

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">October 8, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Chesley Crosbie, Q.C.. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike, Q.C. NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Blair Pritchett. . . . Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBIT P-3030 Pg. 201</p> <p>EXHIBIT P-3119 Pg. 201</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>MR. TERRY GULLIVER - RESUMES THE STAND</p> <p>Examination by Sandra Chaytor, Q.C. Pgs 4 - 366</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 COMMISSIONER: 2 Q. Ms. Chaytor. 3 MR. TERRY GULLIVER, EXAMINATION BY SANDRA CHAYTOR, Q.C. 4 (CONTINUED) 5 CHAYTOR, Q.C.: 6 Q. Good morning, Commissioner. Good morning, Mr. 7 Gulliver. 8 MR. GULLIVER: 9 A. Good morning, Ms. Chaytor. 10 CHAYTOR, Q.C.: 11 Q. Mr. Gulliver, we've heard here about 12 interventions that Dr. Ejeckam made in 2003. 13 Any time prior to then had anyone raised any 14 concern with you with respect to IHC testing 15 and in particular ER/PR, any issues regarding 16 fixation or any other issue that was affecting 17 the quality of product that the technologists 18 was producing? 19 MR. GULLIVER: 20 A. Not to my knowledge, no. 21 CHAYTOR, Q.C.: 22 Q. And given everything that's happened after 23 that point, do you think if people had raised 24 those issues with you, you would have a 25 recollection of it?</p>

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1 MR. GULLIVER:
 2 A. Oh, definitely, yes.
 3 CHAYTOR, Q.C.:
 4 Q. So the first time you hear of any issue
 5 regarding the IHC is when Dr. Ejeckam brings
 6 it forward in 2003?
 7 MR. GULLIVER:
 8 A. Well, I guess the issues that he was
 9 addressing in those memos.
 10 CHAYTOR, Q.C.:
 11 Q. So were other issues brought to your
 12 attention?
 13 MR. GULLIVER:
 14 A. Well, I mean, it's a practising laboratory,
 15 you know, things are changing all the time.
 16 Obviously, I mean, if you don't perform those
 17 tests every single day, week after week, month
 18 after month, year after year and there's never
 19 an issue, it could be a simple issue, but
 20 nothing to the issues of what Dr. Ejeckam was
 21 doing.
 22 CHAYTOR, Q.C.:
 23 Q. Yes. So nothing that would cause you to
 24 question whether or not the tests were being
 25 done properly?

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1 MR. GULLIVER:
 2 A. No, never.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. Were you aware of tests having to be
 5 repeated prior to Dr. Ejeckam becoming
 6 involved?
 7 MR. GULLIVER:
 8 A. I was aware of the ER/PRs being repeated, but
 9 I was aware of that from more of a technical
 10 perspective. I know the antigen retrieval
 11 part of the procedure where you had to
 12 actually take patient slides and boil them for
 13 20 minutes on a hotplate, just with my
 14 technical background I know that would lead
 15 quite often to the tissue just pretty well
 16 boiling or washing off the slide and therefore
 17 you'd have to repeat the procedure.
 18 CHAYTOR, Q.C.:
 19 Q. So what were you aware of and what time frame
 20 would that have been?
 21 MR. GULLIVER:
 22 A. Oh, that was sort of, I won't say common
 23 occurrence as every time a batch was run, but
 24 certainly it was frequently enough that you
 25 knew that one of the challenges was to keep

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

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1 different in terms of the slides that were in
 2 use?
 3 MR. GULLIVER:
 4 A. Well, I didn't really determine it. It was
 5 the company who came out and said, "We now
 6 have newer slides that you could use that
 7 would help keep the tissue on the slide from
 8 washing off."
 9 CHAYTOR, Q.C.:
 10 Q. And in terms of the tissue washing off the
 11 slides in and of itself and what would be
 12 causing that, was there any inquiry made as to
 13 what would be causing that in the first place?
 14 MR. GULLIVER:
 15 A. Just quite simply, you have tissue on a slide,
 16 boiling it on a hotplate, just that function -
 17 CHAYTOR, Q.C.:
 18 Q. So that wasn't an unexpected finding?
 19 MR. GULLIVER:
 20 A. No, no.
 21 CHAYTOR, Q.C.:
 22 Q. So other than that, so what you're saying is
 23 that the only issue that was brought to your
 24 attention was really a non-issue, something
 25 that you would expect to be happening and that

