULLIVER:

A. To consolidate all pathology services.

THE COMMISSIONER:

Q. So he wasn't going to force the issue.

MR. GULLIVER:

A. Exactly.

THE COMMISSIONER:

Q. Whatever his personal view was, he wasn't going to force the issue, and his--you had the impression that Dr. Williams felt that you and Dr. Cook had to be on the same page?

MR. GULLIVER:

A. Exactly.

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THE COMMISSIONER:
Q. Okay.
CHAYTOR, Q.C.:
Q. And you mentioned your monthly leadership meeting. So those meetings were with Dr. Cook, Dr. Williams and yourself, I take it?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And those happened fairly regularly, once a month?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. In those monthly leadership meetings, did you ever speak to Dr. Williams and raise with Dr. Williams, Dr. Ejeckam's concerns? So back in April, May, June of 2003.
MR. GULLIVER:
A. I don't think so, Ms. Chaytor, no.
CHAYTOR, Q.C.:
Q. So even though those meetings would have been taking place on a regular basis, April, May, June, it never came up for discussion with Dr. Williams that there's been some issues that

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Dr. Ejeckam has identified and is working on?
MR. GULLIVER:
A. I don't remember me bringing them up and I don't remember Dr. Cook bringing them up.
CHAYTOR, Q.C.:
Q. And in terms of the letter that you received then, June 19th, 2003 letter, that too did not discussed in your monthly leadership meeting?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. What's the purpose of your monthly leadership meeting with Dr. Williams?
MR. GULLIVER:
A. Well, he's our Vice President and he has multiple portfolios that he's, you know, responsible for, and our monthly meetings, and if you look through some of the agendas, you know, we talk about the operations of laboratory medicine. We do talk about, you know, our goals, objectives, and where we're going long term. Dr. Williams would share back information from an executive level, more organizational things. We talked about budgets every meeting, and he would give us

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updates on where the Health Care Corporation were from a budget perspective. We would talk about capital equipment, what needs were within the laboratory, what funds were available from, you know, an organizational perspective. Dr. Cook would give updates on pathologists recruitment. For example, when we needed to put in a process with Dynacare in Ottawa to, you know, send samples there for interpretation, that would be discussed with Dr. Williams to make sure that we're putting in the proper organizational processes. So it could be, you know, multiple issues.
CHAYTOR, Q.C.:
Q. If we could have, please, P-1576? And this is a meeting of the division of anatomical pathology, pathologists meeting at the General Hospital site, September 24th, 2003, and if we look at, you can see the doctors who are in attendance, including Doctors Ejeckam and Carter, Fontaine and Parai, and if we look at page three, "laboratory technical quality." Under new business, item 4.1, "this was discussed with Barry Dyer, Terry Gulliver and Dr. D. Cook. The discussion included the

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technical quality of the slides, error of labelling, floater and others. Some of these issues have been documented. Dr. G. Ejeckam has given a lecture on quality assurance of the laboratory which was attended by one senior technologist. This program is available for all the lab technical staff at a suitable time if interested. A log book is available in the reporting room to record all problems."
Mr. Gulliver, it indicates that there has been a discussion with yourself and Mr. Dyer and Dr. Cook regarding the laboratory technical quality, and it goes on to say "the discussion included the technical quality of the slides, error of labelling, floaters and others." What do you recall about that?
MR. GULLIVER:
A. This is in the main routine part of pathology where, you know, the staff are cutting sometimes upwards of 600 paraffin blocks a day. They average 1,000 slides a day that will go back to multiple pathologists, mostly H & E slides and routine histochemical stains. This was talking about during that technical

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process. When the technologists are cutting slides and putting tissue samples on a glass slide, some pathologists were coming back and saying that oh, there was a floater on one slide or there was a fold or a wrinkle in the tissue, and then they may go back and ask for recuts to get other H & E's. This had nothing to do with the IHC part of pathology.

CHAYTOR, Q.C.:

Q. And you specifically recall that and recall the discussion?

MR. GULLIVER:

A. I can remember meeting with Don and Barry talking about that and that was, it was just a general pathology main--the routine laboratory.

CHAYTOR, Q.C.:

Q. And did it have anything to do with fixation issues?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. If we could see, please, 2946? And this is one of your leadership meetings, December 19th, 2003. So I take it it's your monthly

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meeting for December 2003 between yourself, Doctors Cook and Dr. Williams, and it's indicated here that, under budget, "November saw a surplus of $18,000. However, the program is still $400,000 over budget. Terry presented Dr. Williams with a detailed analysis of the budget to March 31st, 2004." So Mr. Gulliver, in terms of, at this point in time, as of December 2003, into your fiscal year, I guess by three-quarters, you're $400,000 over budget at that point in time. Did that have any--did the fact that you were running a deficit of that magnitude have any bearing on whether or not you spoke to Dr. Ejeckam about--or sorry, spoke to Dr. Williams about the issues raised by Dr. Ejeckam and looking for any additional resources that may be available?

MR. GULLIVER:

A. I can't say that it did, Ms. Chaytor, and the submission to Dr. Williams was trying to project to the end of the fiscal year, would the laboratory be in a balanced position or would we still be in a deficit position, and even though it states $400,000 over budget,

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that's probably maybe two percent of the lab program budget, you know. I mean, our annual budget is close to $40 million. So by that, after nine months, so it's probably a two percent deficit in our lab program budget.

CHAYTOR, Q.C.:

Q. So that wasn't considered to be a particularly bad year?

MR. GULLIVER:

A. That's a normal year.

CHAYTOR, Q.C.:

Q. That's a normal year.

MR. GULLIVER:

A. For lab.

CHAYTOR, Q.C.:

Q. And if we could have then--well, I guess, from there on, you look at this is the end of '03.

MR. GULLIVER:

A. And you can see the next items here. Just before the break, we talked about it.

CHAYTOR, Q.C.:

Q. Your lab plan.

MR. GULLIVER:

A. Where microbiology services moved from St. Clare's to Health Sciences and consolidated

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and then Ms. Predham is doing a review about the pathology technical consolidation.

CHAYTOR, Q.C.:

Q. Right, and I take it there wasn't anything in Ms. Predham's review detected that would have warned against any pathology technical consultation?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. So moving on then into 2004, the end of 2003/2004, we understand the Ventana machine was acquired. Was there any particular reason why you went with the Ventana system?

MR. GULLIVER:

A. Well, it wasn't me in particular. I mean, it's for the pathology division. I mean, my role as program director for all of our divisions is to ensure that we have the financial capacity to implement such new technology as I had done for biochemistry hematology, other parts of the program.

CHAYTOR, Q.C.:

Q. So who would have made the decision as to it being Ventana, if it's not you, who did, who

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made the decision?
MR. GULLIVER:
A. Well, really, it's sometimes it's almost no decision. What you have to do, when you're doing these large operational leases, you have to write a tender. You have to follow the provincial tendering guidelines. Eastern Health or at the time, Health Care Corporation Purchasing Department would review and submit all the logistics in a tender and pretty well, we just go out to the marketplace and say that we're looking for the latest technology. We're looking for it to be all inclusive, that includes service. It would include staff training on the equipment, and it would include providing reagents to be able to operate the equipment and whichever vendors bid on your business, the one that best meets your needs and meets all your tender specifications and is also the cheapest bid, that's the one that you have to assess first.
CHAYTOR, Q.C.:
Q. And so then you go through that process and who responds?
MR. GULLIVER:

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A. I think initially, I think this was retendered, that when it first went out, we only had one response from DAKO and DAKO were still offering the same DAKO autostainer that we had had for seven or eight years. At that point in time, they never had any new technology.
CHAYTOR, Q.C.:
Q. So why is it then that you retendered? What is it that you were looking for that the DAKO system couldn't offer?
MR. GULLIVER:
A. Oh, because both Barry and I knew that there were newer systems out in the marketplace and I think what had happened, when you send these things to purchasing, they rely upon vendors to know what tenders are on the Health Care Corporation website. But most often, we do send over a list of vendor names that we think could be potential bidders.
CHAYTOR, Q.C.:
Q. Okay. What I'm -
MR. GULLIVER:
A. So I think the second go-round, that's what Barry did.

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CHAYTOR, Q.C.:
Q. But what I'm getting at Mr. Gulliver is what is it about--you had a response from DAKO. You had your current system in place. I take it there was nothing wrong with your current system. Your machine was functioning properly, was it?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Yes, okay. So what is it, why did you go looking for a new system and why is it that the DAKO system and DAKO's response to your initial tender wasn't acceptable? What additional--what were you looking for?
MR. GULLIVER:
A. Well, I think the DAKO would have been acceptable if it was the only thing on the marketplace. But we had seen--I mentioned to you earlier, I had seen and we had gotten information about the new Ventana automated system, which you know, and again, you know, I'm the program director for all the laboratories, but because my background is in pathology, you know, I'm better able to

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understand some of the technology in pathology. If this had been a piece of equipment for microbiology, my input would not have been as great because it's not my technical background. But in the Ventana system, clearly you could see that the antigen retrieval process was now going to be done on board with the instrument. Therefore, it would reduce, you know, the boiling of slides on a hot plate and the chance of tissue boiling off. Everything, all their reagents were pre-diluted. Therefore, eliminated having to make up your own dilutions on the bench. Everything was bar coded. The slides, reagents were all bar coded. The equipment had more capacity than the DAKO instrument. The time it took to do the procedure for IHC from beginning to end would be less amount of time, therefore better utilizing our staff. It would just more automate the whole function from beginning to end.
CHAYTOR, Q.C.:
Q. Okay, and the automation of the antigen retrieval or having antigen retrieval on board the system and the issue of the pre-diluted

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antibodies, did you have any concerns regarding antigen retrieval that was currently taking place on the DAKO system and the use of other than pre-diluted antibodies? Had there been concerns brought to your attention regarding those?

MR. GULLIVER:

A. No concerns had been brought to my attention, either as the pathology manager years ago when testing first went in place with Dr. Khalifa, and neither for the last, the years I was program director. It's just--you know, it's a no-brainer that you got two choices. You can manually take your slides and put them on a hot plate and boil them or you can put them on the instrument and the instrument would do each slide individually.

CHAYTOR, Q.C.:

Q. Did you consult with Dr. Ejeckam, in terms of your--to get his opinion on which system to acquire?

MR. GULLIVER:

A. I don't remember if I did it personally. I'm sure Barry had talked to Dr. Ejeckam and the staff in the lab. I know Dr. Parai, I think

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at the time, was site chief. He would be informed and involved that we're hoping to get new technology, and again, even though you're acquiring new technology, in all these contracts and tenders, there still is an evaluation process that needs to take place once it comes into your laboratory, that there's an out clause that if you find it doesn't meet your needs or it's not what you expected, that you don't have to finalize the agreement.

CHAYTOR, Q.C.:

Q. So you didn't personally consult with Dr. Ejeckam and do you know then whether or not anyone consulted with Dr. Ejeckam to get his advice? He's, at this point in time, the person who's looking after IHC.

MR. GULLIVER:

A. Well, once the equipment is in, Dr. Ejeckam is the one who spends several months, you know, correlating and validating the Ventana instrument.

CHAYTOR, Q.C.:

Q. So whether he was consulted beforehand, you don't know?

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MR. GULLIVER:

A. I can't tell you directly, no.

CHAYTOR, Q.C.:

Q. And what about Dr. Cook, would that be something that you would speak to Dr. Cook and consult Dr. Cook regarding?

MR. GULLIVER:

A. I think for Dr. Cook, it would be more like an FYI, like for your information, as we would do for upgrading chemistry analyzers or hematology analyzers or other things like that.

CHAYTOR, Q.C.:

Q. Where did the funding come from to acquire the Ventana system?

MR. GULLIVER:

A. As I said, I mean, by that point in time, the growth we had seen in our IHC lab, the amount of dollars that we were spending currently in our pathology budget on reagents, antibodies, detection kits, slides, you know, all the things that go into it, you know, we did not know until the quotes came back. Would I have to go look for new dollars to add to the pathology budget to acquire this technology

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and do a reagent lease or do we have enough money already in our operating budget that we're spending with various companies that we could pool our resources and sort of give, you know, most of our money to Ventana to be an all-inclusive reagent lease? And pretty well, the vast majority of the dollars were in our budget.

CHAYTOR, Q.C.:

Q. If we could look, please, at P-1891.

THE COMMISSIONER:

Q. Ms. Chaytor, I just want to--on the matter of the acquisition of the Ventana, do I take it from what you said that the Ventana was acquired not because you were on some kind of a normal replacement program for your machinery, and not because you had any problems with the DAKO machine, but because you felt it potentially could be more efficient for your then workload?

MR. GULLIVER:

A. Actually, you just made a good point first. At this point in time, I think our DAKO contract was expiring.

THE COMMISSIONER:

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Q. Okay.
MR. GULLIVER:
A. And it coincided with, you know, this is new testing and new parts of pathology. It happened to coincide with other vendors coming out with newer technology.
THE COMMISSIONER:
Q. So you were going to have to have a new lease, in any event.
MR. GULLIVER:
A. I think, in any event, yes, around late 2003.
THE COMMISSIONER:
Q. And what happened--does DAKO then come along and take out the old machine and it goes back to some machine space in the sky wherever old DAKO machines go, or whatever?
MR. GULLIVER:
A. Actually, it all depends, Justice Cameron. We have some reagent leasing contracts in laboratories where at the end of the lease, the vendor still owns the equipment and they will come and take it and decommission it.
THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:

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A. We have other leases where at the end, the equipment belongs to us, because pretty well it's either they know its outlived its useful life or it's now older technology.
THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:
A. The DAKO one, when it was finished, when we bought the DAKO contract originally, it was not really an operational lease, it was we were purchasing the equipment and committing to buy reagents from DAKO, and they were letting us pay off the value of the equipment over a five year period.
THE COMMISSIONER:
Q. So you were actually purchasing the DAKO?
MR. GULLIVER:
A. Originally, we did. We were paying, I think, like $12,000.00 a month toward the purchase cost of the equipment, so we owned the equipment when it was done.
THE COMMISSIONER:
Q. So your lease wasn't expiring, you were actually getting a piece of equipment?
MR. GULLIVER:

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A. At the beginning, we did, but then by '03, we had a five year commitment to purchase reagents from DAKO at a certain value a month.
THE COMMISSIONER:
Q. Your commitment to purchase the reagents was expiring?
MR. GULLIVER:
A. It was expiring, yes.
THE COMMISSIONER:
Q. It wasn't--yeah, okay.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. But you actually owned the machine at that point?
MR. GULLIVER:
A. By that time we owned the machine, yes.
CHAYTOR, Q.C.:
Q. You had spent enough to own it?
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. And that was--I took you to that lease, I believe, last day. That's the lease that was $65,000.00, I believe, was the cost of the

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machine?
MR. GULLIVER:
A. Yeah, yeah.
THE COMMISSIONER:
Q. So at that point, you had to either get a new contract for reagents -
MR. GULLIVER:
A. For DAKO.
THE COMMISSIONER:
Q. Or purchase -
MR. GULLIVER:
A. Or do an all inclusive.
THE COMMISSIONER:
Q. Or purchase on a wider basis and get a new -
MR. GULLIVER:
A. Right.
THE COMMISSIONER:
A. All right.
CHAYTOR, Q.C.:
Q. And you did a cost benefit analysis or some sort of feasibility study and made the determination that it was more cost effective to go out and purchase a new machine?
MR. GULLIVER:
A. Well, by this time, we had--well, we wanted to

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get the tenders first to see what we would be offered, and, you know, to see if we could afford to acquire new technology and update our current technology, in conjunction with maintain our reagent base.

CHAYTOR, Q.C.:

Q. So did you do that, did you figure out that it was just as cost effective to have a new piece of machinery and enter into a new reagent lease as it was to continue on with your piece of equipment that you now owned and enter into a reagent -

MR. GULLIVER:

A. I don't know if Barry did an exact feasibility study. However, I do realize that overall the Ventana System would probably cost us a bit more than operating the DAKO autostainer in conjunction with the DAKO reagents, but we were able to--as you can see, all the benefits of the Ventana System compared to the manual method, are part of the thing you also would look at was that the Ventana instrumentation would reduce technical time on the bench, doing tasks that the instrument could do, and that also would be sort of a savings, a

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technologist savings in the lab. So, therefore, staff can be able to spend more time, as Dr. Ejeckam had mentioned, more time reading journals and learning IHC as opposed to performing the test on the DAKO. So it was much more efficient also.

CHAYTOR, Q.C.:

Q. Okay, P-1891, and this is your annual report then for the laboratory program, and it's fro the fiscal year ending March 31st, '04, and under number three, we look at, "Negotiated a five year reagent lease for immuno pathology services. This provided new equipment that improves quality and turnaround times". I take it, Mr. Gulliver, that's reference to the acquisition of the Ventana machine?

MR. GULLIVER:

A. Ventana.

CHAYTOR, Q.C.:

Q. Okay. And in terms of the new equipment improving the quality, what specifically do you believe was improved by the purchase of the Ventana machine?

MR. GULLIVER:

A. Well, again quality, I'm talking about overall

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quality of the service. Quality could include the fact that you have on board antigen retrieval; therefore, you reduced or minimize the opportunity for tissues to boil off the slides. Quality would mean that the Ventana System operates under pre-diluted and sort of pre-optimized antibodies when they come in. Therefore, you minimize the risk of manually having to make your own antibody dilutions and titrations on the bench. Quality also means that the Ventana System bar coded all the reagents, so when you put your reagents on the instrument, the instrument read the bar codes to ensure that the slide matched the reagent and those things, so it's just--it's all inclusive, and -

CHAYTOR, Q.C.:

Q. If we could have--sorry.

MR. GULLIVER:

A. And I would say then during the process where the instrument was being assessed before it was put in full operation, I know that--I mean, I spoke to many pathologists and technologists and their view was the overall quality of the slide itself was better.

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CHAYTOR, Q.C.:

Q. If we could have 1903, please. This is your leadership meeting and it's for the month of January, 2004, yourself and Drs. Cook and Williams, and it indicates here, "A tender has been awarded for a six year reagent lease for immuno pathology, which includes new equipment. Also pathology awarded the tender for purchase of an automated stainer. Currently working through awarding tender for automated slide and cassette labellers". What's being referred to there, Mr. Gulliver?

MR. GULLIVER:

A. Well, again this is the--this would be the Ventana contract, and when we're going forward with the IHC part of the lab, Ventana also has an automated stainer that you can use for the histochemical staining, not just immunohistochemical staining, and they would be some of the routine stains in the main part of pathology, so we actually committed, I think, to a six year agreement and then included and piggybacked the bigger agreement for IHC to be able to put some automation into the routine part of pathology.

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CHAYTOR, Q.C.:
Q. So this is two pieces of equipment?
MR. GULLIVER:
A. I think there was three. There were two for the IHC part of our lab, and then there was another stainer that came in to do routine histochemical staining.
CHAYTOR, Q.C.:
Q. Okay, and all through Ventana?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Through the same -
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Through the same negotiations?
MR. GULLIVER:
A. Through the same contract.
CHAYTOR, Q.C.:
Q. If we could have, please, 1913, and this is a meeting of site chiefs and divisional manager, and Dr. Cook, Parai, and Robb are in attendance. It's March 31st, 2004. 4.2, there we go, under new technology, "The

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immunoperoxidase stainer appears to be working generally well, however, there continues to be some problems with estrogen and progesterone receptors". Mr. Gulliver, do you know what at the end of March, 2004, what problems were continuing with ER/PR?
MR. GULLIVER:
A. I have no idea.
CHAYTOR, Q.C.:
Q. That wasn't discussed with you at the time?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And if we could have, please, P-2325, and this is June 15th, 2004, and it's a meeting of laboratory division managers and yourself, Mr. Dyer, Ms. Wade, are in attendance, amongst others, and the program--it's indicated here the program has ended, it's '03/'04, with a $609,000.00 deficit. "Terry has no indication of the '04/05 budget at this point". So in terms of finishing off your year that year, your budget is $609,000.00 deficit, and so I take it based on your remarks earlier, that would not be unusual for your program?

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MR. GULLIVER:
A. I think that might have been our worst year, I don't remember, but again in '03/04 or '02/03, our budget was cut multiple times before this, and actually when we were going through budget preparations for the next fiscal year, I used to argue to our financial people that the big issue with the laboratory being in deficit all the time is that you don't give us enough money to start the year off with. Like, you under fund us to begin the year, and you expect us to balance the budget at the end of the year, but you know full well, and I know full well that it ain't going to happen, because lab services as such that we cannot control demands, we cannot control volumes. At the same time, in my first couple of years, the biggest piece of our budget that were going in deficit was in our blood collection staffing, that we didn't have enough blood collectors to do in-patient out-patient collection for all the facilities. We were constantly paying overtime, constantly putting on extra staff, to try to reduce patient wait times, and I'm thinking this year, I think

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about $400,000.00 of that deficit was simply in blood collection services.
CHAYTOR, Q.C.:
Q. Okay, so if we could have then, please, P-3113. I just want to follow along with a couple of more exhibits and finish off the 2004 year. I take it, once the Ventana came in in 2004, you didn't hear any complaints about the product or the quality of the slides after that?
MR. GULLIVER:
A. I didn't hear, not one.
CHAYTOR, Q.C.:
Q. And this is an exhibit I took you through yesterday, just the memo part of it. It was the accreditation of 2004, and you gave your views on that in terms of it being somewhat of a superficial -
MR. GULLIVER:
A. I mean, what they're asking is, like, where do you have services, what services do you have on what sites, those kinds of questions.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:

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A. And this is the list of questions I submitted, I gave Dr. Williams a copy of.
CHAYTOR, Q.C.:
Q. Okay, yes, so this is what would have been -
MR. GULLIVER:
A. Given to the surveyors.
CHAYTOR, Q.C.:
Q. Okay, so the survey guidelines, this would be given to you, I take it, and then the list of questions, these would be your answers, is that right, or is that -
MR. GULLIVER:
A. And I actually think either myself of Lynn Wade probably worked on these.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. Even though Lynn wasn't quality manager at the time, she was client services manager, but I'm thinking myself and Lynn did most of this.
CHAYTOR, Q.C.:
Q. Okay. So, for example, at page seven, where we have under areas to improve, "Many specimens collected by other health care providers in the hospital are delivered by a

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porter or other designated person. Presently there's no provision for documentation of receipt in the lab of the delivery time, only a processing time. There needs to be an improved mechanism in place to track specimens from collection to receipt by the lab". Would that be--are you saying that is something you and Ms. Wade would have come up with, or is that something the accreditors came up with?
MR. GULLIVER:
A. That's something that Lynn would come up with. Lynn was our client services manager in charge of blood collection for the front end of specimens, but this is talking about not pathology specimens, this is the blood specimens that we do about 5,000 a day, and when the bloods come into the lab, we have--the automation in the lab records the receipt of the specimen in the lab, but we had no idea when the blood was collected and how long it took to get to the lab for processing.
CHAYTOR, Q.C.:
Q. Would that, though, be any different for tissue specimens as opposed to blood collection?

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MR. GULLIVER:
A. Well, for tissue specimens, they were brought down from the OR and from the day surgery, and when they came to the lab, the lab had a logbook to document every surgical specimen that came into the lab.
CHAYTOR, Q.C.:
Q. This says, "Presently there is no provision for documentation on receipt in the lab at the delivery time, only at processing time".
MR. GULLIVER:
A. That's blood specimen.
CHAYTOR, Q.C.:
Q. So blood specimen. You're saying that was, in fact, in place. There was a procedure in place for pathology?
MR. GULLIVER:
A. In pathology--when pathology specimens came down, there was a logbook where the porter who brought them down had to sign, the technologist who received the specimen signed, and it's a book kept in the gross room.
CHAYTOR, Q.C.:
Q. So was it timed then, Mr. Gulliver?
MR. GULLIVER:

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A. I don't know if the time was placed in the logbook in the pathology lab. I mean, you'd have to ask--Mr. Dyer could answer that question better than I could, I mean, he's in pathology, but his issue here is talking about you know, we--at the Health Sciences at the time, I think, on average 5,000 tubes of blood a day, and, you know, there was always kinds of questions on--calls from emergency saying we don't have the results back on our stat (unintelligible) or stat glucose, and stat amylase, and the lab will be saying, well, we only received it at this time, and there's no documentation of when the nurse or physician, whoever collected the blood in emergency, and how long it took for that specimen to actually get to the lab to be processed.
CHAYTOR, Q.C.:
Q. What was Ms. Wade's position at this point in time?
MR. GULLIVER:
A. She was manager of client services, which included blood collection, reporting and the pre-analytical pieces of overall for the laboratory.

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CHAYTOR, Q.C.:
Q. And if we could have, please, P-1583? And the area of improvement that Ms. Wade noted regarding the blood collection, do you know was that remedied at the time that it was brought up in 2004?
MR. GULLIVER:
A. As far as I know it was. What, and what we put in place for most of the bloods collected in the system, are collected by laboratory staff, so we have a process in Meditech where you actually have to go in there and receive the sample and bar code--wand it in, and who the collector was. The main issue that Ms. Wade was talking about there were the hundreds of bloods a day collected by nurses and doctors that didn't follow the same protocol that laboratory staff would follow. What the staff did, I think, on the power processor which is the automated equipment that would do it, they enabled some of the function there to record the time when it first came to the pre-analytical part of the lab and then the instrument that performs the test recorded the time that the blood got to the instrument.

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CHAYTOR, Q.C.:
Q. P-1583 is a meeting, minutes of a meeting, Division of Anatomical Pathology Pathologists' meeting at the General Health Site on November 2nd, 2004, and there's a number of doctors in attendance, as well as Mr. Dyer and on page 3 under "New Business: Pathologist assistants. Much discussion on this issue. It is agreed by the pathologists that the issue should be brought to the attention of the vice-president of Medical Services. Dr. D. Robb, chairman of the discipline, will write to Dr. Williams recommending pathologist assistants as per the Royal College recommendation. It is also pointed out that the anatomical pathology division is earning over $100,000.00 per year by billing for the technical work. It is expected that some of the money should be given to the pathology budget to hire pathologist assistants." Mr. Gulliver, was this discussed with you at the time and that Dr. Robb would write directly to Dr. Williams?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:

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Q. Okay, and were you in favour of that approach?
MR. GULLIVER:
A. Of hiring pathology assistants?
CHAYTOR, Q.C.:
Q. Of having Dr. Robb approach Dr. Williams directly?
MR. GULLIVER:
A. Oh sure, I mean, at the time I think Dr. Robb had become the chairman of the University Chair, as opposed to our clinical chief and, you know, I felt that Dr. Robb was also a practising pathologist, he's someone who, from everyone in the program respected and felt that if Dr. Robb can weigh in on the issue and put his support behind it, it can only help us.
CHAYTOR, Q.C.:
Q. And the idea of taking the $100,000.00 and somehow allocating a certain amount of that towards the expenditure, is that something that you could do or was that something that had to go through Dr. Williams?
MR. GULLIVER:
A. It's a can of worms you opened up there because laboratory medicine is one of the

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programs, if you look at laboratory service is the United States, everything is fee for service, so laboratories are revenue generating in their health care system. In our system, you know, lab services are free to the patient; however, our laboratory provided specialty services to many other labs in hospitals in the province and for certain things, we had approval to bill for the technical component. In chemistry we billed for--we used to bill for B12's and folates and different kinds of tests. And our lab program would generate over a million dollars a year in revenue. I think right now we're at 1.5 million in revenue. That money goes into general revenue for the Health Care Corporation. It goes right now to general revenue for Eastern Health. The lab has no say in how that money is distributed throughout the organization. We have on many, many occasions over the years proposed to VPs, not just Dr. Williams, but prior to Dr. Williams and prior to him, that if the lab is generating this much revenue, we should be able to access a part of that revenue, either

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for staff education, for out-of-province travel or for other services in the program and we've never ever gotten a yes on it.

CHAYTOR, Q.C.:

Q. Even though you've looked for it, that's never came to fruition.

MR. GULLIVER:

A. And I think from an organizational perspective, I think it will be, well if they do it for the lab, they have to do it for all parts of the organization that generate revenue. I think the organization relied upon this revenue to help with the shortfall of funding overall for the health care organization.

CHAYTOR, Q.C.:

Q. And they allocated it back, I take it, in terms of whatever the priorities was seen fit by the management?

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. Under "New Business" then on page 4, 4.5 "New Tissue Processor: Pathologists are asked to get familiar with the new work station and cut

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the specimen at certain thickness to be processed in the new tissue processor." Mr. Gulliver, is that the Sakura Express?

MR. GULLIVER:

A. It would be, yes.

CHAYTOR, Q.C.:

Q. And where did the money come from to acquire the Sakura Express?

MR. GULLIVER:

A. That came direct funding from our capital equipment funding from the organization to the lab program.

CHAYTOR, Q.C.:

Q. So that was acquired some time in 2004?

MR. GULLIVER:

A. I think it was 2004, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. And do you recall how much that piece of equipment cost?

MR. GULLIVER:

A. I think it was between two hundred and fifty thousand dollars.

CHAYTOR, Q.C.:

Q. And has that tissue processor ever been used?

MR. GULLIVER:

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A. Has it ever been used? Yes.

CHAYTOR, Q.C.:

Q. Is it currently in use?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And for how long was it used?

MR. GULLIVER:

A. It was, when it first came in, you know, Barry and pathologists at the Health Sciences and staff, they were processing a lot of small biopsy specimens through the new tissue processor cycle, doing their routine H&E stains, did some IHC stains and it went on for a period of maybe six months, you know, trying it out and testing it and seeing, comparing what a slide looks like going through the old tissue processor or the old way of doing things, verses the new tissue processor which is a microwave processing cycle.

CHAYTOR, Q.C.:

Q. And whose decision was it to acquire the Sakura Express?

MR. GULLIVER:

A. It was a part of my decision, a part of

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Barry's, Dr. Sushil Parai was in favour of it. Again, when the instrument came in, we had sort of an outlet clause that if we felt that it didn't meet our needs, that we didn't have to complete the purchase. But at the Health Sciences it was generally supportive that this will be good to get this new way of processing our tissue.

CHAYTOR, Q.C.:

Q. And we've heard Ms. Wegrynowski express some concerns about the use of this type of a processor, given that it uses, I understand it's alcohol base, as opposed to your normal fixatives would have been done, your normal fixative would have been formalin and so, for example, your control bases, your control tissue has to be treated in the same manner as your patient tissue.

MR. GULLIVER:

A. Oh yes.

CHAYTOR, Q.C.:

Q. Were you aware of that at the time you acquired the Sakura Express?

MR. GULLIVER:

A. Well at the time Sakura, myself and Mr. Dyer,

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we went and did a site visit with Sakura, we went to the University of Miami Hospital. We spoke to Dr. Morales who is a leading pathologist in the United States. Dr. Nadji actually I think his name was, he was the IHC person for University of Miami, a well renowned IHC pathologist. We got to spend a couple of days down there to see the tissue processor, how they were using it, what things they used it for, spoke to technologists on the quality of cutting the sections after they're processed using microwave technology, spoke to pathologists on the quality of the slides they've seen. We spent about two or three hours with Dr. Nadji talking about the IHC slides that were done using microwave processing upfront and this technology was being, you know, implemented and used in many large health care centres in North America.

CHAYTOR, Q.C.:

Q. But were you aware that if you were to acquire this machine, then all the specimens you have in your control bank would have to be redone so that they would then be treated through the new processor in the same manner that you were

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proposing to treat the patient tissue?

MR. GULLIVER:

A. And that would apply, I would assume, to the controls being used in the IHC part of the lab, that if you are going to do IHC testing on tissue that is microwave processed, that your control tissue would have to be replaced and go through the same processes that your patient tissue would.

CHAYTOR, Q.C.:

Q. And so you were aware that that would have to be done at the time the machine was acquired?

MR. GULLIVER:

A. Well again, I'm not the pathology manager, Ms. Chaytor, I'm the director. This is something that I would not be involved in.

CHAYTOR, Q.C.:

Q. You and Mr. Dyer went to Miami together to look at acquiring the machine, was he aware of it? Did you have discussions about that and in terms of any additional work then that would -

MR. GULLIVER:

A. I can't answer for him.

CHAYTOR, Q.C.:

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Q. So it wasn't discussed between you and Mr. Dyer that it may involve additional work for your technologists then if you have to create new controls?

MR. GULLIVER:

A. I'm assuming it was discussed with Mr. Dyer and the pathologists who were doing the validation on this new microwave processing.

CHAYTOR, Q.C.:

Q. Do you know that?

MR. GULLIVER:

A. I said I assumed it was discussed amongst them.

CHAYTOR, Q.C.:

Q. Okay, so it wasn't discussed with you and do you know whether or not it was discussed with anyone?

MR. GULLIVER:

A. I don't know.

CHAYTOR, Q.C.:

Q. So, Mr. Gulliver, this cost about a quarter of a million dollars and it was used for a six-month period?

MR. GULLIVER:

A. I think they were about six months into

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looking at--because, I mean, this is not just a piece of equipment, Ms. Chaytor, this is actually changing the practice of pathology. As you are all aware right now that when a tissue comes into pathology, once it's grossed, fixed and grossed, it goes through a tissue processor. The tissue processors are normally about a fourteen hour timeframe, so what would happen generally, you would gross all day, you may have as many as five or six hundred samples, they would all be batch processed, they would all go on tissue processors, we had two of them. They would be processed overnight and the next morning, the technical staff would start the function of embedding, then cutting and producing slides later on in the day. With this new technology, it eliminated batch processing in pathology. What it meant was that at a gross bench you could gross a specimen at 9:00 in the morning and instead of waiting until 5:00 in the afternoon to go on the tissue process for that function, you could gross at 9:00 and you could actually put your specimens, 40 at a time, on the new microwave tissue processor

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and it took an hour and fifteen minutes to process a tissue sample as opposed to 14 hours. So you could do same time turn-around time for urgent cases for pathology and that's what it was being used for in the University of Miami.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. They had three of these in Miami. They had one of these processors actually in their cancer centre and a patient who came in for biopsy, the patient would not go home until that same day, the lab processed the tissue, cut and stained it and a pathologist read it and gave the result back to the oncologist, so they could decide what to do with that patient before the patient left.

CHAYTOR, Q.C.:

Q. And so what was the problem with implementing this process in your lab?

MR. GULLIVER:

A. Well again, it meant changing our practises. One of the critical pieces for microwave tissue processing is the thickness of the

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tissue that the pathologist would cut at the gross bench, and as you've heard through this inquiry, there has been many instances where the thickness of the tissue being dissected was too thick for the normal tissue processing; therefore, specimens weren't properly fixed. This required tissues to be even cut thinner because you're going to do an hour and fifteen minute processing cycle. So there was a whole new grossing board we bought with the instrument for pathologists and they had special dissecting instruments to ensure that they cut a nice even thin piece of tissue to be submitted into the tissue block. And that was very difficult to get the pathologists actually to change--that's not true, some pathologists embraced it, other pathologists did not embrace it.

CHAYTOR, Q.C.:

Q. What about discussion with Dr. Cook then, clinical chief before the machine was acquired, if it's going to have ramifications as to how the pathologists are doing their work.

MR. GULLIVER:

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A. Well Dr. Cook is well aware that we were in the process of acquiring this piece of equipment, he was well aware, it was there on our capital equipment request list seeking funding and obviously when the instrument did come in, Dr. Cook would be part of the group of pathologists who would have to give their view point in their assessment. Dr. Cook never expressed any concerns before the instrument was bought and brought in.

CHAYTOR, Q.C.:

Q. And how about afterwards?

MR. GULLIVER:

A. I think Dr. Cook's concern was having to change their schedule and change their work practices.

CHAYTOR, Q.C.:

Q. And the six month period in which the machine or the process was used -

MR. GULLIVER:

A. But it wasn't used, it was being--in that timeframe you were taking side-by-side samples of specimens and being processed traditionally and processed -

CHAYTOR, Q.C.:

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Q. So it was like a validation process?

MR. GULLIVER:

A. It's like a validation process.

CHAYTOR, Q.C.:

Q. So the machine has never been used to actually test patients.

MR. GULLIVER:

A. I don't think it was ever ever used on a current patient that gave a current diagnosis, no.

CHAYTOR, Q.C.:

Q. Okay. And so why didn't the machine go back or be resold or -

MR. GULLIVER:

A. Well I don't think there was ever a decision decided that we would never have the machine or ever use it. Unfortunately by the time the validation process is ongoing and Sakura, they brought in one of their expert pathologists that spend a couple of days with our pathologists to talk about the importance of the thickness of tissues being grossed and sectioned and pretty well saying, look, you know, once you get used to this here, I think that you would really embrace it and you'll

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really like it. By the time we get to that point, Ms. Chaytor, we're almost starting down the path of ER/PR retesting.

CHAYTOR, Q.C.:

Q. So what happened instead, if you needed a new tissue processor have you since had to acquire or--because this one then wasn't put into use, did you acquire a new tissue processor instead?

MR. GULLIVER:

A. We just got two new ones back in December of '07 which are the traditional way of tissue processing.

CHAYTOR, Q.C.:

Q. And why was that decision made to stick with the traditional way?

MR. GULLIVER:

A. Well because the two we currently have were getting fairly old and they were in need of replacement and we were having some mechanical issues with them and I asked directly to Dr. Howell and Louise Jones for funding to purchase two processors and they granted it and we got them.

CHAYTOR, Q.C.:

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Q. And it was two processors that were replaced in the past year?

MR. GULLIVER:

A. Well we have two anyway because for volume, you need to have at least two.

CHAYTOR, Q.C.:

Q. But they were both replaced is my question?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And so you were having some mechanical problems, was that with both processors or?

MR. GULLIVER:

A. I would say yes, and again, the ones before that replaced them, we had them for 10, 12 years, you know, they're mechanical instruments, they're going to break down, just like your car is going to break down, whether it's a Cadillac or whether it's a -

CHAYTOR, Q.C.:

Q. So it was a regular replacement schedule for -

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Pretty much?

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MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. What's the general live of a tissue processor?

A car I would know about, a tissue processor I wouldn't.

MR. GULLIVER:

A. Oh, tissue processors, they're usually about anywhere from 10 to 15 or could be longer. If you look at Carbonear, we have a tissue processor in Carbonear, the same technology, however, they process maybe 40 or 50 blocks a day, so the usage they have will extend the life of the instrument. The Health Sciences processes at full capacity every single day, therefore you will reduce the life expectancy of your equipment.

CHAYTOR, Q.C.:

Q. So the two that were replaced, how old were they?

MR. GULLIVER:

A. I would say about ten years, probably.

CHAYTOR, Q.C.:

Q. Okay. And you said it's the traditional way that you've been doing tissue processing all

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along as opposed to what the Secure Express would have been introducing?

MR. GULLIVER:

A. Well, traditional, sorry, in 1987 is when the automated tissue processing came in place. Before that we processed on the bench.

CHAYTOR, Q.C.:

Q. Yes. But in terms of the new machines that came in, were they any different than what the technologists were using before, was there any difference or are these just replacement with new same machines?

MR. GULLIVER:

A. Replacement with just a few new software additions.

CHAYTOR, Q.C.:

Q. And did the technologists require any training on the new machines?

MR. GULLIVER:

A. No. The company comes in, they set them up, they check them out, verify them and you do like a dummy run, make sure they're working fine overnight and then they're ready to go.

CHAYTOR, Q.C.:

Q. Okay. And in terms of any maintenance or

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anything on the machines, would that be shown by the people selling the machine or how would the technologists know that?

MR. GULLIVER:

A. Well, on the two new ones?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Well, the same maintenance records and logs required on the old ones would be the same on the new ones.

CHAYTOR, Q.C.:

Q. So no change?

MR. GULLIVER:

A. There's no change there, no.

CHAYTOR, Q.C.:

Q. Okay. Mr. Gulliver, then I guess we're into 2005. And tell us then when and how you first heard of what has become known as the ER/PR issue?

MR. GULLIVER:

A. Thank you. I guess I first heard about it and you've heard, you know, testimony here prior to me back in the summer, I was first made aware of the index case, at the time I didn't

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know it was the index case, by Mr. Dyer, the pathology manager.

CHAYTOR, Q.C.:

Q. So Mr. Dyer brought it to your attention. And what did he tell you and how had he heard about it?

MR. GULLIVER:

A. Well, he had just come from a meeting, he told me he just came from a meeting with Don, Don Cook and Bev Carter, and he said a couple of oncologists and they talked about, you know, a patient that was retested and came back negative and for--you know, for the ER/PR. And that's the first time I ever heard about, you know, a change in result for ER/PR. It turned out to be Ms. Peggy Deane, as we all refer to her as the index case when this started.

CHAYTOR, Q.C.:

Q. And we've heard from Mr. Dyer that he attended such a meeting with Doctors Cook and Carter, McCarthy and Laing on May 17th, 2005. So would that be the meeting that you're referring to?

MR. GULLIVER:

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A. That's the one, yes.

CHAYTOR, Q.C.:

Q. Okay, and that was you hadn't heard of the issue prior to that?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Okay. And would that be unusual for Mr. Dyer to be called to that meeting as opposed to, for example, yourself?

MR. GULLIVER:

A. I don't think it's unusual because if there was an issue in pathology, you know, we've had Barry will go to meetings if there's an issue in the perioperative program with maybe specimens or something like, that. I thought it was strange that, you know, that Dr. Cook was there as our clinical chief and that I wasn't asked as the program director to be at the meeting.

CHAYTOR, Q.C.:

Q. Well, perhaps that's, yeah.

MR. GULLIVER:

A. I did, yes.

CHAYTOR, Q.C.:

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Q. Whether, you know, to have him there -

MR. GULLIVER:

A. I didn't know the meeting was taking place.

CHAYTOR, Q.C.:

Q. - instead of you, probably you would not be there, you know?

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. So you would have expected that you would be there along with Mr. Dyer?

MR. GULLIVER:

A. I would have thought so, yes.

CHAYTOR, Q.C.:

Q. Okay. And did you raise that with anyone, did you ask Dr. Cook or anyone afterwards, well, why aren't--why wasn't I included and what's happening?

MR. GULLIVER:

A. I don't remember asking Dr. Cook why. I mean, if he called a meeting, maybe it was the oncologists who called the meeting, I'm not really sure. I don't know if they called the meeting on that same day and just got people together. I don't know if it was set up two

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weeks ahead of time. I just know I found out, Mr. Dyer came to my office, he was--and actually, he was quite upset that he told me about this particular issue. And I think he was upset of things that were said at the meeting.

CHAYTOR, Q.C.:

Q. And what did he tell you was said at the meeting?

MR. GULLIVER:

A. And, you know, I sat here and heard Barry's testimony and I really can't tell you 100 percent exactly what he said to me in my office. I know that he was really upset. I know that he pretty well said that, you know, "and the doctors are blaming me for this."

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. He didn't say anybody's name. I can't remember him saying Dr. so and so or Dr. so and so, but I clearly remember that he was visibly upset.

CHAYTOR, Q.C.:

Q. And he told this to you immediately after having been at the meeting?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And so at that point -

MR. GULLIVER:

A. I think he came straight from the meeting to my office to see if I was there.

CHAYTOR, Q.C.:

Q. And so what did you then do after Mr. Dyer has told you about the index case? First of all, were you told, were there any other cases, was it just the one at that point in time?

MR. GULLIVER:

A. As far as I remember, Ms. Chaytor, it was just the one.

CHAYTOR, Q.C.:

Q. Okay. And Mr. Dyer is upset. So what did you do?

MR. GULLIVER:

A. At that time I don't remember exactly what I did.

CHAYTOR, Q.C.:

Q. And you didn't go to Dr. Cook -

MR. GULLIVER:

A. I did not go to Dr. Cook, no.

CHAYTOR, Q.C.:

Q. Okay. And why not, why?

MR. GULLIVER:

A. I just think I spoke to Barry and I think I just calmed Barry down to say, "You know, look," and I think I was probably saying to him, "Well, you sure they're saying that it's, you know, it's the lab's fault or what the issue is?" And I have no information in front of me, I have nothing here, so I really can't comment on anything at that point in time.

CHAYTOR, Q.C.:

Q. So when did you next then hear anything about the issue?

MR. GULLIVER:

A. It was probably awhile. It might have been a couple of weeks went by before, I think, Dr. Cook had any really direct sort of contact with me to sort of talk about the issue. I think that what he and Dr. Carter--well, what he and Dr. Carter, I'm assuming, were doing, I think were trying to assess to see, you know, really what the issue is and what the implications of this issue could be.

CHAYTOR, Q.C.:

Q. So a couple of weeks went by before you heard anything else about it?

MR. GULLIVER:

A. Yeah, I think he might have wrote Dr. Williams and copied me on it or something like that.

CHAYTOR, Q.C.:

Q. And you -

MR. GULLIVER:

A. But we never had no face-to-face sit-down talk about it.

CHAYTOR, Q.C.:

Q. And in the meantime you didn't make any inquiries of anyone?

MR. GULLIVER:

A. Not that I remember, no. Again, it's a pathology issue, it will be handled by the site chiefs, it'll be handled by the manager and it's being handled by the clinical chief.

CHAYTOR, Q.C.:

Q. But did you know that that was happening?

MR. GULLIVER:

A. Well, Barry told me that Don and Bev Carter were at this meeting, that they were dealing with it and talking to the oncologists.

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CHAYTOR, Q.C.:
Q. So when you heard that Mrs. Deane's test had -
MR. GULLIVER:
A. I didn't know who the patient was.
CHAYTOR, Q.C.:
Q. No.
MR. GULLIVER:
A. I just knew there was -
CHAYTOR, Q.C.:
Q. Well, we now know.
MR. GULLIVER:
A. They sent a patient off for a retesting.
CHAYTOR, Q.C.:
Q. Okay. And we assume it was her test. But anyhow, you were told that a patient's test had been repeated and had changed. Did that cause you any concern yourself knowing how that these tests were done, for example, Fridays, you thought a lot of them were done in batches on the same day of the week, did it cause you to pause and say, "Well, what about every other test that was done in that batch with Peggy Deane's test?"
MR. GULLIVER:
A. No, I didn't, no.

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CHAYTOR, Q.C.:
Q. You didn't think about that?
MR. GULLIVER:
A. No, because, I mean, again, every slide that's performed by the technologist, it is read and interpreted and signed out by a pathologist. And if the pathologist didn't have any concern about it, I wouldn't think about, you know, having a concern about it.
CHAYTOR, Q.C.:
Q. And so whether or not it was a technical issue that may have caused her test to be different, you weren't concerned that, well, what about the other 10 or 12 cases that may have been run with her case, that didn't dawn on you at the time?
MR. GULLIVER:
A. Well, I didn't know who was run with her case, when her case was done. I didn't know at that point what where it was retested.
CHAYTOR, Q.C.:
Q. And could you even do that, if you wanted to find out what other patients had their tests run in the same batch as Peggy Deane's, could you reconstruct that?

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MR. GULLIVER:
A. I think it would take a bit of time, I think you could, because, I mean, you would have to go back and look at the date her test was performed and signed out and then you had to do, like if you do a computer search and look for that week, what ER/PRs were done during that week, and to see if the procedures that were performed and ordered are on the same day. So you know, logically then you'd be able to say, well, I can't swear 100 percent, but, you know, if four patients are, got the ER/PR on June 19th, then if it's--I would pretty well assume those four were done in the same day, on the same batch.
CHAYTOR, Q.C.:
Q. So what would you check, would you check the requisitions?
MR. GULLIVER:
A. We wouldn't have requisitions that were three or four years lying around.
CHAYTOR, Q.C.:
Q. What would you check, what would be in your computer system?
MR. GULLIVER:

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A. We'd go into the Meditech system and look at the patients' reports and look at, and search for those patients done that week.
CHAYTOR, Q.C.:
Q. So those reports would be when the pathologists signed off, though?
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. Right. So anything that had been signed off around the same time period might be -
MR. GULLIVER:
A. I think within a day of each other you can probably assume it was probably in the same batch that week.
CHAYTOR, Q.C.:
Q. And if the pathologist hadn't read the report or read the slides, for whatever reason, for a week later, there's no way to actually go in and say, "Well, here's, Peggy Deane's test was run on this date and these others were also run."
MR. GULLIVER:
A. No, the system records different events when you access a patient's record. So if a

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technologist did a batch, generally that technologist would complete the batch, they would go into each individual patient's report and say, "I've now done the ER/PR" and that date and time is there in the system. The pathologist might not read it and sign out for it a week or a day or they could be all different times signed out. But what I'm saying, under the procedure that was ordered and completed, if you've got four or five patients on the same day in the system recorded, then you can pretty well assume those patients were done in the same batch on the same day irregardless of the time the pathologist read them or signed them out.

CHAYTOR, Q.C.:

Q. Okay. So it would be likely that they were done on the same day?

MR. GULLIVER:

A. Yeah, likely. You can't guarantee 100 percent.

CHAYTOR, Q.C.:

Q. Right.

MR. GULLIVER:

A. But it would be more likely, yes.

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CHAYTOR, Q.C.:

Q. So was that done, did anyone ever attempt to do that?

MR. GULLIVER:

A. Not to my knowledge, no.

CHAYTOR, Q.C.:

Q. And why not?

MR. GULLIVER:

A. I can't tell you, I don't know. The pathologists didn't ask for it, Dr. Cook didn't ask for it, Dr. Carter didn't ask for it who at this time were the two clinical people leading this for the laboratory. Well, and actually, I can't say if it was done or not done. I'm saying to me no one ever came and asked me could it be done or should we do it.

CHAYTOR, Q.C.:

Q. Okay.

COMMISSIONER:

Q. Ms. Chaytor, when you can find a convenient spot, we'll take the luncheon break.

CHAYTOR, Q.C.:

Q. Okay. So using Meditech, can you ascertain for a given date what procedures were done by a particular technologist on that date?

MR. GULLIVER:

A. That's much more difficult because, I mean, in general practice if it was Mary doing the batches this week or Peggy doing it this week, because, I mean, by this time, you know, from '97 up until Les comes, we've only got Mary and Peggy doing the batches. One can only assume that if Mary goes into the computer and she's the one saying the procedures are completed, you would assume Mary is the one that ran the batch. But that didn't happen all the time. Sometimes the workload didn't get inputted until several days later and maybe by that time Peggy's on the bench and she puts all the workload in for last week and this week, but that would not be the norm. But normally the technologist who did the batch would go and record it.

CHAYTOR, Q.C.:

Q. If I could have, please, P-2152? And page 8 of the document, please, Registrar? Do you recognize what this document is, Mr. Gulliver?

MR. GULLIVER:

A. Not really.

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CHAYTOR, Q.C.:

Q. No? This doesn't look familiar to you?

MR. GULLIVER:

A. I think I've seen in now in preparing for this.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. But it's not something I would have seen back ten years ago.

CHAYTOR, Q.C.:

Q. And would this be something that is generated by the DAKO machine?

MR. GULLIVER:

A. I think that's probably where it would have come from.

CHAYTOR, Q.C.:

Q. Computer -

MR. GULLIVER:

A. It's probably like the protocol or something that they were using for antibody, but that's what it looks like to me.

CHAYTOR, Q.C.:

Q. Or would it be the computer records of the DAKO machine for a particular case, for

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example, here -
MR. GULLIVER:
A. It may have been, you know, when the staff or technologist would do a run, they had to go and tell the machine slide one is ER, slide two is LCA, slide three, and they had a template where they set it up.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. The machine, I think, spit out like a piece of paper with a bunch of circles and said, now, when you put your reagents on, you put them in slot number one, two, three, four, five, that kind of template.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. I never ever used the DAKO machine, so I can't tell you, you know, exactly.
CHAYTOR, Q.C.:
Q. So this here in terms of the case number, this looks like a surgical number, 1998.
MR. GULLIVER:
A. From Central Newfoundland.

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CHAYTOR, Q.C.:
Q. From Central Newfoundland. The doctor is Dr. Khalifa and the technician is Peggy?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay. And then we have slide, and the slot numbers, I guess, would be 19 and 20?
MR. GULLIVER:
A. It's ER/PR.
CHAYTOR, Q.C.:
Q. Anti, the antibodies estrogen and progesterone. And then we have the protocol that was used?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And then if this were information generated by the DAKO computer, where would we get that information today?
MR. GULLIVER:
A. Well, as you know, the DAKO computer, we don't longer have it.
CHAYTOR, Q.C.:
Q. But where would this information have gone

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that was on the computer?
MR. GULLIVER:
A. I really can't give you, you know, 100 percent answer. I know you've all been informed that at some point in 2004, I think it was November, that our main pathology lab, in particular, the part of the lab that had been used for IHC testing underwent a flood, ie, all the ceiling tiles came out from the ceiling. I've shown you-I've submitted pictures of that.
CHAYTOR, Q.C.:
Q. Yes, and I'll take you to that when we have more time after lunch.
MR. GULLIVER:
A. And I know when that event happened, it was in the evening. Barry called me. It happened in our microbiology lab also. That's the part of the lab that were really affected. We went in to work as soon as possible. We were trying to cover up equipment with plastic and while ceiling tiles were falling from our heads. And -
CHAYTOR, Q.C.:
Q. And I will ask you about, but, Mr. Gulliver -

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MR. GULLIVER:
A. And I know after that a lot of material had to be discarded in pathology because it was asbestos contaminated.
CHAYTOR, Q.C.:
Q. Yes. And this gives us the date. There's a date up here?
MR. GULLIVER:
A. Yeah. And this would be the log that the computer would keep.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. When the runs were being done, I think, yeah.
CHAYTOR, Q.C.:
Q. So are you able to tell the Commissioner where are the logs from the computer?
MR. GULLIVER:
A. I can't, no, no.
CHAYTOR, Q.C.:
Q. Okay. We'll take the break there, please?
COMMISSIONER:
Q. All right, then. We'll meet again at ten after two. Thank you.
(LUNCH BREAK)

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THE COMMISSIONER:
Q. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Good afternoon, Commissioner. Good afternoon, Mr. Gulliver.
MR. GULLIVER:
A. Good afternoon, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. We have two new exhibits this afternoon, Commissioner. P-3030 and P-3119, if I could have those entered?
THE COMMISSIONER:
Q. 3030 and 3119?
CHAYTOR, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. Entered.
EXHIBIT ENTERED AND MARKED P-3030.
EXHIBIT ENTERED AND MARKED P-3119.
CHAYTOR, Q.C.:
Q. Thank you. Now, Mr. Gulliver, before we broke for lunch I was asking you about the DAKO machine and what happened with the DAKO machine. And we were talking about documentation that was stored on the computer

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of the DAKO machine. I'm just wondering, perhaps you could tell us or tell the Commissioner what, in fact, happened to the DAKO machine?
MR. GULLIVER:
A. To the instrument itself?
CHAYTOR, Q.C.:
Q. Yes, what happened to it?
MR. GULLIVER:
A. To the best of my recollection once the pathology lab had fully implemented the Ventana system, which was in a, you know, a different physical part of pathology lab, the DAKO instrument stayed in the back bench of pathology. It was there for, I guess, many, many, many months. And again, as I alluded to before our lunch break that unfortunately, I think it was November of '04, there was an unexpected event in the lab where there were maintenance workers working on the second floor Health Sciences, they had triggered off the sprinkler system and all the water came down into--and the tiles from pathology, microbiology lab. After that event is when the DAKO instrument was pretty well disposed

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of. It had not been used then for months and months.
CHAYTOR, Q.C.:
Q. Okay. And perhaps then we could look at, please, P-3109? I'm just going to take you to page 2 of this exhibit. There's some photographs.
MR. GULLIVER:
A. And these were taken after we did a bit of covering up and some clean up.
CHAYTOR, Q.C.:
Q. Okay. So these are, these photos depict the damage to the pathology lab after the flood that you're referring to?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And I think we see Mr. Dyer here. Do we have--do you see in any of those pictures, if you want to, you can just scroll down, do you see the DAKO machine in the photographs? If you could point that out to us?
MR. GULLIVER:
A. No, and I don't think--one of my managers gave me these pictures just recently.

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CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. I don't think we have pictures of the very back of the pathology lab.
CHAYTOR, Q.C.:
Q. Okay. So, for example, this is not, this is not the -
MR. GULLIVER:
A. No, that's a microtome.
CHAYTOR, Q.C.:
Q. That's a mic, yeah.
MR. GULLIVER:
A. And that would be an embedding machine.
CHAYTOR, Q.C.:
Q. And that's not it, either?
MR. GULLIVER:
A. And that's the tissue processor in the gross room.
CHAYTOR, Q.C.:
Q. And so what about this tissue processor, was that salvageable?
MR. GULLIVER:
A. Oh, yes, yeah. I mean, when this happened, I put out an alert to several of my managers and

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staff, I don't know if it was a Friday night or a Sunday night, it was like late at night, where we came in and we tried to start covering as much of the big instruments as possible.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. But there was a significant amount of damage done, as you can see. And there was a significant amount of, like, we lost reagents and paperwork, documentation. And the issue, the big issue was that the facilities management people called in this, you know, like a clean-up team immediately and they detected asbestos throughout all parts of the lab.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. And from that point onwards no lab person was allowed in there until it was all cleaned up and finished. And that took about, I think, four, five, six weeks.

CHAYTOR, Q.C.:

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Q. Okay. So there's no photo, though, that would actually show the DAKO machine?

MR. GULLIVER:

A. I don't see it there, no.

CHAYTOR, Q.C.:

Q. Okay. And so then you said this happened when, in late, was it 2004?

MR. GULLIVER:

A. I think this might have been like October, November, 2004.

CHAYTOR, Q.C.:

Q. Yes. And the DAKO machine you said was disposed of shortly thereafter. Where did it go?

MR. GULLIVER:

A. A gentleman who we had a long-term relationship with, Joe White, he's a local technical guy from lab--from a lab technical guy, our lab had used his services for repairing microtomes, microscopes, cryostats, various kinds of things and there were lots of occasions where if we were disposing of, like an old microscope that was 40 years old, he may--we may give it to him and he'd just take it and take it apart and use it for parts for

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repairing new scopes or something that was salvageable. Other times in the lab if we had equipment that was no longer of use, it would just go to the dump. Other times if the company still owned the equipment, the company would have to come in and take the equipment back and pay for the freight and transport. Other equipment in the labs, we would offer to CONA, the third year--the training program for med lab technologists and we would say to CONA, look, you know, we have an old chemistry analyzer, a hematology analyzer, you know, would you need it for training students for simulation labs up at CONA. Sometimes they would say yes and we'd, you know, pass the equipment on to them. So it was various means of disposing of--the DAKO machine that we owned it.

CHAYTOR, Q.C.:

Q. You owned it at that point?

MR. GULLIVER:

A. At that point, yes. I mean, it was end of lease and it was eight-years old and it was really our property. Generally I would either pop an e-mail or make a phone -

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CHAYTOR, Q.C.:

Q. In 2004 it was eight-years old? You acquired it in '98?

MR. GULLIVER:

A. I think '96, '97, '98, so it was like six-years old.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. Yeah. I would either pop an e-mail or make a phone call to our purchasing department, Bruce Gorman, and say, "Look, we have an old piece of equipment here. Do you know anybody wants it?" Or I would tell him that nobody wants it and that we're just going to give it away or throw it to the dump.

CHAYTOR, Q.C.:

Q. And so what happened in this particular situation, it was given, I take it then, to Mr. White?

MR. GULLIVER:

A. In this case Joe, I mean, who had been in our lab lots of times and, you know, fixing microtomes and microscopes and different things, odds and ends, he pretty well said,

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you know, if we're going to throw it out, you know, could he have it. And there was a process the Health Care Corporation had where, like, you call the purchasing, you know, someone could buy it for a dollar, like just to have something like that. And, Ms. Chaytor, I've looked for--I don't have any documentation where, you know, we actually sold it for a dollar to Mr. White.

CHAYTOR, Q.C.:

Q. So there's no paperwork that was -

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. - completed regarding the disposal to Mr. White?

MR. GULLIVER:

A. No. Yeah. But that's where it ended up going to.

CHAYTOR, Q.C.:

Q. And before you would do that, though, why would you just give it away, was it--it was still operational when you stopped using it. That wasn't the reason you stopped using it. And you had acquired then the Ventana. And so

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why would just give it away, was there any kind of appraisal done to determine whether or not it had any value?

MR. GULLIVER:

A. Not to my knowledge, there was no--and it's like all--we have over 1000 pieces of equipment in the laboratories in Eastern Health.

CHAYTOR, Q.C.:

Q. This was a $65,000 piece of equipment six years before.

MR. GULLIVER:

A. Six years before, yes.

CHAYTOR, Q.C.:

Q. And in terms of the depreciated value, do you know what it was worth in late 2004?

MR. GULLIVER:

A. No, I don't. Laboratory tech--laboratory medicine and technology is always changing. We have disposed of chemistry analyzers that were $500,000 to buy or at least six years prior. By that point they've pretty well--technology has changed and really you would have to almost go to, I don't know, I won't say third world countries, but you wouldn't

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find a use for them in another large clinical lab anywhere.

CHAYTOR, Q.C.:

Q. But this DAKO system you would?

MR. GULLIVER:

A. No, I wouldn't, because the DAKO system, the only lab in Newfoundland that was using or doing this technology was the Health Sciences lab.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. So if it was no longer of use to us, there was no sense calling Gander, Grand Falls or Corner Brook or St. Anthony and saying, "Would you like to have this used piece of equipment?" because they don't do the testing -

CHAYTOR, Q.C.:

Q. But it was in use in other places across the country?

MR. GULLIVER:

A. Oh, certainly would be, yes.

CHAYTOR, Q.C.:

Q. Yes, yes. Because you said acquiring the Ventana system was something fairly new and -

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MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. - Newfoundland was one of the first to acquire that system. So I take it that the same machine or same type of machine was in use widespread across the country?

MR. GULLIVER:

A. I would assume so, yes.

CHAYTOR, Q.C.:

Q. Okay. So there was nothing done in terms of determining what the value of the machine was?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Was the machine damaged in the -

MR. GULLIVER:

A. You mean dollar value?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Was the machine damaged, I really can't tell you for sure, Ms. Chaytor. You know, I know that, as you can see in some of those pictures, that pretty well all parts of the

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main pathology lab were what you see there in those pictures. It had been sitting unused by this time for months and months in the old--in the back of the pathology lab. And I guess we were cleaning out the lab, I guess we just thought it was time, well, we're using Ventana now for months, it's fully implemented and actually, I think our first thought was just, well, throw it out with everything else that had to go from this.

CHAYTOR, Q.C.:

Q. So in terms of what we see here in the photographs, would there have been an insurance claim for this damage?

MR. GULLIVER:

A. We, well see most of the damage you see there, luckily enough it could have been significant, luckily enough myself, Mr. Dyer and I think Gail Norris (phonetic) or any other staff, we made phone calls late in the evening and, you know, you see all those plastic things, the plastic, it was us, the lab staff who responded and tried to protect most of our major equipment.

CHAYTOR, Q.C.:

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Q. So was there an insurance claim?

MR. GULLIVER:

A. We never lost any, I think major equipment that was severely damaged. Obviously we had to have people come in and do PMs on the stainers and coverslippers and those things to ensure they're still operational. The damage that we lost was really like documentation and papers that were in drawers and cabinets for a long time. I think we lost about $25,000 in like lab reagents that we could no longer rely upon to make sure that they were okay. I think we lost a refrigerator and I think we might have lost an oven and I had to submit sort of an estimate to our purchasing people and facilities management people for the estimate cost, direct damage cost to the pathology lab.

CHAYTOR, Q.C.:

Q. And was the DAKO machine included on what you submitted?

MR. GULLIVER:

A. I don't think--no, I don't think so, nor was our tissue processors or nor was our coverslippers and stainers and microtomes on

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the list because we had those cleaned up and had them PM'd to put back in use.

CHAYTOR, Q.C.:

Q. Okay, so the machine that -

THE COMMISSIONER:

Q. Sorry, PM'd?

MR. GULLIVER:

A. Oh, preventative maintenance.

THE COMMISSIONER:

Q. Thank you.

CHAYTOR, Q.C.:

Q. So the machine is in the back of the lab at the time of the flood, which is October/November you say, 2004. The Ventana had been up and operationalized since April, 2004 we understand.

MR. GULLIVER:

A. Well it was installed in late December '03, early January '04.

CHAYTOR, Q.C.:

Q. And then there was a period, transition period which we understand both systems would have been used to do the validation. So by April, 2004, the machine, the DAKO machine had not been in use, that's right?

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MR. GULLIVER:

A. (No audible response).

CHAYTOR, Q.C.:

Q. So at what point then--after this you contact Mr. White, did you make the contact with Mr. White.

MR. GULLIVER:

A. Oh, I didn't think at all, no, I think Joe happened to be in the lab and I don't know the exact events, I know Joe was probably in the lab maybe after post flood and he was the one that was doing our microtomes, as you see in some of the pictures with the waterbaths, that he was just kind of servicing our microtomes to make sure everything was functioning and operating properly and I would say it was Joe probably said if you're going to throw out that old autostainer, you know, he could certainly take it and use it for parts or check it out or whatever.

CHAYTOR, Q.C.:

Q. And so there was no paperwork done in terms of the transaction?

MR. GULLIVER:

A. I don't remember, I mean other times, I

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remember, you know, a couple of years ago from Abbott Diagnostics, we disposed of two blood gas machines. They had been sitting out in the corridor in the Health Sciences corridor for months and months and months. I called Abbott to say did you want them back? And they said no, they don't want them, you can throw them out, and I would just call purchasing and say there's two old blood gas machines, we're just going to throw out in the dump and that's where they went to.

CHAYTOR, Q.C.:

Q. Okay. But in terms of the DAKO machine, you don't remember if there was any paperwork done.

MR. GULLIVER:

A. I can't remember.

CHAYTOR, Q.C.:

Q. Certainly no money changed hands, Mr. White didn't pay for it.

MR. GULLIVER:

A. No, if any money, it would be a dollar. I mean, that was the policy of Health Care Corporation.

CHAYTOR, Q.C.:

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Q. And there was no appraisal carried out on the machine to determine whether or not in fact it had a dollar value at the time that the transaction was done with Mr. White?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And Mr. Gulliver, when you're in a situation where there's--you're in obviously fairly tight financial constraints as we've heard throughout your evidence here, why wouldn't you have done that to find out whether or not there's any residual value that you could get from this machine?

MR. GULLIVER:

A. Again, like I just mentioned to you, I mean, I'm director of all medical labs. We have over a thousand pieces of equipment. We are just hardly a week or two weeks go by where we're not upgrading or replacing some piece of equipment. Some are much more expensive, some are not expensive. This piece of equipment that we paid, you know, $65,000 for in 1998, that's sort of a cheap piece of equip--that's cheap for lab equipment. We have analyzers

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that are worth over a million dollars. Again, you're asking me why don't we have a process in place where ever piece of equipment that's now outlived its useful life for us, the process that we have was to dispose of it if it was no good to us. If there were another lab in Newfoundland that I knew would use it or had this testing, I would offer it to them free of charge. We would offer to the college for training of students, but this is not a part of the students' training program for IHC testing and so I knew it would not be useful to them. But, and really to tell you the truth back at the time, I guess I didn't think that it was, a lot of value left on that particular instrument. For example, recently we bought two new tissue processors back in December to replace our current two. We kept one of the current two as a back up to the two and the older one we did go to someone and say, look, we're buying two new ones, do we have any value left in this one? And, you know, they said it was probably worth $1,500 and that's a lot more expensive than what, you know, the autostainer would be. So we're not

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talking about millions of dollars or hundreds of thousands of dollars in value.

CHAYTOR, Q.C.:

Q. The machine itself went to Mr. White, what about the computer that accompanied the machine?

MR. GULLIVER:

A. I'm not sure. Well I know the computer did not go to Mr. White, a hundred percent sure of that.

CHAYTOR, Q.C.:

Q. And how do you know that?

MR. GULLIVER:

A. Well I asked him.

CHAYTOR, Q.C.:

Q. When did you ask him that?

MR. GULLIVER:

A. Well weren't you asked to provide documentation for the inquiry -

CHAYTOR, Q.C.:

Q. And what did Mr. White tell you.

MR. GULLIVER:

A. I spoke to Mr. White and he said he definitely, the computer wasn't even there and I'm thinking the computer was probably thrown

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out in through all this clean up.
CHAYTOR, Q.C.:
Q. So Mr. White just in the past couple of weeks told you that he definitely did not take the computer that went along with the DAKO machine?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And so the computer portion itself then and the records that were stored on the computer, what happened to those?
MR. GULLIVER:
A. I'm just assuming that the asbestos clean up team who came in for that four to six week period the lab was closed down, that those things would have been discarded.
CHAYTOR, Q.C.:
Q. Can the DAKO machine work without the computer?
MR. GULLIVER:
A. I guess so because it's just a mechanical device, it's just a dispenser.
CHAYTOR, Q.C.:
Q. The autostainer.

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MR. GULLIVER:
A. The autostainer?
CHAYTOR, Q.C.:
Q. Does it need though the software that goes with it?
MR. GULLIVER:
A. I have no idea.
CHAYTOR, Q.C.:
Q. The computer then and the records, if we could just go back then please to--we had it up earlier today, P-2152? And I think it was page 8 of this document, Registrar. So this type of document that I was showing you here, Mr. Gulliver, this record and these are the types of records that I understand would be generated by the computer from the DAKO.
MR. GULLIVER:
A. And again, like I said to you, I mean, I've never used the DAKO instrument, so I can't tell you exactly how the instrument, how the computer interacted with the instrument. I do know that when the system came in, that pretty well you took your protocols for your antibodies and put a template into the system, which I know Peggy Welsh did at the time

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because Mary was not really--Mary just didn't like computers and if it was involving computers, Peggy would do the computer work and I really don't believe that, I think this was the template for the ER, one in 50 dilution at 30 minutes. The protocol was your hydrogen peroxidase at five minutes, protein block, the ENVISION label polymer for 30 minutes and your Dabb for 15 minutes.
CHAYTOR, Q.C.:
Q. Uh-hm.
MR. GULLIVER:
A. I think this was like a one-time set up, but when they did their runs, like this didn't come off every single day they did a run, that a bunch of these sheets printed off, I mean, it wasn't like that. They actually had their own manual worksheets that they used to kind of implement into the DAKO system.
CHAYTOR, Q.C.:
Q. So the DAKO autostainer went to Mr. White, the computer was disposed of, you don't know -
MR. GULLIVER:
A. To the best of my knowledge, I think it would have gone post clean up from that flood, the

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damage.
CHAYTOR, Q.C.:
Q. Is there any policy in place to say what has to happen to any records that may be stored on a computer prior to its disposal?
MR. GULLIVER:
A. No. Our policy for recordkeeping is more of a Meditech system which keeps a record of every single procedure a patient has had done, whether it was done, the DAKO instrument, that information is transcribed into the patient's record as a permanent record and our records would be the permanent blocks and slides that were done by the lab.
CHAYTOR, Q.C.:
Q. Were you present when Mr. White removed the autostainer?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Were you present when the computer was disposed of that went along with the autostainer?
MR. GULLIVER:
A. I didn't work in that lab, I -

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CHAYTOR, Q.C.:
Q. No, I'm just wondering if you were there.
MR. GULLIVER:
A. Nobody was there.
CHAYTOR, Q.C.:
Q. So nobody knows what happened to the computer?
MR. GULLIVER:
A. After the flood we were given, I think Mr. Dyer was the only one, we were given a day to go in and identify what equipment has to stay there that we can probably, that we're still using and can be usable afterwards. After that, the whole place was sealed off and there were people in there, you know, working with the gas masks and the white clothing and they pretty well discarded what they--anything they thought that could have been contaminated with asbestos.
CHAYTOR, Q.C.:
Q. So wherever the computer ended up and whatever records were on it -
MR. GULLIVER:
A. I don't know.
CHAYTOR, Q.C.:
Q. You don't know.

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MR. GULLIVER:
A. I can't say, no.
THE COMMISSIONER:
Q. Did I understand you correctly, Mr. Gulliver, that the policy regarding records for Eastern Health covers only Meditech?
MR. GULLIVER:
A. No, no, no, the record that we have is in Meditech every single patient individual report with whatever procedures are performed and tests are performed and the interpretation and results -
THE COMMISSIONER:
Q. I understood that, but is there not a policy regarding disposing of equipment that might contain records related to patients, like the computer?
MR. GULLIVER:
A. I'm not aware of one. It could be, Justice Cameron, it could be an organizational policy.
THE COMMISSIONER:
Q. All right, thank you.
CHAYTOR, Q.C.:
Q. So you're not aware of anything in the way of a policy that has to do with preservation of

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records?
MR. GULLIVER:
A. Well, again records, if you're talking about blocks and slides, there's policies, but you're talking about records that may be on a PC.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. I don't know. Any PCs--generally any PCs that are being replaced, IT are the ones who come and take them away and replace them. So what they do with any permanent records on them, I don't know, but most of the--understand that in pathology at this point in time, that's probably the only PC we had that was used only for the DAKO autostainer.
CHAYTOR, Q.C.:
Q. So you're not even to this day aware of any policy that would pertain to the preservation of records, such as what we're seeing here in P-2152?
MR. GULLIVER:
A. Not that I'm aware of, no.
CHAYTOR, Q.C.:

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Q. Or anything at all that would have information that may pertain to a patient's care?
MR. GULLIVER:
A. Well, this doesn't pertain to the patient's care. There's no patient identification here.
CHAYTOR, Q.C.:
Q. We have a surgical number.
MR. GULLIVER:
A. I know, and that's non-identifier. All you have here is the protocols that were run on the instrument. It's not patient care records.
CHAYTOR, Q.C.:
Q. So for this type of a record, you're saying there's no policy in place in terms of -
MR. GULLIVER:
A. Not to my knowledge, there could be.
CHAYTOR, Q.C.:
Q. And what about the practice that you said has developed in terms of the disposal of laboratory equipment over the years, is there any policy or procedure in place pertaining to acceptable disposal of equipment?
MR. GULLIVER:
A. There is a policy that's from the purchasing

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department where you have to follow through, and if you're going to dispose of a piece of equipment, you know, it can be sold off for a dollar. Like, that's the exchange, but internally in the lab -

CHAYTOR, Q.C.:

Q. So if it's a piece of equipment that's deemed to have no value, or do you have to have anything -

MR. GULLIVER:

A. Well, it has no value to us any more. If we're finished using it, then it has no more value to us on a daily basis to use it. We do make phone calls to the college, which I do, have done regularly, and offer equipment to the college. Now that we are Eastern Health, for example, we have upgraded equipment in the last two years in hematology chemistry, and we've actually taken equipment from Carbonear and put it down in Old Perlican and vice versa to extend the life of the equipment and offer better testing in those sites, but if that's no longer possible, then it's disposed of or just sold for a dollar.

CHAYTOR, Q.C.:

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Q. Did Mr. White do anything or offer any services in exchange for the machine?

MR. GULLIVER:

A. Actually, while you're asking me, I'm thinking that. I think Joe may have come in on a Saturday and Sunday and serviced most of the microtomes in the pathology lab, just to do a routine maintenance cleaning and checking on them, almost like in lieu of taking away the old autostainer.

CHAYTOR, Q.C.:

Q. So like a barter system?

MR. GULLIVER:

A. Something like that, yeah.

CHAYTOR, Q.C.:

Q. And in terms of the decision to allow the equipment to leave the laboratory, who ultimately made that decision?

MR. GULLIVER:

A. Probably myself.

CHAYTOR, Q.C.:

Q. And would you have had to have any approval from anyone else?

MR. GULLIVER:

A. Again I think I'll probably just call Bruce

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over in purchasing and say, Bruce, we have an old stainer here, it's of no use to anyone else in the province, no one else does the testing, and we're going to throw it to the dump or I'm going to give it to Joe White. I think I probably made the phone call and did that.

CHAYTOR, Q.C.:

Q. And this would have been then some time after you flood. So some time after October/November '04. Do you know exactly when it was, Mr. Gulliver?

MR. GULLIVER:

A. I don't know, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Could it have been early on into 2005?

MR. GULLIVER:

A. I don't know. It could have been--I mean, the flood was November '04. It could have been January '05, it could have been February '05, because the lab was really unaccessible for four to six weeks. I can't give you an exact date.

CHAYTOR, Q.C.:

Q. So then this issue of the ER/PR arises in the

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spring of 2005--well, April is Peggy Dean's test.

MR. GULLIVER:

A. Really July '05.

CHAYTOR, Q.C.:

Q. And May 17th is the first time you learn of it in 2005. I'm sorry, why would you say that the issue arose in July?

MR. GULLIVER:

A. We covered May of '05 is when I was made aware that there was one patient who retested and was negative went to positive.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. It's really not until early July before I'm actively involved in it.

CHAYTOR, Q.C.:

Q. Yes, but the issue itself certainly has arisen and you've been part of meetings then after that. Within two weeks, you told us earlier this morning, you were -

MR. GULLIVER:

A. No, I think within two weeks, I receive a copy of a memo from Dr. Cook or Dr. Williams showed

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me a memo that was written to Dr. Williams.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Talking about several more cases.
CHAYTOR, Q.C.:
Q. And then in June, you're involved in meetings?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. So I'm just wondering then, when it comes up in the spring and summer of 2005, and we see in some of the documentation that there's concern is this a machinery issue, is this an equipment issue, is it because of the change from the new to the old system, did anyone ask where's the old system, where's the machine?
MR. GULLIVER:
A. I don't think so, because we had been using the Ventana by this time, '05, for a year and - almost a year and a half.
CHAYTOR, Q.C.:
Q. So nobody thought to ask that, you know, where's the piece of equipment that we were using?

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MR. GULLIVER:
A. Not to my knowledge, no.
CHAYTOR, Q.C.:
Q. And did you think about that? Did you think about, well, if we're thinking it may have been something with the old DAKO system, maybe I should contact Mr. White and ask do you still have it?
MR. GULLIVER:
A. No, because I did never think it was the old DAKO system.
CHAYTOR, Q.C.:
Q. You never thought that?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. You never thought it was the equipment?
MR. GULLIVER:
A. It's--it's a liquid dispenser. It doesn't perform the test. It aids in performing the test, so I never thought the DAKO instrument was at fault and where is the old instrument to. That wasn't my thinking.
CHAYTOR, Q.C.:
Q. So in terms of it being explained through any

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difference in the equipment, what were you thinking?
MR. GULLIVER:
A. What exactly are you asking?
CHAYTOR, Q.C.:
Q. And maybe I misunderstood you last day when we were talking about this, but did you at all think there was any--that any of this could have been attributable to the fact that you had gone from the DAKO system to the Ventana System?
MR. GULLIVER:
A. No, at the time what I thought was the new Ventana System, which you've asked and we've seen now, the new Ventana System with the on board antigen retrieval, with the minimizing the human interaction in performing the procedure, that the new system was giving us positive results, I didn't think it was giving us positive results because the old system wasn't working, it was giving us better results because the new system was a better system.
CHAYTOR, Q.C.:
Q. But if the new system is better, and the old

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system gave you negative, isn't there something wrong with the old system?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. No.
MR. GULLIVER:
A. And I'm going to apply the same principle to the other thousand pieces of equipment that we have in the lab. You bring in new equipment with new technology, and do we say, well, if we're getting a better more accurate INR results from this new automation, does that mean what we did for the past eight years was inaccurate.
CHAYTOR, Q.C.:
Q. I just want to be clear then, Mr. Gulliver. So it wasn't that you weren't of the view that the change of platforms may have been a factor; you, in fact, thought that was what was happening and that the new Ventana System was much more better, so you were getting positive results from your new Ventana System which were showing up as negative results in your DAKO System?

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MR. GULLIVER:
A. I'm saying that that could be a possibility, yes.
CHAYTOR, Q.C.:
Q. And that's what you thought at the time?
MR. GULLIVER:
A. Yeah.
THE COMMISSIONER:
Q. So at no point did you think there was a deficiency or DAKO was causing a problem, or there were errors in DAKO?
MR. GULLIVER:
A. I never did.
THE COMMISSIONER:
Q. You just thought--you just upgraded and this new system is calling things better?
MR. GULLIVER:
A. Right, and, I mean, we shouldn't even say the DAKO System and compare it to Ventana System. The Ventana System in my opinion is a system that it automates the antigen retrieval, it automates your slide during the procedure, you have your pre-optimized diluted antibodies, it's under a much more controlled environment. The DAKO was a machine, it wasn't a system.

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It was a machine that you took your slides off the bench, you put them on the machine, and you programmed the machine and it dispensed the liquids that you already made up yourself and made your own dilutions. That's all it did. So I never once thought the DAKO machine was something wrong with it and was malfunctioning for six years.
CHAYTOR, Q.C.:
Q. And you had no maintenance records, I take it, that would have suggested that, that there had been something wrong or something -
MR. GULLIVER:
A. Nothing major, just routine mechanical things. maybe the pump had to be replaced, or a tubing replaced, because it's just a mechanical instrument, but nothing to alert us to say that the DAKO machine wasn't functioning properly for an extended period of time or for a long period of time.
CHAYTOR, Q.C.:
Q. Or for any period of time?
MR. GULLIVER:
A. Or for an period of time.
CHAYTOR, Q.C.:

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Q. So Ms. Gulliver, the DAKO machine itself, as far as you knew, was functioning fine, there was nothing wrong with the machine itself, and I take it you would have been aware that that was a machine that was widely used across the country?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. If we could have, please, P-1586. This is an e-mail from Deborah Thomas to a number of people, including yourself, Mr. Tilley, Dr. Cook, and Heather Predham, July 20th, 2005, copied to Ms. Bonnell, and it's regarding a briefing note on ER/PR, "Hi, as discussed, here is the briefing note updated to today. Any changes please call me", and her number is there, "We can sign off. I'll wait to hear from you", and this is the briefing note. On page four of this exhibit, the last bullet says, "Dr. Williams has also asked if we could repeat any of the negative tested samples again on the "old DAKO system" to confirm that it was indeed the system and not a lab error. Terry Gulliver says it is unlikely we would be

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able to obtain such a system at this time to retest on that method", and do you remember that, Mr. Gulliver?
MR. GULLIVER:
A. Probably.
CHAYTOR, Q.C.:
Q. And did you, in fact, advise that it would be unlikely to be able to obtain such a system?
MR. GULLIVER:
A. I think so. I mean, this is summer of '05 and you know, the DAKO autostainer we had in '98, I think by this time DAKO has--you know, they have the new improved, the DAKO autostainer two. So the exact one that we had, I knew that it was gone.
CHAYTOR, Q.C.:
Q. And you made no inquiries of Mr. White to see whether or not he still had it?
MR. GULLIVER:
A. No, I didn't, no.
CHAYTOR, Q.C.:
Q. Okay, and you made no inquiries of anywhere else to find out who else may, in fact, be using that system?
MR. GULLIVER:

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A. The exact system, no, I didn't call every lab in Canada and ask them what system are they using.

CHAYTOR, Q.C.:

Q. And if we could have P-0075, please? So you take--you don't take exception with that, and that is accurate of what you would have told Dr. Williams at the time?

MR. GULLIVER:

A. Yeah, I can see myself saying that, yeah.

CHAYTOR, Q.C.:

Q. And that ends up in the briefing note that goes to Minister Ottenheimer on July 20th or July 21st, I believe it was given to him. So we see that same paragraph here. So when Dr. Williams is making the inquiry about the possibility of repeating the negative tests on the old system and you tell him that, well, it's unlikely you're going to be able to obtain such a system, you don't have any discussion with him about "well, it's only been two or three months or four months or however, how long since Mr. White walked out of here with the system. Maybe I'll make some inquiries and see what we can do"?

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MR. GULLIVER:

A. No, I did not, and the system we're talking about, the machine we're talking about, as you see in the flood, I had no idea what the--if it was still operational, not operational, what condition it was in when it left. It had not been used for months and months and months. It was sitting in the back of the lab. It's been just sitting there unused and what I did suggest is that we would contact Montreal University Health Network. I knew Montreal had a DAKO system and maybe we should send some of our cases out to another site and ask them to retest on their DAKO system to compare results. That would be my best suggestion, as opposed to us trying to find another mechanical instrument somewhere and having it flown into St. John's to see if we could retest to see if it was the system.

CHAYTOR, Q.C.:

Q. And the first time then that you do contact Mr. White is in the past couple of weeks after we made further inquiry regarding the location?

MR. GULLIVER:

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A. Pretty well, yeah, just to verify that yes, he was the--his company is the one that actually took away the instrument.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-3109 again? This is the exhibit with the photographs, but on the first page we have a letter and Registrar, if you could just increase that, please? It's a letter signed by Joe White, general manager of General Technical Services, dated September 17th, 2008. Mr. Barry Dyer, pathology manager, Eastern Health. "Hi, Barry. In response to your inquiry regarding the DAKO Autostainer, I removed the instrument from the Health Sciences Complex somewhere in the general time frame of late 2004, early 2005 with the permission of lab director, Mr. Terry Gulliver." And so why do you understand that Mr. White provided this letter at this time?

MR. GULLIVER:

A. Oh, well, we were being asked by, you know, here, during this Inquiry, you know, where is the old machine to and who--how did we dispose of it. So I was asked to provide--to contact

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Mr. White at General Technical Services and you know, ask him to verify that he indeed is the one that took away the old machine.

CHAYTOR, Q.C.:

Q. Okay, and did you have any other conversations then with Mr. White about this?

MR. GULLIVER:

A. I think I asked him about the old computer and he said there was definitely no computer. That was already gone.

CHAYTOR, Q.C.:

Q. Okay, and -

MR. GULLIVER:

A. See, the machine sat, Ms. Chaytor, in the lab. The computer was on this bench and the machine was on a separate table over here. So most of what's on the benches, all the tiles fell mostly where the computer was to.

CHAYTOR, Q.C.:

Q. And did he tell you what he did with the machine?

MR. GULLIVER:

A. Well, I asked him what he did with it.

CHAYTOR, Q.C.:

Q. Yes.

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MR. GULLIVER:
A. And he said that he took it away. He cleaned it up. He said he did a PM on it. It was mechanical stuff and he knows mechanical things, like microscopes and microtomes and cryostats and stainers and those things. He said he took it away, he checked it out. He fixed it up, did the PM. He did like what he called the diagnostics check or something like that on it, and then I think he probably sold it to contacts in third world countries or there's other--there's people in the world that look for old equipment.
CHAYTOR, Q.C.:
Q. And that's what he told you, it went to a third world country?
MR. GULLIVER:
A. No, no, I'm saying there are organizations in the world, I think you can go on Google on e-bay, you might find those kinds of things.
CHAYTOR, Q.C.:
Q. Yes, where did this machine go, to your knowledge? What did Mr. White tell you?
MR. GULLIVER:
A. Well, he told me that he sold it after he did

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the PM, the diagnostics and fixed it up, and I think he said that it went to the Bahamas or Bermuda or somewhere like that.
CHAYTOR, Q.C.:
Q. Or maybe the United States?
MR. GULLIVER:
A. No, the Bahamas is what sticks out in my mind.
CHAYTOR, Q.C.:
Q. And if we could have, please, 3110? And do you know whether or not, Mr. Gulliver, the machine is still in existence working anywhere?
MR. GULLIVER:
A. Say it again?
CHAYTOR, Q.C.:
Q. Do you know whether or not the machine -
MR. GULLIVER:
A. I think it's--well, he told me, he said he thinks it's still in operation somewhere in Bahamas.
CHAYTOR, Q.C.:
Q. And 3110 and this is e-mail exchange between myself and Mr. Simmons about the location of the machine, and then on September 18th, 2008, Mr. Simmons provides to me and Mr. Coffey "a

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summary from Terry Gulliver of how the DAKO autostainer came to be disposed of. I have asked Terry to let me know if he knows what Mr. White did with it, and if Mr. White knows where it is now" and then he quotes and there's a quoted section here, and he says "the DAKO instrument was physically located in the back bench of the main pathology laboratory where IHC testing took place up until early 2004. Once the new Ventana system was installed, the IHC testing was physically relocated to its own space where it currently exists today." Mr. Gulliver, I should ask you, is this--this is the information, I take it, you provided to your counsel?
MR. GULLIVER:
A. I sent this e-mail back, yeah.
CHAYTOR, Q.C.:
Q. And "the DAKO instrument remained in the back of the pathology lab for many months unused, as the Ventana system was fully implemented. In late 2004, the pathology suffered an unexpected flood that brought many of the ceiling tiles down on the pathology benches, floor, etcetera. The DAKO machine was sitting

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in the flooded part of the pathology lab. It was decided to dispose of the old DAKO machine after the flood, along with a lot of other items in the pathology laboratory." And so the decision to dispose of the old DAKO machine, Mr. Gulliver, whose decision was it?
MR. GULLIVER:
A. Well, it's just generally the lab. I mean, the division who's using it first will decide. "Well, we're no longer using it. It's not of use to us, so we have to get rid of it."
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. I don't decide to dispose of chemistry analyzer. The chemistry division people say "okay, we have this old equipment. We need to get rid of it. What are we going to do?"
CHAYTOR, Q.C.:
Q. So you and your pathology manager decided?
MR. GULLIVER:
A. It would be, yes.
CHAYTOR, Q.C.:
Q. "In December 2004 or January 2005, the old DAKO instrument was taken away by Mr. Joe

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White, General Technical Services. Mr. White has dropped off a letter indicating that he indeed took away the old instrument." The dates of December '04, January 2005, where do you get those?

MR. GULLIVER:

A. That's just my recollection. That's all.

CHAYTOR, Q.C.:

Q. That's your own recollection?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. "The old computer with the DAKO machine, along with a fair bit of paper documentation was discarded during the clean up of the flood," and again, we've talked about that.

MR. GULLIVER:

A. That's the best of my knowledge, yeah.

CHAYTOR, Q.C.:

Q. Best of your knowledge, but--and you've made inquiries, I take it, and nobody knows where the actual computer ended up?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

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Q. Nor the records from the computer?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Is that correct?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. "The pathology laboratory, Barry Dyer was given permission then to enter the area to identify equipment that could be saved, and Mr. White has confirmed that he only took the DAKO instrument and not the old PC. There were no records kept with the DAKO machine's hard drive." And what does that mean?

MR. GULLIVER:

A. Well, on the machine itself, I mean, there was no hard drive on the -

CHAYTOR, Q.C.:

Q. On the autostainer.

MR. GULLIVER:

A. - on the autostainer, right.

CHAYTOR, Q.C.:

Q. There were also no records, disks, from the old PC anywhere in the lab, and what inquiries

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have you made, Mr. Gulliver, to be able to assert that?

MR. GULLIVER:

A. Well, it's over in the lab. I mean, Mary Butler, the technologist, and Les Simms and Ken Green and Barry have searched to provide documents for this Inquiry, started at year ago, and they were not able to find--whatever we found, we passed it in. But in that part of the lab where IHC used to take place, there were multiple large drawers and they would keep their paper records and requisitions and those things in there and pretty well most of that stuff was gone.

CHAYTOR, Q.C.:

Q. Okay. So in terms of we received some new documents from you yesterday that you found in an old filing cabinet. I'm just wondering was there any--is this any new information.

MR. GULLIVER:

A. Oh no, no, no.

CHAYTOR, Q.C.:

Q. Was there a new search done?

MR. GULLIVER:

A. No.

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CHAYTOR, Q.C.:

Q. So this is whatever was done -

MR. GULLIVER:

A. Back done a year ago.

CHAYTOR, Q.C.:

Q. Yes. "We can only assume then that when the PC was discarded after the flood, any disk, paper records went with it." And then on page three of the exhibit, a couple of days later, September 22nd, 2008 and Mr. Simmons again e-mails to us with your reply to the question about what Joe White did with the DAKO autostainer. "When Joe came in with the letter, I asked him that question. He said that when he took it, he cleaned it up, did a few minor repairs, performed diagnostic check and preventive maintenance. At some point, he sold it to a surplus equipment place and he thinks it is in Bermuda or Bahamas." And Mr. Gulliver, in terms of--you had a chat, I take it, when Mr. White dropped off the letter?

MR. GULLIVER:

A. Just for a few minutes, yes.

CHAYTOR, Q.C.:

Q. And what does it mean to perform a diagnostic

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check? How do you do that?
MR. GULLIVER:
A. I don't know. I mean, it's a technical services kind of thing that they do.
CHAYTOR, Q.C.:
Q. And do you know whether or not you need to have -
MR. GULLIVER:
A. I think he's just saying to see if the thing is still operational, you know, just the mechanical parts function, I would assume.
CHAYTOR, Q.C.:
Q. Do you know if you need a computer to be able to do that?
MR. GULLIVER:
A. I seriously doubt it.
CHAYTOR, Q.C.:
Q. So is there any other information that you have or anything about the whereabouts of the DAKO machine or how it, in fact, left Eastern Health?
MR. GULLIVER:
A. That's--everything I've told you is the best knowledge I have about it.
CHAYTOR, Q.C.:

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Q. And has there been any subsequent inquiries--because when we began asking about this, it was not just the machine itself, not the autostainer, but we were looking for records related to the disposal of the machine and related computer and data from the machine and the computer. So since when this was received obviously efforts were made and inquiries made in terms of the disposal of the machine portion, but what inquiries were undertaken in terms of what happened to the computer that accompanies the machine and any data on the computer?
MR. GULLIVER:
A. I did nothing new two weeks ago when this was asked for. I'm just restating that we had done this when this Inquiry started and we knew that the computer was gone. We knew that that part of the lab, most of the things there were thrown away, and I'm just restating what we had said a year ago.
CHAYTOR, Q.C.:
Q. So in terms of making any other inquiries as to the location of the computer portion of the machine, there hasn't been any further

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inquiries?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And to your knowledge, you're unable--you don't know where the computer ended up?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Nor its records?
MR. GULLIVER:
A. And I would say, if you check Robin Hood Bay, it's probably down there somewhere. That's where probably most of this stuff went to.
CHAYTOR, Q.C.:
Q. Okay, Mr. Gulliver, take you back then to the ER/PR and what's happening in the spring and summer of 2005, and perhaps you can tell the Commissioner what your involvement was in terms of trying to get at the root of the problem and identify patients who may need retesting?
MR. GULLIVER:
A. Well, I guess, you know, by the time I start doing the computer searches to identify

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patients who required retesting, up to that point, there's sort of an escalation, where I really, at the very beginning, with Dr. Cook and Dr. Carter who were pretty well the main laboratory people involved in this issue with the oncologists, I really don't get drawn into--I think it might be end of June, early July, and I think I was drawn into it at that point because Barry Dyer, who was our pathology manager, who would have been the person dealing with this directly, had just started vacation leave. So because I had a pathology background, that's why I think they came to me to talk about this pathology issue. So I guess, you're going to have to separate out what events you'd like me to talk about first, because there's a lot of events at that -
CHAYTOR, Q.C.:
Q. Well, why don't you just tell us? Tell us what you were involved in.
MR. GULLIVER:
A. Well, again, I mean, I got involved in the issue. It was after Dr. Cook and Dr. Carter had confirmed that there was more than one

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patient who had--and it was that point actually that I realized that they had had several patients retested on our new Ventana system, where they were originally reported as negative in 2002 and they retested positive in 2005 on the Ventana system. Up to that point, like May 17th, I didn't realize that they had that woman retested in house first.

CHAYTOR, Q.C.:

Q. You thought it had been done elsewhere?

MR. GULLIVER:

A. I thought it had been done outside elsewhere first.

CHAYTOR, Q.C.:

Q. So then you become aware of a number of others?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And how many others at that point in time?

MR. GULLIVER:

A. I think by that time, there might have been five or six that they originally did, and then I knew that Dr. Cook and Dr. Carter, and these patients were--I think these patients were

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given to them by the oncologists and these patients had to have been--they were in the year 2002 and to my understanding, Dr. Cook and Dr. Carter then were reviewing all negative cases that were reported in 2002 and were going to have them retested.

CHAYTOR, Q.C.:

Q. And did you understand that--what did you understand negative meant at that time?

MR. GULLIVER:

A. To me, negative was always zero, zero.

CHAYTOR, Q.C.:

Q. And were you asked to be involved in identifying any of those patients or pulling slides, blocks for those patients?

MR. GULLIVER:

A. The original ones, no.

CHAYTOR, Q.C.:

Q. In 2002 bunch?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And we understand there was, I believe, an original 57 patients or thereabouts.

MR. GULLIVER:

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A. I think there were five first. Then they added 57 more on doing the big picture for 2002.

CHAYTOR, Q.C.:

Q. Yes, and where did you understand those 57 were tested or retested, I should say?

MR. GULLIVER:

A. To my knowledge, I thought Dr. Carter was having them sent to Mount Sinai to get them retested.

CHAYTOR, Q.C.:

Q. Okay. So even at that point in time, when you become involved in this, you thought those original 2002 cases were all sent away for the first retest?

MR. GULLIVER:

A. The first five I knew -

CHAYTOR, Q.C.:

Q. Were done in house.

MR. GULLIVER:

A. - were retested in house.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. The next 57 were to be sent to Mount Sinai,

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because she had contacts with people in Mount Sinai.

CHAYTOR, Q.C.:

Q. And you weren't aware that they were done in house?

MR. GULLIVER:

A. At that time, no.

CHAYTOR, Q.C.:

Q. And when did you become aware of that?

MR. GULLIVER:

A. I can't tell you the exact time. It might have been two months after, three months after. I'm not really sure.

CHAYTOR, Q.C.:

Q. And so go ahead then, what do you get involved with? What are you asked to do?

MR. GULLIVER:

A. Well, I guess then, you know, I think by this time, Dr. Carter and Dr. Cook have been doing this, dealing with the oncologists and I think Dr. Cook had been keeping Dr. Williams informed up to that point, and then it comes up to our program leadership discussion with myself, Dr. Cook, Dr. Williams, and I think by this time, Dr. Cook has indicated that there's

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been more--there's been multiple patients retested and they've retested from negative to positive, and that could be early July, Ms. Chaytor. I'm not sure of the exact date time, because there was--there might have been 75 meetings in the month of July, once this started.

CHAYTOR, Q.C.:

Q. Okay. Well then, I'll take you through a couple of them, might help with your memory. If we could look at P-0492, please? And this is mid June, June 14th, 2005, and it's a memo that Dr. Cook sends out to all lab directors, and -

MR. GULLIVER:

A. And that's not--wouldn't be me.

CHAYTOR, Q.C.:

Q. No, you're not involved in this part. But were you aware then that this memo was being sent out across the province?

MR. GULLIVER:

A. I don't think I was made aware at the time, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Okay, and you'll see here where Dr. Cook is

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asking them to send in--it says "most of these false negatives have occurred during the year 2002." Had that been communicated to you at that point, that most of them were thought to have been -

MR. GULLIVER:

A. I knew the first four or five that they had done were 2002.

CHAYTOR, Q.C.:

Q. Okay, and "presently, we are in the process of retesting all negative ERs and PRs for that particular year." Was there anything communicated to you that there was a concern regarding 2002, and if so, why 2002?

MR. GULLIVER:

A. There was no particular concern relayed to me and I think it was Mr. Dyer who actually told me that what Don and Bev are doing now, they're going to go and get all the 2002 cases retested because the four or five patients the oncologists identified, including the index case, that's the year that they were originally tested in, and I guess Dr. Cook and Dr. Carter was thinking that if there was something that had not been picked up, was

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there something in particular for the year 2002.

CHAYTOR, Q.C.:

Q. And it says "presently we're in the process of retesting all negative ERs and PRs for that particular year" and did you understand that was negative ERs, as well as negative PRs that were being tested?

MR. GULLIVER:

A. Well, I hadn't seen the memo. To my understanding, it was negative ER was the main one.

CHAYTOR, Q.C.:

Q. So when you get involved and you're asked to start identifying patients, what criteria did you understand? What were you asked to look for?

MR. GULLIVER:

A. Oh, so by the time I'm involved with this, a lot happens between this time and, as you know, between--by the end of July, the multiple, multiple, multiple, multiple meetings and discussions about this issue. When I start the process to do the review and identify patients through computer searches.

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By that time we've been instructed that there was a cutoff point, a clinical cutoff point versus a technical issue. In the lab side, we see a negative as being zero, zero, and the oncologists had informed that, well, how they practised for the earlier years, they were using a 30 percent or greater would receive treatment and then in 2001 it was a ten percent or greater for ER, you know, for the hormone receptors, actually, hormone therapy. And those are the cutoffs that I was instructed to use.

CHAYTOR, Q.C.:

Q. Okay. So you never used negative ER and negative PR, you always looked at just the ER when you were identifying patients?

MR. GULLIVER:

A. Well, ER was the most critical one, yes.

CHAYTOR, Q.C.:

Q. Right. You weren't looking for people who were negative, negative. You were looking for anyone negative ER -

MR. GULLIVER:

A. Oh, no, no, no, no, no -

CHAYTOR, Q.C.:

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Q. - regardless of PR?
MR. GULLIVER:
A. - negative, negative, number one. Zero, zero is negative, negative was number one.
CHAYTOR, Q.C.:
Q. Right. But you were looking for anyone who had a negative ER and negative was later defined for you in terms of the 30 percent and then 10 percent cutoff?
MR. GULLIVER:
A. Anything less than -
CHAYTOR, Q.C.:
Q. Regardless of what their PR -
MR. GULLIVER:
A. - 30 or less than 10 -
CHAYTOR, Q.C.:
Q. Regardless of their PR -
MR. GULLIVER:
A. - regardless of the PR.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. If we could look at P-2357, please? Okay, so

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that's not the right document, 2357.
MR. GULLIVER:
A. This looks like your Ventana protocol or something, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Yeah, okay. All right, we'll come back to it. I was looking for, we have spreadsheets belonging to you and I'm not sure if they're somewhere in this. I don't think that's the right document at all. We'll come back to it. If we could have P-0497, please? I probably have my numbers backwards again, it might be 2537. Okay. And this is a meeting then on July 8th. And this is Dr. Williams' notes. He says he "met earlier in the day with Dr. Cook and Mr. Gulliver. On review of this situation the problem appears to be--appears not to be confined to a few negatives that have converted to positives in one batch, but a larger problem." And were you involved at all in that, Mr. Gulliver, in determining the scope of the problem and whether it was confined to just -
MR. GULLIVER:
A. No, I think by this time, July 8th, I think

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Dr. Cook and Dr. Carter has done enough retesting from 2002 that you couldn't say that it was one batch. I mean, I -
CHAYTOR, Q.C.:
Q. So you wouldn't be the source of that information is what I'm asking?
MR. GULLIVER:
A. I very--I wouldn't--I very well could be because, as I explained to you earlier, this test was performed for many years and they were batched, so--and it was mostly on a Friday. So it could be five patients one week, four the next week, ten the next week, eight the next week, four the next week, it varied. And, you know, and that was the think--someone was thinking, I wonder if there was a bad batch in 2002. But when you see results change and you can see the time frame was from different months, well, there's no way could you say there was one batch.
CHAYTOR, Q.C.:
Q. Okay. And then "Have been advised that all runs of tests had control/controls which should be documented." Would you be the source of that information?

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MR. GULLIVER:
A. Probably. For sure I would tell Dr. Williams that a part of the protocol for running IHC testing, in particular, ER/PR, that known positive controls must be run with every single time the procedure was run. And I guess documentation, it all depends on what your interpretation of documentation is.
CHAYTOR, Q.C.:
Q. Well, what would you have told Dr. Williams?
MR. GULLIVER:
A. I would have told Dr. Williams that the original slide, control slide should be with the patient's permanent record; that in most instances it would be documented in the computer system that there was a quality control slide run; and the documentation may exist in the pathologist's own--in the report if the pathologist documented I read and viewed the positive control.
CHAYTOR, Q.C.:
Q. And the control slide being put with the patient's slide, that would depend how many controls were run?
MR. GULLIVER:

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A. That was only at a certain time period. We're talking about now over the whole time period. By and large -

CHAYTOR, Q.C.:

Q. There wasn't a -

MR. GULLIVER:

A. - I'm saying to him--yes.

CHAYTOR, Q.C.:

Q. - control slide for every patient, there wasn't a -

MR. GULLIVER:

A. At times there was a control slide for every patient; a times there was a control slide for every pathologist; at times there was a control slide just for the batch.

CHAYTOR, Q.C.:

Q. Yeah. And the fact that the runs had documented--or controls documented, that the only documentation that would exist on that would be what?

MR. GULLIVER:

A. Well, depending on the year that we're talking about. Again, the places where you could find documentation is, one, here's the control slide. So if there's the slide, to me that's

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documentation the slide, the control slide was run. If you're looking for further documentation, there were times when the pathologists would report in their report and document I've viewed and read the external control and it worked fine. In the Meditech system the technologist who performed the procedure, they would order an ER/PR and they would go into another piece of the computer system and say that they took quality control slides for immunohistochemistry today.

CHAYTOR, Q.C.:

Q. If we could have, please, P-0501? And this is another meeting. And I take it you don't have any independent recollection or anything, and if at any point you do have any recollection beyond what's in Dr. William's notes, by all means, let us know. This is July -

MR. GULLIVER:

A. I will.

CHAYTOR, Q.C.:

Q. Yes. July 12th, 2005. And it's Dr. Cook, yourself, Ms. Predham and Dr. Williams. And it's follow-up on the status. "Prior to 2004 semi-automated, semiannual DAKO testing

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procedure" is referred to. And there was "A system of positive controls," it says. There's been--"October, 2003 the laboratory medicine program visited Ventana at the Montreal Jewish Hospital. January, '04 the Ventana system purchased." And it says, "We have pulled all cases in September, 2001 to review findings and retest. There was an issue of erratic staining in early 2003 and testing pulled for six weeks. Titration times and staining times were adjusted. Tests sent out for six weeks to other labs." And who would have been the source of that information in this meeting?

MR. GULLIVER:

A. I think, well, it's a combination. Either myself or Dr. Cook. And realize, this is July 12th, '05. You know, this is an issue that, you know, the vice president is asking about and we're pretty well just giving him basic information on the history of the test and the changes in the laboratory over the--during the time period.

CHAYTOR, Q.C.:

Q. And were the tests sent out for six weeks to

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other labs, to your knowledge?

MR. GULLIVER:

A. This is talking about when Dr. Ejeckam stopped the testing. I don't, I actually don't think there was ever one sent out during that time frame. I think there was a hold on them, that Dr. Ejeckam said to the other regions, "If you have an urgent case, well, you're better off sending it out and have it done somewhere else" until his puts testing back in place. I think they just came in and they were held until he was fine to put them back in place and then did them.

CHAYTOR, Q.C.:

Q. Okay. And then it says, "For breast tissue samples, should be in formalin for 48 to 72 hours. Controls are in formalin for optimal time." The idea of the breast tissue samples being in formalin for 48 to 72 hours, would that come from -

MR. GULLIVER:

A. That would be Dr. Cook, it wouldn't from me.

CHAYTOR, Q.C.:

Q. That would come from Dr. Cook?

MR. GULLIVER:

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A. Yeah.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. And here we're giving him some history about when it was done in chemistry versus the biochemical assay, when it switched to immunohistochemistry testing in pathology.
CHAYTOR, Q.C.:
Q. Okay. And the decision coming out of this meeting it says to "Test all samples of living patients. What are our positive rates for infiltrating lobular and ductal cancer? Look at our rate of positivity per year. Check out procedure versus DAKO standards. Set up process to inform oncologists. Check with Dr. Ejeckam re the process in 2003. And implement recommendations May 24th, 2005 correspondence." What, if any, of those were you to follow-up on?
MR. GULLIVER:
A. Well, certainly number one. I agreed with, you know, testing all samples on living patients because I was asked if we--if we could retest all the patients, could we do it.

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And my answer was, "Well, a part of our pathology policy is that we keep the permanent pathology records for 29 years," ie, the pathology block and the pathology slides. So it is, we could do it, we could actually go back to the old filing systems and take patient samples that were four and five and six, seven years old and we could actually have them retested. Now, whether it was retested in-house or out of house would be a different decision, but it could be done. The next thing that I was really involved with was looking at, this was the next question, was wondering, well, by year do we have any idea what our positive, negative ratios were, which no one knew; it wasn't tracked. And -
CHAYTOR, Q.C.:
Q. And why would that be important at this point in time when you're about to retest the patients?
MR. GULLIVER:
A. Because I think Dr. Cook had made some inquiries by this time and asking questions about, you know, what would you expect to see, how many--what percentage of your patients

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would you expect to see that should be positive versus negative on this procedure. Again, it's around this time, Ms. Chaytor, that, you now, I'm trying to explain to Dr. Williams and other people in the organization who are non-lab people, it's certainly a complicated issue for them to get their heads around. Myself and Dr. Cook would also be talking to Dr. Williams, telling him that we know, like, this procedure, this test, even when it's done perfectly, still has a false negative rate built into this procedure. So I guess knowing that, Dr. Cook had made inquiries asking about overall positivity--positive, negative rates by year. So that was -
CHAYTOR, Q.C.:
Q. And were you to then be involved in that?
MR. GULLIVER:
A. - this is the first thing that I was really started to do.
CHAYTOR, Q.C.:
Q. So that's what you started to do, look at positivity rates?
MR. GULLIVER:

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A. Yes.
CHAYTOR, Q.C.:
Q. And who asked you to do that, was that Dr. Williams?
MR. GULLIVER:
A. No, well, Dr. Williams, I would assume, yes.
CHAYTOR, Q.C.:
Q. What did it mean, number four, "Check out procedure versus DAKO standards."
MR. GULLIVER:
A. I think what Dr. Williams was--well, again, I can't speak for Dr. Williams, but when I'm reading this here, I think what Dr. Williams meant was ensure that we were following the procedure that DAKO had recommended.
CHAYTOR, Q.C.:
Q. And were you asked to go and check on that?
MR. GULLIVER:
A. I don't know if I was asked to go and check on it, but I do know, I mean, I spoke to Barry, the technologist and in particular Mary, that yes, I mean, the DAKO protocols is what we followed.
CHAYTOR, Q.C.:
Q. These spec sheets you mean, is it?

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MR. GULLIVER:
A. And the PAP procedure and if DAKO sent in -
CHAYTOR, Q.C.:
Q. The PAP procedure that we looked at yesterday in your evidence?
MR. GULLIVER:
A. Yes, I mean, that's still the basic theory of, principles of the procedure, but if DAKO had sent in an antibody where the recommended a one and 20 dilution or one and fifty, I mean, the procedure still would not change, except when you did ER/PR, as you know, the DAKO protocol for the antigen retrieval for the ER/PRs. And that's, I think that's what Dr. Williams was asking me to make sure.
CHAYTOR, Q.C.:
Q. And if we could look at, please, P-0323?
THE COMMISSIONER:
Q. Could you just go back to that for one second, I just want to confirm a point with Mr. Gulliver. Number one, Mr. Gulliver, is test all samples of living patients. Do I read that -
MR. GULLIVER:
A. Oh, no, not positives. This was testing all

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the negatives.
THE COMMISSIONER:
Q. All negative ERs of living patients.
MR. GULLIVER:
A. Yes, good point.
CHAYTOR, Q.C.:
Q. And this is a memo from Dr. Williams to-- sorry, to Mr. Tilley and it's an update on ER/PR receptor testing. And it says, "The following activity has taken place since the memo of Dr. Cook to Dr. Williams", which was dated May 24th, 2005 and he's giving him a run down of what's taken place. And he says in his fourth bullet, "It has been determined that positive controls were conducted every day as part of the quality assurance process within the lab. The results were read and documented daily by pathologists. Also the processes used by Health Care Corporation St. John's technicians were those outlined in the DAKO procedure manual." And Mr. Gulliver, I believe when this came up before, it was indicated that this information would have-- you would have been the source of this information?

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MR. GULLIVER:
A. Probably, and it might not have asked me directly for this, it might have been information Dr. Williams had received for me over a period of maybe five meetings and two days, I don't know, but certainly I would probably be the main source for this information.
CHAYTOR, Q.C.:
Q. And had it been determined that positive controls were conducted every day?
MR. GULLIVER:
A. Well they were run every day. In IHC lab, you run positive controls with your antibodies every single day.
CHAYTOR, Q.C.:
Q. And what were you able to do to determine that in fact had occurred?
MR. GULLIVER:
A. Because that's protocol, it's policy, it's procedure, you run controls.
CHAYTOR, Q.C.:
Q. And what did you have to confirm that the protocol and procedure had been adhered to?
MR. GULLIVER:

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A. I guess I had faith in the technologists that they did it and if there was no positive controls gone to the pathologists over all these years, I certainly would have heard about it.
CHAYTOR, Q.C.:
Q. The results were read and documented daily by pathologists and where would it be documented that -
MR. GULLIVER:
A. Well that's the pathologists--I mean, how Dr. Williams wrote this, I mean, I can't speak for it. I think what he's saying is that the results were then read by a pathologist and the pathologist would have to document if everything was okay.
CHAYTOR, Q.C.:
Q. And the process used by the technician being those outlined in the DAKO procedure manual, is there a DAKO procedure manual or is that the spec sheets?
MR. GULLIVER:
A. Well there's a, the procedure manual, there was a manual with the old instrument really on how to operate the instrument.

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CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. But pretty well the procedures are the procedures that were used and the protocols that were put into the DAKO templates, which includes spec sheets, yes.
CHAYTOR, Q.C.:
Q. If I could have, please, P-0506? And these are Dr. Williams' notes of July 15th, 2005 and it looks like this is your leadership team. It's yourself, Dr. Cook and Dr. Williams and it says "reviewed meeting of July" -
MR. GULLIVER:
A. I don't think this--this was just still, just separate ER/PR stuff.
CHAYTOR, Q.C.:
Q. Okay. So in addition to meeting for your regular leadership monthly meetings, you would be having separate meetings for ER/PR?
MR. GULLIVER:
A. Back in this time we might have met two and three times a day, I can't remember, it was just constant.
CHAYTOR, Q.C.:

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Q. And it says you reviewed meeting of July 14th, re: "identifying all patients and getting tests done as soon as possible. Plan: pull one to two people to start process and assign Mary to be assigned to cutting and testing only. Dr. Cook is to contact pathologists in other centres. Terry advises that each patient slide was processed along a control slide and the control slides were read and no reporting done until all control read as positive." And is that correct?
MR. GULLIVER:
A. Well that's what the pathologist was supposed to do. They got the control slides, you know, if the control slide didn't work, well the pathologist is not going to sign the case out, they're going to come back to the lab and say repeat it or is there something going on here? If the pathologist reports the case, one can only assume that they read the positive control and they were fine with it.
CHAYTOR, Q.C.:
Q. So I just want to be clear then, so you, in advising of that, you would have been telling Dr. Williams this is what is supposed to

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happen, that there's supposed to be a patient slide and a control slide.
MR. GULLIVER:
A. A technical, the positive external control, yes.
CHAYTOR, Q.C.:
Q. And were they being run, each patient slide being processed along side a control slide and the control slides then being read and no reporting done until the control read is positive. You're telling Dr. Williams that's what's supposed to have happened.
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. As opposed to, I can verify to you, Dr. Williams, that in fact is what happened.
MR. GULLIVER:
A. That's what's supposed to happen and I would hope that is what happened.
CHAYTOR, Q.C.:
Q. And that's what you were telling Dr. Williams?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:

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Q. And do you recall any discussion, the last bullet here is Dr. Cook to see if Dr. Laing can provide article from Sloan-Kettering on research and the change of ER/PR receptor testing. Do you recall any discussion around that?
MR. GULLIVER:
A. Not really, I just think Don was wondering, you know, has someone else seen this in other places.
CHAYTOR, Q.C.:
Q. And if we could have, please, P-0070? And this is July 15th from Deborah Thomas to Susan Bonnell. "Hi Susan, here's today's update from Heather Predham." And there's a number of bullets and your name comes up here. "Terry G. says he has documentation that shows positive controls were done daily (Heather yet to see it)." And, Mr. Gulliver, did you in mid July, 2005 advise that there was documentation showing positive controls were done daily?
MR. GULLIVER:
A. I don't think I said that directly, the way you're interpreting it. I think I'm saying

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through all these meetings that positive controls were run with IHC testing, documentation was you had the procedure in the computer system, you went in and recorded that you did a QC control. The documentation is the actual slide is still there physically looking at you, there's your control slide, we still have it and another further level of documentation would be if the pathologist dictated that in their file or report. I don't think I ever said to them that oh, here is all the documentation that you're looking for for every control slide that was run.

CHAYTOR, Q.C.:

Q. Yes. Mr. Gulliver, did Ms. Predham ever come to you and ask you what documentation that you did have to show that positive controls were done?

MR. GULLIVER:

A. I think so and I think--this is what I just said to you is what I would have explained to Heather and relayed to Heather at this time.

CHAYTOR, Q.C.:

Q. And was there ever any suggestion or anything said to you in terms of any concern about

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inadequacy and documentation regarding controls?

MR. GULLIVER:

A. I certainly think so. I mean and again -

CHAYTOR, Q.C.:

Q. I'm sorry, I just want to be clear I asked whether or not there was anything indicated to you as to an inadequacy regarding the documentation around controls?

MR. GULLIVER:

A. I think from Heather, when these people were getting involved with the issue outside the lab, I think Heather probably did make statements that, from her risk management position, you know, the document--what she considers to be documentation is different than what our documentation was.

CHAYTOR, Q.C.:

Q. So she expressed concerns it wasn't what she was hoping or anticipating to see.

MR. GULLIVER:

A. I know, I think Heather expected to see a book that was eight years old where every single day there was something in there where a pathologist signed off and said, yeah, here's

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the control today, I signed it, read it and verified it and here's the date, time stamped and updated. We didn't have that kind of documentation. I think that's what Heather was expecting or would like to see.

CHAYTOR, Q.C.:

Q. Or perhaps similar to what Trish Wegrynowski was expecting to see.

MR. GULLIVER:

A. No, even that would be more than what Trish would see.

CHAYTOR, Q.C.:

Q. Heather's expectations were even higher, you're saying?

MR. GULLIVER:

A. Probably because she's used to dealing with the risk management issues and dealing with legal counsel and what legally people think documentation is and what they expect to see.

CHAYTOR, Q.C.:

Q. If we could have, please, P-1930? And this is an e-mail from Ms. Predham to Dr. Williams, Dr. Cook and yourself and its subject is "Update from Mr. Tilley, July 18th, 2005" and it's the update on the ER/PR document. And

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she says, "Hi, here's the update from Mr. Tilley, please review it and add anything you feel necessary. I'm not sure who this should go from, so I left it blank. It didn't include any information re: Dr. Ejeckam's memos .... should we? Thanks. Heather" and then when you see the document here, it's similar to the one that I showed you a few minutes ago. Do you recall receiving this e-mail Mr. Gulliver?

MR. GULLIVER:

A. I guess so.

THE COMMISSIONER:

Q. It doesn't sound exactly -

MR. GULLIVER:

A. I know, you're asking me something from three years ago where I -

THE COMMISSIONER:

Q. But the question is do you recall it? You may not recall it, if you don't -

MR. GULLIVER:

A. I don't recall it like specifically, but I can't say I didn't get it, you know, because there's probably been ten thousand e-mails, but at this particular time there's e-mails of

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meetings every five minutes.
CHAYTOR, Q.C.:
Q. Yes, and this is for a briefing note or an update for Mr -
MR. GULLIVER:
A. Tilley.
CHAYTOR, Q.C.:
Q. Tilley, yes, and we see on the third bullet, the DAKO test is referred to, and it says, "Extra resources have been identified within the HCCSJ lab undertake identification and retesting. The list of patients will be double checked with the names on the Cancer Registry to ensure none have been missed". Were you involved in identification of extra resources within the lab to undertake this?
MR. GULLIVER:
A. No, by this time--I mean, at this time, still Dr. Carter was going to be the lead person with Dr. Cook to do this review, and Dr. Carter had asked for a dedicated technologist to be assigned to her at St. Clare's, and for clerical support, which is what we provided to Dr. Carter to do this.
CHAYTOR, Q.C.:

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Q. And then we have the bullet that I've already taken to, "That it's been determined about positive controls conducted every day". Then if we could have, please, 2950, and this can perhaps answer the question for you as to whether or not you received it because you responded to it the same day at approximately noon, July 18th, 2005, you respond, "Heather, looks fine to me. I would not include Dr. Ejeckam's letter. I think Dr. Williams or Dr. Cook should send the memo". So she had asked who it should go from, and you're indicating it should go from Dr. Williams or Dr. Cook. Now why wouldn't -
MR. GULLIVER:
A. No, I'm--no.
CHAYTOR, Q.C.:
Q. Sorry, that's not right?
MR. GULLIVER:
A. I can't say it's not right, but my intention here would be to, yes, this memo, if it's coming from us, information Dr. Williams has gathered from us, then Dr. Williams should speak to George Tilley, and I'm also saying, or should indicate "and Dr. Ejeckam's

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letters", I think that should come from Dr. Williams or Dr. Cook. I mean, they're the clinical people.
CHAYTOR, Q.C.:
Q. So if we just scroll down the questions she had asked was--she didn't include the information re; Dr. Ejeckam's memo, should we, and her other question was, "I'm not sure who should this go from, so I left it blank". So your response, just explain that again because you responding saying "it looks fine to me", so I take it you had no trouble with the content?
MR. GULLIVER:
A. With the wording, the content that was in there, obviously.
CHAYTOR, Q.C.:
Q. "I would not include Dr. Ejeckam's letter. i think Dr. Williams or Dr. Cook should send the memo". So what is it that you're saying?
MR. GULLIVER:
A. I guess I'm saying, "I, Terry Gulliver, don't feel like I should give Dr. Ejeckam's letters to George Tilley, that that should come from Dr. Williams, the Vice President, or Dr. Cook,

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the clinical chief".
CHAYTOR, Q.C.:
Q. Because you're saying -
MR. GULLIVER:
A. Because once George gets them, he's going to want explanations on them.
CHAYTOR, Q.C.:
Q. But this wasn't going--just let me be clear now because it says, "I would not include Dr. Ejeckam's letter. I think Dr. Williams or Dr. Cook should send the memo". What memo are you referring to?
MR. GULLIVER:
A. I guess this overall memo that Heather has sent us asking for our opinion on it.
CHAYTOR, Q.C.:
Q. Right. So you're saying that that should go from Dr. Williams or Dr. Cook, the memo that I showed you before, that she had left blank, she didn't know who to send it from, and you're saying that should go from Dr. Williams or Dr. Cook, is that correct?
MR. GULLIVER:
A. That's what I'm saying, yeah.
CHAYTOR, Q.C.:

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Q. Yes, and that's how I had interpreted it, that you're answering her question down here where she says, "I'm not sure who this should go from, so I left it blank", and if we could just go back to -

MR. GULLIVER:

A. I know--I guess what you're indicating here is a couple of things. One -

CHAYTOR, Q.C.:

Q. No, I'm just asking the questions, Mr. Gulliver.

MR. GULLIVER:

A. I'm saying the memo looks fine to me, however, I don't think we should let George Tilley know about Dr. Ejeckam's letter, and that's not what the intent here is at all. I'm saying that Dr. Williams and Dr. Cook should send the memo and inform George Tilley of Dr. Ejeckam's letter. That's what would be in my mind and my intent.

CHAYTOR, Q.C.:

Q. Okay. So if we just go back to 1930, please. This is the memo and you'll see she's drafted it and she left the "from" blank, and if we could just go back then again, please, "looks

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fine to me", and she's asking the question who it should go from. So you're saying, yes, it should go from Dr. Cook--Dr. Williams or Dr. Cook, the memo, meaning the memo that Heather has attached that's going to go to Mr. Tilley to update him on the ER/PR? So we're clear on that, that's what you're saying?

MR. GULLIVER:

A. That part there, yes, that the memo should go from Dr. Williams or Dr. Cook.

CHAYTOR, Q.C.:

Q. Yes, okay. Now her other question was, "I didn't include any information re; Dr. Ejeckam's memos".

MR. GULLIVER:

A. And I'm assuming she means the ones from 2003.

CHAYTOR, Q.C.:

Q. Yes, well, are you aware of any others?

MR. GULLIVER:

A. No, only ones I ever got.

CHAYTOR, Q.C.:

Q. And then, "looks fine to me". So I take it you're saying the memo that she's drafted looks fine, the content is fine. "I would not include Dr. Ejeckam's letter". So what is it

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that you're saying you intended to relay to -

MR. GULLIVER:

A. I just--I know I just said to you that my mind, my intention would mean that this whole thing should come from Dr. Williams and Dr. Cook and Dr. Ejeckam's letter, if they want to include it. I'm saying I wouldn't include Dr. Ejeckam's letter for me to give it to George Tilley. Now you can also see here what my typing skills are like in responding, they're all higher case, I mean, and who knows how many things I'm doing this day. I'm just saying to you that would be my intention, what would be in my mind at that time, and I can't explain it any clear.

THE COMMISSIONER:

Q. Okay, let me try. You are saying that your intention when you're sending this was to say that Dr. Ejeckam's letter should be conveyed to Mr. Tilley, but you were not the appropriate person to do it?

MR. GULLIVER:

A. Pretty well, yes.

THE COMMISSIONER:

Q. And you think that's--and you think that's

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what Ms. Predham would have understood that to mean?

MR. GULLIVER:

A. I don't know. Did she ever reply back and say, like, anything or clarification or -

CHAYTOR, Q.C.:

Q. On P-0300, she says that she's incorporated the changes and that it's going to go from Dr. Williams, and there's no reference to Dr. Ejeckam in what goes to Mr. Tilley.

MR. GULLIVER:

A. And I don't know what finally went to Mr. Tilley.

CHAYTOR, Q.C.:

Q. You don't?

MR. GULLIVER:

A. I don't think so. I don't know.

CHAYTOR, Q.C.:

Q. This was sent to you here, P-0300, the update on ER/PR.

MR. GULLIVER:

A. I know the update went to Mr. Tilley, but I don't know if they sent Mr. Tilley the copies of those three memos.

CHAYTOR, Q.C.:

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Q. So you know that the memo that's being discussed here did go to Mr. Tilley and it didn't have any reference to Dr. Ejeckam in the update?
MR. GULLIVER:
A. I don't.
CHAYTOR, Q.C.:
Q. You don't know that?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. So this e-mail then that goes out to you, or goes from Heather to Dr. Williams indicating she's heard back from Dr. Cook and Terry Gulliver re; the letter, and the changes have been made, "Both agree it should come from you", to Dr. Williams, and it goes to Dr. Williams, anyhow, and what's attached here would not have reference to Dr. Ejeckam in it. So if at the end of the day it got further changed and reference to Dr. Ejeckam got put in the memo or otherwise sent along, you're not aware of that?
MR. GULLIVER:
A. I don't think at the time I was. I don't

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know.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. You know, I wasn't involved--I didn't draft the thing. If I was drafting it, I probably would have paid much more attention to it. This is something Heather is saying, okay, does this look like a summary to go to George Tilley. I probably skimmed through it and said, yeah, looks fine to me.
CHAYTOR, Q.C.:
Q. Except she asked a couple of specific questions and I just want to be clear on what your response was. If we could go back to 2950.
MR. GULLIVER:
A. I know, and I typed that back, and I'm saying irregardless how I typed it here, my intention was as I explained to you earlier.
CHAYTOR, Q.C.:
Q. Right.
MR. GULLIVER:
A. That if Dr. Williams or Dr. Cook should bring those memos to Mr. Tilley, it should be their

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decision.
CHAYTOR, Q.C.:
Q. And that's what you intended to convey to Ms. Predham?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And why wouldn't--I mean, one of those letters, certainly the one you would be most acutely aware of, is the one addressed to you, June 19th, 2003. So why wouldn't it be appropriate -
MR. GULLIVER:
A. It's copied to Dr. Cook also.
CHAYTOR, Q.C.:
Q. But it was addressed -
MR. GULLIVER:
A. And the two prior, I didn't get copies of them.
CHAYTOR, Q.C.:
Q. So you had the June 19th, 2003, was actually addressed to you. So why wouldn't that be appropriate? Why would you be concerned that that not go from you when it's your letter? You're the one who, I would take it, would

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have the original of the letter?
MR. GULLIVER:
A. I know. This is an update that's going to the CEO. Dr. Williams is my vice president. I just assumed that he should decide what goes to the CEO.
THE COMMISSIONER:
Q. Ms. Chaytor, when you find a convenient spot, we'll break for the afternoon.
CHAYTOR, Q.C.:
Q. Just go back to P-0300 for a moment, please. This is the same e-mail from Ms. Predham, and she goes on to say, "I was speaking to Deborah Thomas today and the Department of Health has been notified and is now involved. They would like a letter sent to each woman outlining the problem and the steps we are to taking to address it, and the draft letter will have to be seen by our lawyers first, of course". Were you aware of that or how the Department of Health came to become aware of the situation by July 18th?
MR. GULLIVER:
A. Not really. I mean, even though I'm cc'd from Heather, it's not something that I was really

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actively involved in. I think this is more FYI type of thing.

CHAYTOR, Q.C.:

Q. So you weren't involved in any discussions in terms of notification to the department, and you're not aware who notified the department as of July 18th?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. This is a good place, please, Commissioner.

THE COMMISSIONER:

Q. Take the afternoon break.

(BREAK)

THE COMMISSIONER:

Q. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner.

THE COMMISSIONER:

Q. Oh, I guess we should announce for the benefit of those who maybe want to change their plans for the evening that while we had anticipated that we would be sitting in the evening today, that plan has been changed and we'll be ending around five.

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CHAYTOR, Q.C.:

Q. Thank you. If we could have, please, P-516. This is a meeting, July 21st, 2005, and again it involves yourself and Drs. Cook and Williams. It says, number one, "Agreed to get Dr. Carter's information she needs. Number two, Dr. Carter to do only this service. Mary Butler to report and take direction from Dr. Carter. Will arrange someone from QA to be assigned. We have proficiency testing and microhematology and biochemistry need to have proficiency testing and QA program for immuno pathology. Immunohistochemistry in separate space while awaiting final space. Dedicated techs to immunohistochemistry, don't have enough work for three techs, but need three people for holidays, sick leave, etc, and then when Barry Dyer and Dr. Ejeckam return, they will work with Dr. Cook and Mr. Gulliver to deliver QA and proficiency testing program". Mr. Gulliver, in terms of the reference here to the immunohistochemistry in separate space while awaiting final space and the dedicated techs to do the work, this is now July 21st, 2005. At that point in time, wasn't the

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immunohistochemistry already in its own space, hadn't that happened the end of December '03?

MR. GULLIVER:

A. Mr. Dyer--we physically moved them, but what I'm alluding to here was the file space was to actually have the space upgraded to today's standards, like new benches and work benches for the whole pathology lab that had been promised back as far as 1998.

CHAYTOR, Q.C.:

Q. I'm sorry. So you were moved into your separate space?

MR. GULLIVER:

A. In the lab you've seen -

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. - I mean, they'd been there.

CHAYTOR, Q.C.:

Q. Since December, 2003, or thereabouts?

MR. GULLIVER:

A. Right, but within that lab, even though they were in their own space, we had still expected facilities management to put in new bench work and upgrade the space like 2005, and not still

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operating in a facility that was built in 1978.

CHAYTOR, Q.C.:

Q. What does it mean, "while awaiting final space"? Was it anticipated that the lab would be moved again?

MR. GULLIVER:

A. No, no, no, I just think that's Dr. Williams notes of the way or wrote it.

CHAYTOR, Q.C.:

Q. And the dedicatedtechsto immunohistochemistry, don't have enough work for three techs, weren't they already, as you said earlier, dedicated?

MR. GULLIVER:

A. Yes. Again, I think, this is probably Dr. Williams early on trying to get a grasp on the issue and just getting background information. I was probably saying at the time we have three techs who are trained for immunohistochemistry, they used to rotate to the gross bench, but they are now dedicated techs for IHC.

CHAYTOR, Q.C.:

Q. And perhaps was it because they were also

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rotating, was this perhaps trying not to have them rotate through, is that -

MR. GULLIVER:

A. I don't think at this time they were rotating anywhere else. They were just doing the immunohistochemistry work for the lab.

CHAYTOR, Q.C.:

Q. Okay, and if we could have then, please, P-0520. Actually, I think it's P-3091 first. Sorry, 3092, and this e-mail originates with Ms. Predham, I believe, or perhaps with Ms. Bonnell. Yes, Ms. Predham, here we go, July 19th, 2005, and she sends this to yourself along with others, including Drs. Williams and Dr. Cook, "I had a long conversation with representatives from HIROC yesterday evening. As a bit of background, they are currently defending a class action lawsuit against Health Labrador", and it goes on from there, "and the organization felt the need to disclose publicly, ran it by their legal counsel, and then wrote letters to every person affected and send out a news release. Sound familiar. Their vulnerability comes from of lack of weighing out the risk from the

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exposure versus the anxiety of being told about it", and she goes on, "This leads us to our situation. It's not that they don't want us to disclose, they just don't want us to disclose until we are sure of our facts. I've had a quick voice mail from Dan after my chat with HIROC. They contacted him after they hung up from me reiterating this, and they will be in touch again in the morning. So I guess we will have to reevaluate where we are before we plan to send those letters, etc. Should we chat about this face to face", and then Ms. Bonnell gets back to her, and you respond as well saying that, "Your calendar is free all day". This is July 19th, 2005, and do you recall did you then attend a meeting in which this subject was discussed?

MR. GULLIVER:

A. I do remember attending a meeting where it was discussed about disclosure and contacting patients, and I know I was at a meeting where Dan Boone was in attendance because that was the first time I had ever met Dan Boone. I don't know if it was this day, or which exact day it was, Ms. Chaytor.

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CHAYTOR, Q.C.:

Q. Okay, and what -

MR. GULLIVER:

A. I was at meetings where we talked about patient disclosure. I'm not saying that I actively, you know, was involved in that discussion or the decision making piece of it.

CHAYTOR, Q.C.:

Q. Okay, and if we could look then, please, at 521. and this is a meeting of the same date which does include Dan Boone and yourself, along with Ms. Predham, and it's July 19th, 2005. So what do you--this is the first time, you say, you would have met Mr. Boone?

MR. GULLIVER:

A. I think it was the first time I ever met Dan Boone, yes.

CHAYTOR, Q.C.:

Q. And this meeting then, do you recall the issue of notification of patients or possible public disclosure, those things being discussed?

MR. GULLIVER:

A. I think so because it was, I guess, the background--I think by this time I certainly would assume that Dr. Williams, Dr. Cook,

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myself, and Heather, and communications people, would have a fair idea of what the background was, like, numbers of patients we're talking about, average tests per year, question mark, the 2002 results. So I think we're probably giving this to Dan Boone because this is probably his first time meeting with us and asking about this.

CHAYTOR, Q.C.:

Q. And what do you recall--what else do you recall being discussed at that meeting?

MR. GULLIVER:

A. I'm assuming this is the meeting where if Susan is there, Bonnell, who was our Communications Director, and Deborah Thomas from Communications, I'm assuming we're talking about communicating to the public and to the patients.

CHAYTOR, Q.C.:

Q. And what do you recall being discussed about that?

MR. GULLIVER:

A. I--you know, I don't know if it's this exact meeting, Ms. Chaytor.

CHAYTOR, Q.C.:

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Q. Perhaps you can just tell us what you recall being discussed?
MR. GULLIVER:
A. Well, I recall--probably various meetings, not just this one.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. There was other meetings with more people than this there.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. We had a meeting later on with the--it's a broader group where it includes--the oncologists are there, and other pathologists are there.
CHAYTOR, Q.C.:
Q. Yes, and I think that comes a little bit later.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And I'll ask you about that.
MR. GULLIVER:

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A. I do remember, though, that Susan Bonnell, I mean, she's the Director of Communications, you know, they were looking to me for advice as Director of Laboratory, looking for background information. I know quite clearly Susan was early on, you know, in favour of having a public announcement or some kind of public disclosure of this issue, even though at this time no one really knew how broad an issue it could be.
CHAYTOR, Q.C.:
Q. And the issue in terms of--that appears to have precipitated the meeting, Ms. Predham, indicating that she had spoken with HIROC, and their views or concerns regarding, particularly in the context that they were involved in a class action out of Labrador, do you recall that being discussed?
MR. GULLIVER:
A. No, not at this meeting.
CHAYTOR, Q.C.:
Q. Do you recall that ever being discussed?
MR. GULLIVER:
A. This Labrador issue? No, never.
CHAYTOR, Q.C.:

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Q. Do you recall being in attendance at any meeting where the views of HIROC, the insurer, was discussed with respect to anything to do with this issue?
MR. GULLIVER:
A. I don't remember, and I think I might have been at two or three different meetings after where Dan Boone was there. I don't ever remember him, you know, saying that we shouldn't be going out public or making disclosure. My meetings with him, it was more for him to get a grasp of what's going on and what the issue could be, and what the potential could be.
CHAYTOR, Q.C.:
Q. Right, and I don't want you to go into any detail of anything between yourself and Mr. Boone. What I'm wondering is in terms of the issue the notification of the patients and HIROC's views on that, whether or not you were ever in attendance when that issue was discussed?
MR. GULLIVER:
A. I don't think I heard HIROC's views directly. I just know Susan was one of our early

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advocates who wanted immediately to go public and make some kind of statement.
CHAYTOR, Q.C.:
Q. And who was saying anything other than that?
MR. GULLIVER:
A. Well, I think it kind of evolved over the next week or two. As more and more information was being gathered, you know, about the hormone receptor testing, and the treatment of, and, I think you've heard it here already that by the time the organization is ready to make a decision on public communications, by that time I know I was at meetings where the oncologists--the oncologists were never concerned about disclosing to the public. The oncologists were concerned about not having enough information to go to their patients, and they were concerned about people who had this test performed who would not be affected by a retesting or outcomes, that it was going to actually put undue stress on those, the patients who would not be affected by this.
CHAYTOR, Q.C.:
Q. And -
MR. GULLIVER:

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A. So, I mean, I just know, I mean, and I'm not a communications person, but I do know in hearing the discussions that, boy, it would be very hard to decide to do one without another.

CHAYTOR, Q.C.:

Q. Okay, and so in terms of, though, making any kind of statement to the public and if that were to happen, then a lot of different patients out there would hear about that. Weren't the oncologists concerned about that?

MR. GULLIVER:

A. Yes, that was their -

CHAYTOR, Q.C.:

Q. Yes, they were concerned.

MR. GULLIVER:

A. That was a part of their concern.

CHAYTOR, Q.C.:

Q. And what else did you hear, was there anything else, any other factors or any other reasons of concern articulated by the oncologists?

MR. GULLIVER:

A. Again, it's, you know, they wanted to have more information that they felt like, you know, if I'm going to call up one of my patients and say, "Listen, you know, we're not

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sure about your original hormone receptor testing. We're going to have it retested. I can't tell you how long it's going to take to get retested. You have to wait for me to call back; it could be a week, four weeks, six weeks." At this time early on Mount Sinai had said they may have our retesting done in six weeks, and we know that just didn't happen. Again, I just think it was the uncertainty around the whole thing.

CHAYTOR, Q.C.:

Q. And did you hear any concern articulated as to the number of phone calls that the oncologists would receive if there were to be any kind of public announcement?

MR. GULLIVER:

A. Well, certainly. I mean, once the discussion was ongoing, I mean, that was a part of the discussion is that, you know, how many patients are going to call and, you know, want to speak to them directly and knowing--not knowing what they would tell the patients.

CHAYTOR, Q.C.:

Q. And did you hear any issue discussed as to any concerns regarding whether they would--whether

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the timing of notification to patients or the manner of notification to patients could impact insurance coverage?

MR. GULLIVER:

A. Not at all, no.

CHAYTOR, Q.C.:

Q. Okay. If we could have, please, P-0521? Oh, this is 0521, sorry. Yes, so that was the meeting on the 19th. And there's nothing else sticks out in your mind as to what happened at that meeting, is that right?

MR. GULLIVER:

A. No, no.

CHAYTOR, Q.C.:

Q. Okay. Looks like then on July 20th you also attend a meeting with Mr. Tilley this time, Doctors Williams and Cook and Ms. Predham and Ms. Thomas. And take you down through these bullets and then down at the bottom "Technical consultant from Mount Sinai coming in on September 12th, 2005." So I take it that's Trish Wegrynowski?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

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Q. So by July 20th that had been set up. And "No issues brought up at tumour board rounds." Do you know what that was in relation to?

MR. GULLIVER:

A. No. I'm thinking, I'm thinking George Tilley asked, you know, "Is there tumour board rounds and was this issue ever raised before amongst the pathologists, oncologists and those kinds of clinical groups?"

CHAYTOR, Q.C.:

Q. Okay. And P-0514, please? And, Mr. Gulliver, this is dated July 20th, 2005. It's for you, from you. And its subject is "Review of ER/PR Stats from 2000 to 2004, 2005." Perhaps you could tell us what this document is?

MR. GULLIVER:

A. Well, this is again at this point in time, remember we had seen a meeting maybe a the week before, it was trying to look at overall in our laboratory the numbers of tests we did a year and trying to ascertain, you know, how many do we have, how many positives and how many negatives do we have in our laboratory. And this was the very beginnings of starting that process. And, I mean, along the way you

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may see another 20 updates.
CHAYTOR, Q.C.:
Q. Of this document?
MR. GULLIVER:
A. Or similar documents where I'm adding years. I think after this one I went back then to do '97, '98, '99 as they were much more difficult to do in trying to access three different computer systems which you've heard, the Grace, you know, St. Clare's and the General.
CHAYTOR, Q.C.:
Q. Okay so this is the exercise of -
MR. GULLIVER:
A. But this beginnings of that.
CHAYTOR, Q.C.:
Q. - trying to show the positivity rates -
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. - through the various years?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And did this just include the primary breast cancer patients?

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MR. GULLIVER:
A. I can't--I have to say no.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. My intention, when this was being done--and this wasn't just me, I had other staff help me.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. This meant going in--to get to this one simple page took hours and hours and days and days and days because if you look at, take the year 2000, when I searched the Meditech system looking for the ER/PR procedures that were performed in our lab, it meant printing up hard copies of the patient's report; it meant then physically reading the reports to see what the pathologist's interpretation was, if they simply called it positive/negative, if they simply--or if they said a percentage; and then tabulating from those hard copies what the positive and negative rates were. At the time I tried to remove the non-breast

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primaries because you do ER/PR testing sometimes for metastatic disease to the liver or lung or other parts of the body. Those were taken out. But I do know upon further review, when we did the NLCHI stuff and reviewed all this again and reread every report again to verify, these numbers changed, they do change a little bit, not significantly, there were some years where there might have been some specimens that were left in that should have been taken out.
CHAYTOR, Q.C.:
Q. Yes. Now, Mr. Gulliver, you said originally Dr. Williams had asked you to undertake this?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And did you tell him it's taking hours and hours and days and days to get this information together?
MR. GULLIVER:
A. Oh, I think, I think he knew that. And at this time my pathology manager, Barry Dyer, was on vacation, so I'm pretty well, I think, doing most of this reading myself. And then

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myself and Barry, Mary Butler, actually, Mary actually helped me with some of these, too, at some point in time. I think might have been 2000 that Mary did. But Dr. Williams was aware that it's time consuming.
CHAYTOR, Q.C.:
Q. Yes. And in doing this, I take it, this had nothing to do with the actual getting the patients retested? This is -
MR. GULLIVER:
A. At this point in time, no.
CHAYTOR, Q.C.:
Q. That's not what this was about. This is -
MR. GULLIVER:
A. The first -
CHAYTOR, Q.C.:
Q. - to check your positivity rate?
MR. GULLIVER:
A. Right. This is the first exercise to start identifying patients who had ER/PR testing done and this was the first go through looking at the positive and negatives. And then the next exercise was Dr. Carter was going to review all the patient reports and her role was going to be to identify patients who

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should be retested and she was going to have them retested and then correlate that results with the oncologists.

CHAYTOR, Q.C.:

Q. Okay. So up to this point in time you weren't involved in that, that's something you take on in terms of the patient identification -

MR. GULLIVER:

A. That happens maybe a week or two after this.

CHAYTOR, Q.C.:

Q. After this, after you've got this piece done?

MR. GULLIVER:

A. Yeah. And again, I have to emphasize, you know, this is not--this was not scientific methodology that was used; this was simply at home in the nighttime, lots of times, just reading and writing numbers up and adding up and doing that kind of thing.

CHAYTOR, Q.C.:

Q. And did you tell that to--so I take it you had some concerns that, you know, these are basically just some rough numbers and -

MR. GULLIVER:

A. Exactly. And this, we're looking at--and really, that's what we're looking at, sort of

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a rough idea.

CHAYTOR, Q.C.:

Q. Yes. And not anything, you know, not anything to put any great reliance on in terms of your positivity rate?

MR. GULLIVER:

A. I wouldn't say not great reliance on, but at least it gave us a snapshot or an indicator. That no one had ever looked on a year-by-year from our laboratory what the positives and negatives were that were coming from the lab.

CHAYTOR, Q.C.:

Q. And that wasn't being tracked at the time?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Is that tracked now, Mr. Gulliver, your positivity rates?

MR. GULLIVER:

A. I really can't tell you for sure. I thought Dr. Carter before she left was tracking that and I think Dr. Elms may be. I mean, that's now a subspecialty breast group who are reviewing that and that really would be something that they would be doing as the

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pathologists.

CHAYTOR, Q.C.:

Q. And here we see, for example, in 2004, '05 it indicates a 90 percent positivity rate. Has that subsequently been checked and -

MR. GULLIVER:

A. That's been changed, yes.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. But see the '04, '05, those '04, '05s, sorry, Ms. Chaytor, it's a long day, they were--that's the Ventana ones.

CHAYTOR, Q.C.:

Q. Yes. And they were subsequently changed then. Do you know how it came about that that number was changed?

MR. GULLIVER:

A. I know I reviewed--and you see, the, I guess most--at this point in time most of the focus was on the ER/PRs that were done in 2002 and then broadened to really look at the DAKO system. Because we had gotten good positive feedback from, you know, from April, '04 to, at this point, July, '05, we had gotten good

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feedback from the pathologists in the Ventana system and the quality of slides from there. We had also, by this time, from Ventana, had retested some of the 2002s on our internal system and had gotten positive results. So it really wasn't at this point questioning the validity of Ventana. So -

THE COMMISSIONER:

Q. I think the question, Mr. Gulliver, was directed towards what--as I understood it, the 90 percent change subsequently.

MR. GULLIVER:

A. Yeah, I guess my--I guess my point is -

THE COMMISSIONER:

Q. The question was how did it change.

MR. GULLIVER:

A. At this point in time we just did the raw numbers for Ventana and never focused as much--paid much attention to it. Later on I reread every single report from Ventana and I had not removed the non-breast primary specimens like the livers and the brains that were done looking for metastatic disease. And then once I pulled those out, we had a--it changed, I think, down to 82 percent, maybe 82, 18 -

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CHAYTOR, Q.C.:
Q. And do you know whether Dr. Gown was involved in pointing that out in terms of -
MR. GULLIVER:
A. Oh, well, I don't think Dr. Gown was pointed it out. When he was in, there was some issue about are we getting too many positives off the Ventana. He just seemed -
THE COMMISSIONER:
Q. Mr. Simmons, do you want to stand on your feet at this point?
MR. SIMMONS:
Q. I was just going to say, anything to do with information passed on from Mr. Gown -
THE COMMISSIONER:
Q. From Mr. Gown.
MR. SIMMONS:
Q. - is -
THE COMMISSIONER:
Q. Considered privileged.
MR. SIMMONS:
Q. Perhaps, I mean, you know, perhaps I guess the question might be did it arise out of some interaction with Dr. Gown that (inaudible) go back and look at those (inaudible).

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THE COMMISSIONER:
Q. You do not tell us what Dr. Gown may have said because his -
MR. GULLIVER:
A. Okay, I didn't realize that.
CHAYTOR, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. - particular consult is regarded as -
CHAYTOR, Q.C.:
Q. We could look at -
THE COMMISSIONER:
Q. - being under privilege.
CHAYTOR, Q.C.:
Q. P-1135, please? And this is some time later then, June of 2006, Dr. Williams to yourself. "As per your request, in light of the remarks from Dr. Gown regarding our 2004, '05 Ventana ER/PR rates, I've reread each report and have identified the total number of positives previously reported and also included specimens that were ER/PR positive that were not breast specimens." So it appears that something that Dr. Gown said then caused the changes or to look at the 2004 Ventana ER/PR

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rates?
MR. GULLIVER:
A. That's correct.
CHAYTOR, Q.C.:
Q. That's correct.
THE COMMISSIONER:
Q. So, in looking at the earlier exhibit then for 2004, 2005 I should substitute these new results?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. Thank you.
CHAYTOR, Q.C.:
Q. What about the results for the first three months of 2004?
MR. GULLIVER:
A. They should be--do you have them on another -
CHAYTOR, Q.C.:
Q. We can go back to the other exhibit.
MR. GULLIVER:
A. For January, February, March, the last three months of DAKO?

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CHAYTOR, Q.C.:
Q. So they are all lumped in here, is that right, in this--is this where they are?
MR. GULLIVER:
A. No, no.
CHAYTOR, Q.C.:
Q. No?
MR. GULLIVER:
A. No, I don't--no, at this point in time they weren't.
CHAYTOR, Q.C.:
Q. No?
MR. GULLIVER:
A. Again, this is the beginnings of it.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. This certainly grows and adds to it. I probably at this point in time, July 20th, had these years fully reviewed and then I did the January, February, March of '04 as a separate group for DAKO. And then I did '97, '98, '99.
CHAYTOR, Q.C.:
Q. Okay. The adjustment that was made at some comment from Dr. Gown and this number 90 comes

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down, insofar as that included other than primary breast cases, do you know whether or not further adjustments were made in your other years to allow for whether or not -

MR. GULLIVER:

A. Yes, there was.

CHAYTOR, Q.C.:

Q. There were adjustments?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. So all of these numbers came down eventually?

MR. GULLIVER:

A. I don't think all of them did, no.

CHAYTOR, Q.C.:

Q. But -

MR. GULLIVER:

A. I think, I think what you see here, 2000 may have come down a little bit afterwards. And maybe '98. But you'll probably see it some other point, exhibits we've given you, so that the final, the final statistics for this kind of review, and was after refining and updating, refining and updating.

CHAYTOR, Q.C.:

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Q. And what purpose did you think that Dr. Williams was going to use this information?

MR. GULLIVER:

A. I thought just so we can get an idea in the lab what our--and Dr. Cook, what our positive--total positives and negatives were.

CHAYTOR, Q.C.:

Q. And did you realize the information would be included in the briefing note to the Minister?

MR. GULLIVER:

A. No, no, I didn't.

CHAYTOR, Q.C.:

Q. Okay, and if we could look, please, at P-0075? And on page two of this document, you'll see July 20th, "upon review of the statistical data, it" I think that should be, "has been concluded that the positivity rates are, while on the low end of the scale, within acceptable range" and then total positivity numbers and it goes on from there and you'll see those numbers, including the 90 percent. So you didn't realize that this was going to be forward?

MR. GULLIVER:

A. I was just asked by Dr. Williams. What he was

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going to do with it would be his, you know, his decision.

CHAYTOR, Q.C.:

Q. And then as time went on -

MR. GULLIVER:

A. But I have to say, even for myself and for our lab, you know, it was also a good exercise to be able to see, you know, really--Dr. Cook had said that he had made some phone calls and some people said that you should get around a 75 percent, 25 percent ratio. Other people said it could be like 65 percent. So at least we could see where do we fall in as a trend type of thing.

CHAYTOR, Q.C.:

Q. Yes, and when the testing resumed in February 2007, you're not sure if anybody tracked the positivity rates then over the next year or so that the tests were done here in St. John's?

MR. GULLIVER:

A. I'm not 100 percent sure if Dr. Carter or Dr. Cook was doing that, or Dr. Elms.

CHAYTOR, Q.C.:

Q. And this exercise of tracking the positivity rates or going back over the tests, you

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continued to do that for a period of time, I take it?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And we see updated versions from time to time. For example, if we look at P-0522, it's just a few days later. There's another document here.

MR. GULLIVER:

A. That's Sunday, so another three or four nights doing it and now added 99 to it, and -

CHAYTOR, Q.C.:

Q. '99 was added, yes.

MR. GULLIVER:

A. - I still don't see the -

CHAYTOR, Q.C.:

Q. No, the '04, beginning of '04.

MR. GULLIVER:

A. No, three months, January, February, March.

CHAYTOR, Q.C.:

Q. Do you see that here?

MR. GULLIVER:

A. I thought I had them in there, Ms. Chaytor, as a separate three months.

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CHAYTOR, Q.C.:
Q. Okay, well, we'll -
MR. GULLIVER:
A. I don't think I added them to the 2003's.
THE COMMISSIONER:
Q. On the side (inaudible) there's 2004 with numbers. Is that it?
CHAYTOR, Q.C.:
Q. Right over here.
MR. GULLIVER:
A. That's not my writing.
THE COMMISSIONER:
Q. Oh, okay.
CHAYTOR, Q.C.:
Q. That looks like Dr. Cook's, I believe, okay, and perhaps it is somewhere. We can certainly check, but you basically went through this exercise throughout then 2005 and 2006 and you were updating this from time to time?
MR. GULLIVER:
A. Most of the work was done in the first, you know, in the first few weeks of this here. The refinement came, you know, at a later date, and I guess, the final review, when I worked with NLCHI in--who were, as you know,

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doing the database or what we call the database, we went back and reviewed all those reports to verify, because they wanted to see exactly, here are all the reports, to make sure this number is the final number type of thing.
CHAYTOR, Q.C.:
Q. Okay. If we could have, please, P-0515? And this is a meeting of July 21st, 2005. You're not in attendance at this meeting. It's Doctors Carter, Cook and Williams and I just wanted to bring your attention though to--it says here, "some runs, on retrospect, were not normal." Was that discussed with you around this time, that some of the runs -
MR. GULLIVER:
A. Dr. Carter never discussed any of this, any findings that she may have had, with me.
CHAYTOR, Q.C.:
Q. Okay, "inconsistency from one batch to another," was that discussed with you?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. "Techs may need to be retrained in

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immunoperoxidase and need controlled access to the room." Was that discussed with you?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. "Training of techs," then it says again "in immunohistochemistry."
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. "Need separate service. Need QA and proficiency testing." Those points were discussed. We've seen those in -
MR. GULLIVER:
A. At a later point. I think when Dr. Ejeckam comes back from holidays and Barry comes back, they start looking at some of that.
CHAYTOR, Q.C.:
Q. Okay, and the second bullet here, "the sentinel case, reviewed old slides. Program would not always run a control."
MR. GULLIVER:
A. Well, I think that's--this is probably Dr. Williams' notes. I think what really it should say there--well, that's not think,

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that's completely wrong, the program would not always run a control. I think what he's probably trying to understand is that the program wouldn't always run a control for every single pathologist. At some point in time, they ran a control for the batch. There were times where controls were run for--it could be five controls in the same batch, depending on if there was five different pathologists were going to interpret the slides. So I think what you have written there really is completely wrong.
CHAYTOR, Q.C.:
Q. What Dr. Williams has recorded you mean from the meeting?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Yes, and so, and I take it, he didn't come back to you and ask you anything else about this -
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. - in terms of, you know -

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MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. - "well, Mr. Gulliver, would the program run controls? Because you've indicated to me that they did."
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. That wasn't an issue brought up with you by Dr. Williams after this?
MR. GULLIVER:
A. Not that I remember, after this, no.
CHAYTOR, Q.C.:
Q. Okay. If we could have then, P-2001? And then this is a July 24th meeting and it is a fairly large group and these are Dr. Cook's notes. So we don't have a typed version, but it appears to include Mr. Tilley, Dr. Gardiner, Dr. Williams, Heather Predham, Dan Boone, yourself, Susan Bonnell, Dr. Laing, Alan Kwan, Dr. Kwan, Deborah Thomas.
MR. GULLIVER:
A. I think this is the one now we're talking about, the disclosure and stuff.

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CHAYTOR, Q.C.:
Q. So this is the one you think -
MR. GULLIVER:
A. I think so, yeah.
CHAYTOR, Q.C.:
Q. - concerning the--and the oncologists stating their views on disclosure?
MR. GULLIVER:
A. I think so.
CHAYTOR, Q.C.:
Q. And there's a comment in here and this says, Dr. Cook said it in his evidence, "large percentage of conversions probably due to technical changes, technical change" and do you recall that being discussed at this meeting?
MR. GULLIVER:
A. Well, whether it was this meeting or not, I can't tell you, but certainly there was discussion talking about, at this point in time, Dr. Cook had sent cases to Mount Sinai, you know, older cases, and there was a lot of debate--well, first of all, it was a lot of -
CHAYTOR, Q.C.:
Q. This is July 24th, 2005.

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MR. GULLIVER:
A. Yeah, but we've already got, I think, some things retested at this point in time. I know there was a lot of -
CHAYTOR, Q.C.:
Q. At Mount Sinai?
MR. GULLIVER:
A. I'm thinking by July 24th.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. Yeah, I think so. But there was some debate too about the whole science behind this test, and the people in the room who, you know, really are decision makers who are not lab medicine people, they're not pathologists or technologists, is trying to make them aware and understand some of the science behind this test and this discussion was really about--even over the years, if you look at how this test was performed in '97 and the actual step-by-step process, it didn't really change much in 2004. What changed over the years, as you know, the new and improvements that you see from the vendors, you know, at some point we

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got a new detection kit. You might have changed your antibody clone. You have a new--we got a new pH for boiling the slides on the hot plate. So all those technological changes that took place over the years that the new--the old specimens being retested the new way, there was some discussion around, and wonder what impact--has that had an impact on the changed results, you know, because we retested it in 1999 using this kit and this reagent and this one and now it's retested six years later using the newer reagent and new upgrade, you know, would that have an impact on the change in results. That was this discussion.
CHAYTOR, Q.C.:
Q. So if Dr. Cook attributed this comment to you that a large percentage of the conversions could probably be due to technical changes, would you take issue with that?
MR. GULLIVER:
A. I don't think that can be attributed to me saying that. I'm just saying I think that was some of the discussion that was going on amongst the group, was talking about just the change in technology, not equipment

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technology, but just changing and upgrading the different reagents and antibody clones in any test that you do over the years.

CHAYTOR, Q.C.:

Q. And who in this group, out of people that we've identified here, would be discussing those issues?

MR. GULLIVER:

A. Well, I think most of them there are physicians and it's something that physicians would certainly be well aware of. There's changes in practice all the time. Whether it's a lab practice or lab procedure, whether it's an oncology practice or oncology procedure or you have a new MRI system come in that's better than the old one. I mean, that's the kind of discussion that was going on.

CHAYTOR, Q.C.:

Q. But there's no pathologist in attendance, except for Dr. Cook.

MR. GULLIVER:

A. Dr. Cook is there.

CHAYTOR, Q.C.:

Q. Yes, except for Dr. Cook, and the rest

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certainly wouldn't be very familiar with the laboratory medicine program, I take it.

MR. GULLIVER:

A. No, no, we're talking in general, in any program.

CHAYTOR, Q.C.:

Q. Okay, so that's your recollection -

MR. GULLIVER:

A. Where there is a change in -

CHAYTOR, Q.C.:

Q. - as to what this was about?

MR. GULLIVER:

A. That's my best recollection, yeah.

CHAYTOR, Q.C.:

Q. And you're not taking credit or blame for this statement that "a large percentage of the conversion is probably due to technical change," that wasn't something you were putting forward?

MR. GULLIVER:

A. No, but the fact is there was technical change. You know, the issue was did a percentage of these conversions, was that a cause of the conversion.

CHAYTOR, Q.C.:

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Q. P-0078, please? This is an e-mail from Ms. Predham, July 28th, 2005, to yourself and Mr. Cook and it's copied to Dr. Williams re: ER/PR, and she writes "the more I thought of it last night, the more I realized that it is critical that we get the results for the time we ran both the DAKO and the Ventana system in April 2004. This would give us exactly what we need, our positivity rate with both systems and our conversion rate as well. We would have been in close contact with the company at that time and our rates during that period obviously were satisfactory to all involved because we went live on the Ventana system. Can we get the results for that period of time quickly? Also, I hate to nag. Could you give me the numbers of samples we sent to Mount Sinai during that six-week period in 2003? If we had more than about 15 or so, we should probably look at the positivity rate, as they were done elsewhere. Thanks, Heather."

Now Mr. Gulliver, what do you recall about this and any response that you would have provided to Ms. Predham on those issues?

MR. GULLIVER:

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A. I think where Heather was--again, it's the early days. People are trying to understand even the lingo, what goes on in a medical laboratory. I think what Heather was asking, "well, if you had the Ventana system and you are validating it and you're still operating DAKO for a period of a few months that you were reporting off DAKO, was there side-by-side testing done on both and is there interpretation from both?" So did a pathologist take a test off Ventana, the same patient off DAKO and compare results? And I don't think that happened. I think what happened was Dr. Ejeckam just took cases and had them run through the Ventana system to assure and to get the results he expected to get from that particular patient. I don't ever remember seeing a side-by-side direct comparison from this breast cancer patient and the same patient over on this side. Now I could not be 100 percent sure. Mr. Dyer may know more, and Dr. Ejeckam certainly would know more.

CHAYTOR, Q.C.:

Q. And this was sent to you and -

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MR. GULLIVER:
A. But this is what she was actually asking for.
CHAYTOR, Q.C.:
Q. Yes, so I take it, it was sent to you and Dr. Cook, so you made inquiries as to what happened, I would take it, back in 2005 when you received this, and what were you able to find out?
MR. GULLIVER:
A. I think that's what I just told--what I said to Heather, what I just told you.
CHAYTOR, Q.C.:
Q. So you made inquiries of Mr. Dyer?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And did you have any discussions with Dr. Ejeckam about it?
MR. GULLIVER:
A. I don't even know if Dr. Ejeckam was even back then.
CHAYTOR, Q.C.:
Q. Well, you know, around this time period.
MR. GULLIVER:
A. I don't remember asking Dr. Ejeckam.

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CHAYTOR, Q.C.:
Q. Back from vacation, you mean?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Is that what you mean?
MR. GULLIVER:
A. And I don't know if Dr. Cook responded to Heather either.
CHAYTOR, Q.C.:
Q. Okay, and the fact that samples weren't sent out is what you're able to ascertain in that six-week period?
MR. GULLIVER:
A. I know, and really I don't think that any samples were sent out during that time, that few weeks where Dr. Ejeckam was optimizing those antibodies.
CHAYTOR, Q.C.:
Q. When you went through -
MR. GULLIVER:
A. I think they were just held in house.
CHAYTOR, Q.C.:
Q. Okay, and when you went through in--and we'll get to what you did in trying to identify the

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patients. When you went through all the pathology reports, did you see any evidence of that period of time that tests had been sent to Mount Sinai in the spring of 2003?
MR. GULLIVER:
A. I didn't, see. I mean, that's the thing. When I read those reports, obviously there's the occasional report that was probably a consult. It was like a pathologist asking for a second opinion on a particular case, but it wasn't asking for a second retest anywhere else. But you know, I didn't come across a period where like there was 20 or 30 that were resulted from Mount Sinai.
CHAYTOR, Q.C.:
Q. Okay. All right, Mr. Gulliver, we understand there was another--shortly after this, there was another large group meeting on August 1st and it involved Mr. Tilley, the CEO. Did you attend that meeting?
MR. GULLIVER:
A. Yeah. Well, there was--there was lots of them, but there was another one where George called it and there was a large group there.
CHAYTOR, Q.C.:

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Q. Okay, and what happened at that meeting? What do you recall from that meeting?
MR. GULLIVER:
A. I think, you know, is that a few days after this one, on a Sunday or Monday or something? I think George called that meeting. Again, I still think, you know, from the organization's perspective, to get their heads around, you know, like where do we go from here? You know, if we have this much information so far, what are we doing as an organization now to deal with this particular issue? I think that was the context of the meeting as a group, and to, I guess to lay our plan so he would know, as the CEO, like what are we planning to do to deal with this.
CHAYTOR, Q.C.:
Q. And leading up to that meeting, Mr. Gulliver, did you hear anything--Mr. Dyer, back on May 17th, had come to you and was upset about whatever had transpired in that meeting and felt that the lab was being blamed. Did you hear, yourself, any accusations along those lines after that, following into June, July of 2005?

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MR. GULLIVER:
A. No, I never heard nothing directly, but you know, in some of the e-mails or letters, I mean, if I'm reading them, I kind of can infer something from them. I don't really hear that again, as you know, until the meeting with Mr. Tilley, the August 1st of 2nd meeting, whenever it may be.
CHAYTOR, Q.C.:
Q. And so then you attend the large group meeting and what do you recall happening at that meeting?
MR. GULLIVER:
A. Well again, I mean, it was a cross group of oncologists, you know, Mr. Tilley, my Vice President, Dr. Williams, Dr. Cook was there. Dr. Carter was there. I actually think I brought Barry Dyer, my pathology manager, to this meeting. He's back from vacation. I think he's just back actually from vacation, and I think Susan Bonnell and Heather Predham, there was a large group there, and again, it was George wanted to get an update from all the groups of how are we dealing with this issue, what's the next action plan that's

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going to happen.
CHAYTOR, Q.C.:
Q. And so what happens? What's discussed?
MR. GULLIVER:
A. Well, again, we're talking about--well, obviously the lab is a big piece of the discussion. You know, up to this point, no one still has any idea really, you know. There's some debate about, well, we have a new Ventana system, so is that why we have result changes? Or do we have result changes because the old system really wasn't working? We've got other people who were saying, you know, there's also a false negative rate built into this test. There's also a science behind this whole testing, and then there's also an interpretation to this test by the pathologists and then an application of that interpretation by the oncologists to the patients. I mean, that really was the big picture discussion that was going on at this meeting.
CHAYTOR, Q.C.:
Q. So was there any discussion that pathologists somehow weren't interpreting the slides

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properly?
MR. GULLIVER:
A. Not really. Most of the lab discussion was being carried on, I guess, early on by Dr. Carter and you know, you just opened up that avenue what you just said earlier about the May 17th, the meeting with Mr. Barry Dyer. At this meeting, this is the one where after some discussion and, you know, all these different kinds of theories were being put around the testing. This is the one where Dr. Carter, who was sitting across the table from me, and Mr. Dyer. You know, Dr. Carter, it was her opinion that our laboratory was making mistakes and errors and she made several statements or comments that really, I think really ramped up the whole, everyone in the room, really ramped up the whole issue.
CHAYTOR, Q.C.:
Q. And how so?
MR. GULLIVER:
A. Well, I think you're sitting in a room with people who doesn't have--don't have a good understanding of lab medicine and you've got the CEO there and the Vice President, I think

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Dan Boone may be there from HIROC. You've got our communications people, our risk management people, and here you have a doctor sitting there, a pathologist, you know, pointing across the table at myself, whether it was me or Mr. Dyer or both of us, and saying that, you know, "your lab is making mistakes and errors" and she said that, you know, "your lab." She said that I have--at one point in time, she said that she never seen a positive result from your lab in over six months, when she went to St. Clare's, and she said things like "your lab should have been running negative controls along with the positive control." I mean, those are the kinds of things that Dr. Carter was saying to me, and when she finished saying them, it was--well, I guess the room was a bit silent, and I mean, I felt, as director of the program, that I really had to respond to her and respond to her, you know, right there and not at a later date, and I certainly did respond to her.
CHAYTOR, Q.C.:
Q. And what did you say?
MR. GULLIVER:

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A. Well, I think my first thing, I mean, well first of all it was just absorbing of what she was pretty well saying. I think my first response to her was that, well, Dr. Carter, you're a part of the lab, you know, when she was saying "your lab was making mistakes and errors" that, you know, she's a part of the lab program also. And I said to her that, you know, if you're informing me now in 2005 that you seen a six month period where you didn't see one positive result for six months and I think it was in 2003 she was talking about, that it's two years later that you're even telling someone that. And I also said to her that you've been here as our breast specialist for over two and a half years and why is it now just at this meeting that you are recommending to run negative controls with IHC, you know, why has it taken you two and a half years to recommend that? At that point, things were getting really heated. She was starting to get pretty well, you know ansy, and Mr. Tilley pretty well called the meeting to order and finished the meeting.

CHAYTOR, Q.C.:

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Q. Okay, and how did Dr. Carter respond to the things that you pointed out in terms of why you were only now being informed of those issues?

MR. GULLIVER:

A. She didn't make no other comment. She left the meeting.

CHAYTOR, Q.C.:

Q. Did anyone else speak up and defend the Laboratory Medicine Program or the lab?

MR. GULLIVER:

A. I don't think they had time because I think Mr. Tilley at this point realized that this meeting, you know, I don't think it was getting what he figured it was going to accomplish -

CHAYTOR, Q.C.:

Q. It had deteriorated, I take it.

MR. GULLIVER:

A. And I think he was--he decided that, you know, we'll just adjourn the meeting and we'll discuss this again later.

CHAYTOR, Q.C.:

Q. Was there then any decision at the end of that meeting as to how everybody was going to go

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forward to investigate the problem at hand?

MR. GULLIVER:

A. At that meeting there was no decision, no. But now immediately following that meeting and -

CHAYTOR, Q.C.:

Q. And I'll ask you about that, but before we leave the meeting, other than this somewhat of a confrontation, I would take it between yourself and Dr. Carter -

MR. GULLIVER:

A. I don't know if it was a con--I mean, she said her say and I had my say.

CHAYTOR, Q.C.:

Q. Yes, okay, well the heated discussion, I think "heated" was your word, was anyone else--was anyone else engaging in that kind of a discussion? For example, did anyone else say that they thought it was the lab's fault or the technologists' fault?

MR. GULLIVER:

A. Not--no, I mean, there was no one else there who was pointing a finger and saying it was the lab's fault. I just think people wanted to try and get a grasp and understand the

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testing and the implications from the testing.

CHAYTOR, Q.C.:

Q. And was there any kind of accusations amongst any other professional groups where -

MR. GULLIVER:

A. I did not, like the oncologist weren't blaming the pathologists; the pathologists weren't blaming the oncologist, no, that wasn't going on.

CHAYTOR, Q.C.:

Q. And did you ever hear of that, did you ever hear anybody suggest well the oncologist should have picked up on this or the pathologists weren't doing their job properly?

MR. GULLIVER:

A. I didn't hear directly.

CHAYTOR, Q.C.:

Q. And where did you hear it indirectly?

MR. GULLIVER:

A. Well this is after this meeting and I guess it's the fall out from this meeting.

CHAYTOR, Q.C.:

Q. Okay, well then continue on and tell us this story.

MR. GULLIVER:

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A. Because the fall out from this meeting was that when I left this meeting, by this time, you know, I'm almost a month and I mean, a month, day and night, you know, dealing with and responding and reading reports and doing positive rates and negative rates and at meetings. At this point in time and I think it was late in the evening by the time the meeting was over, myself and Mr. Dyer were walking back to my office and I was going to resign the next day.

CHAYTOR, Q.C.:

Q. And why is that?

MR. GULLIVER:

A. Because I didn't think that our lab warranted -

CHAYTOR, Q.C.:

Q. Because of what had just transpired with Dr. Carter?

MR. GULLIVER:

A. (No audible response).

CHAYTOR, Q.C.:

Q. That's okay, take your time.

MR. GULLIVER:

A. As it happened, when I got back to my office,

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Dr. Williams called me and he said to me that George was with him in the office, George Tilley and he said that George wanted to rely that he was impressed how I handled myself at that meeting and he apologized for how he let the meeting get out of hand. And that really made my decision to stay at my job, to hear that from Dr. Williams. And that evening, I stayed however long it took, I don't know how many hours, but I did do a Meditech search. I looked for and I think it was 2003, Ms. Chaytor, I could be wrong, but I'm thinking it was 2003, but the year, the six-month period that Dr. Carter had said that there hadn't been a positive result come from the laboratory, I printed every patient report, I sorted them by positive, by negative. I tabulated the results and then the first thing the next morning, I called Dr. Williams, I went to meet with him in his office and I showed him the actual facts and statistics. Obviously Dr. Williams was very upset. He called Dr. Cook on the phone who was at St. Clare's and asked Dr. Cook to come over to the office immediately. We waited for Don to show

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up and we showed Don the actual patient reports and the facts, that there was more positives every single month reported than negatives for the time period Dr. Carter had said that she hadn't seen a result from the lab that came out positive. And Dr. Cook, you know, he did not defend Dr. Carter; however, he did say, "well you know, Bob, you know what Bev is like, you know, she really ramps things up and she says things before she thinks about them and, you know, I don't know if that's exactly what Bev really meant at the meeting yesterday". Anyway, so Dr. Williams asked Dr. Cook to call Dr. Carter at St. Clare's and ask her to come over and meet with them and I was last then to leave the meeting. And to my knowledge, Dr. Carter came over and she met with Dr. Williams and Dr. Cook.

CHAYTOR, Q.C.:

Q. And in looking and reviewing those reports for that six-month period, was that something you did on your own initiative or did Dr. Williams -

MR. GULLIVER:

A. I did it myself, yes. I was not asked to do

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that.

CHAYTOR, Q.C.:

Q. And did you ever have occasion afterwards to discuss this with Dr. Carter?

MR. GULLIVER:

A. No, because either the next day or the day after, it was very shortly after this here, the next thing I knew Dr. Carter had then sent over her letter of resignation to Dr. Williams resigning from any review that she was supposed to be the one who was going to review and identify patients for retesting and do all that piece of the work, because I had brought all those reports, the two boxes of reports that I had gone through for positivity rates, were the same reports we had to review and identify patients who should be retested.

CHAYTOR, Q.C.:

Q. So you had gone into Meditech, is that right and found -

MR. GULLIVER:

A. That was all done.

CHAYTOR, Q.C.:

Q. And printed off all the pathology reports, reviewed them for purpose of positivity rates

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and then delivered them to -
MR. GULLIVER:
A. Dr. Carter.
CHAYTOR, Q.C.:
Q. Dr. Carter.
MR. GULLIVER:
A. At St. Clare's. So to this day when she resigned from doing the review, then I was asked by Dr. Williams, well, you know, who is going to do, review all these reports and I said, well, I will do it. And I drove back to St. Clare's that same day, I think, and went to Dr. Carter's office and I removed the reports I had given her a couple of weeks prior. And that's when I started the review then of taking on that responsibility, I guess.
CHAYTOR, Q.C.:
Q. And you didn't, in getting the reports back from her, discuss the issue with her?
MR. GULLIVER:
A. I did not, no.
CHAYTOR, Q.C.:
Q. And do you know whether or not she attempted to discuss it with you or Barry Dyer?

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MR. GULLIVER:
A. No, the only thing that happened was and it's all within the same day or two of each other, Dr. Carter had called Mr. Dyer. She got his voice mail and she left him a message on his voice mail system and it seems like she immediately hung up and called back again, like ten seconds later because she forgot to say something and, you know, when that happened, Barry--I knew the voice mails were there in Barry's system and I don't know why, I said to Barry, don't ever erase those, keep them. And then we had them taped and transcribed and gave them as evidence for the Commission of Inquiry.
THE COMMISSIONER:
Q. Wherever you can find a spot, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. So perhaps then we'll just have a quick look at P-0079 and then we'll pick it up next time with how you then go about identifying the patients. And this is the letter where it's August 7th, 2005 to Dr. Cook, where Dr. Carter in fact resigns from her involvement and at the time were you--had you seen a copy of this

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letter and the reasons set out by Dr. Carter?
MR. GULLIVER:
A. No, she never sent me a copy, no.
CHAYTOR, Q.C.:
Q. And the fact that she writes, "Meeting with Mr. George Tilley on August 1, 2005, showed in my opinion that Mr. Terry Gulliver and Mr. Barry Dyer do not have a good understanding of the limitations of automated immunohistochemistry, rigorous clinical and technical validation of antibodies against ER and PR and establishment of reliable and reproducible means of providing ER/PR results to our patients. Using the substantial published peer reviewed and accepted scientific literature on the development of a continuous monitoring of immunohistochemical testing protocol." And Mr. Gulliver, what in the meeting of August 1st, 2005 was discussed that could lead Dr. Carter to think this?
MR. GULLIVER:
A. There was nothing discussed of this nature at that meeting, nothing.
CHAYTOR, Q.C.:
Q. And did she ever at any other point in time

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bring this up with you that her, what she felt were the limitations of your knowledge and that of Mr. Dyer?
MR. GULLIVER:
A. Never directly.
CHAYTOR, Q.C.:
Q. And she also writes, "It also became clear to me during that meeting that the current administrative structure within Eastern Health and within the laboratory allows decisions regarding the development of a reliable and reproducible system for assessing hormone receptor status to remain in the hands of professional staff within the laboratory." And the issue or a concern regarding the decision making under the current administrative structure, was that ever discussed with you directly by Dr. Carter or the letter is being written to Dr. Cook?
MR. GULLIVER:
A. No, she never spoke to me about it, no.
CHAYTOR, Q.C.:
Q. It's also being copied to Dr. Williams. Did Dr. Williams bring either of those issues up?
MR. GULLIVER:

A. I think Dr. Williams--after this happened when Dr. Williams asked would I then, you know, take on this role, I think this is when I seen this letter.

CHAYTOR, Q.C.:

Q. So Dr. Williams showed you the letter. Did he also speak to you about the concerns that were expressed by Dr. Carter?

MR. GULLIVER:

A. No, I don't think he had the same opinion.

CHAYTOR, Q.C.:

Q. And just one other question about the August 1st meeting, do you recall Dr. Carter taking issue with any public or any assertion to be made to the public that the reason for the conversions could be due to changes in technology?

MR. GULLIVER:

A. I don't think Dr. Carter ever believed that it was a change in technology.

CHAYTOR, Q.C.:

Q. Yes, and she was taking issue with any assertion that would be made along those lines, do you recall that being discussed? I don't remember her taking issue with it, but I

would certainly think, you know, that Dr. Carter's opinion would have been that this is not a technology issue type of thing.

CHAYTOR, Q.C.:

Q. Yes. Thank you, Commissioner.

THE COMMISSIONER:

Q. We'll adjourn now until 9:30 in the morning. There's another witness scheduled for the morning who is coming in from outside of the province. Mr. Gulliver, your counsel and Commission counsel will work out the date when we can continue with you.

MR. GULLIVER:

A. Thank you.

THE COMMISSIONER:

Q. Thank you.

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 8th day of October, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 8th day of October, A.D., 2008

Judy Moss

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