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1 was -
 2 MR. GULLIVER:
 3 A. Correct.
 4 CHAYTOR, Q.C.:
 5 Q. And that was taken care of by purchasing
 6 different slides?
 7 MR. GULLIVER:
 8 A. Yeah.
 9 CHAYTOR, Q.C.:
 10 Q. Or different adhesive for the slides. In
 11 terms of the actual product, then, that was
 12 produced at the end of the day, the quality of
 13 the slides, was anything of that nature
 14 brought to your attention?
 15 MR. GULLIVER:
 16 A. No.
 17 CHAYTOR, Q.C.:
 18 Q. And the fact that what you're telling me is
 19 that at times the technologists would have to
 20 repeat their procedure because they were
 21 having difficulty keeping the material on the
 22 slide. But the fact that there may have been
 23 tests repeated after they had already gone
 24 through the technical process and been
 25 interpreted by a pathologist, the fact that

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1 any tests were repeated, was that brought to
 2 your attention at any time prior to Dr.
 3 Ejeckam's intervention?
 4 MR. GULLIVER:
 5 A. No, it wasn't. But again, I have to say, in
 6 pathology there are lots of instances where--
 7 and it's not just for ER/PR, it could be a
 8 routine histochemical stain in the pathology
 9 lab, for some reason the pathologist may want
 10 to have a repeat. They may come in and say,
 11 "You know, you did those stains on block C.
 12 Upon review, I think I'm going to choose block
 13 F and could you repeat the stains on a
 14 different block or different part of the
 15 tissue?" You know, that's not an uncommon
 16 practice within the pathology environment.
 17 CHAYTOR, Q.C.:
 18 Q. And whether or not it was a concern around
 19 those repeats from a pathologist's point of
 20 view in terms of an unexpected finding or a
 21 change in results, anything along those lines
 22 ever brought to your attention?
 23 MR. GULLIVER:
 24 A. Never heard a thing, no.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. So what do you hear from Dr. Ejeckam,
 2 what's the first time that you hear that Dr.
 3 Ejeckam sees need to take certain
 4 interventions?
 5 MR. GULLIVER:
 6 A. I think, well, I'm pretty sure it was,
 7 actually it was Mr. Dyer, the pathology
 8 manager. He had come to me with a notice, a
 9 very short notice that Dr. Ejeckam had
 10 written, I think he addressed it to
 11 pathologists in general across the province,
 12 where he informs them for a short period of
 13 time there are certain antibodies in the
 14 laboratory that we will stop reporting on and
 15 performing that he wants to optimize or tweak
 16 the system.
 17 CHAYTOR, Q.C.:
 18 Q. And if we could look, please, at P-0113? I
 19 take it, Mr. Gulliver, that's the April 4th,
 20 2003 memo?
 21 MR. GULLIVER:
 22 A. Yeah.
 23 CHAYTOR, Q.C.:
 24 Q. Is that what Mr. Dyer brought to your
 25 attention, is it this document?

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1 MR. GULLIVER:
 2 A. Yes. And I think Barry had seen it, maybe in
 3 the gross room posted or something like that.
 4 But I didn't get informed directly -
 5 CHAYTOR, Q.C.:
 6 Q. Well, it's copied to Mr. Dyer.
 7 MR. GULLIVER:
 8 A. - or he got it, yeah.
 9 CHAYTOR, Q.C.:
 10 Q. And all technical staff. But this wasn't
 11 copied to you and you didn't receive your own
 12 copy?
 13 MR. GULLIVER:
 14 A. No.
 15 CHAYTOR, Q.C.:
 16 Q. And so Mr. Dyer brought this to you. And what
 17 did you then do, did you make any inquiries of
 18 Dr. Ejeckam as to what was the problem?
 19 MR. GULLIVER:
 20 A. No, I didn't. You know, Dr. Ejeckam at this
 21 point sort of, I guess, voluntarily, was
 22 interested in the IHC lab and, you know, he
 23 simply states that he's going to be doing a
 24 review of the stains, and it's a clinical
 25 thing. You know, I'm not the pathology

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1 manager at this point so I'm not there in the
 2 pathology lab.
 3 CHAYTOR, Q.C.:
 4 Q. I'm sorry, did you say it's a clinical thing?
 5 MR. GULLIVER:
 6 A. Well, I mean, he's a pathologist and he was
 7 going to review those particular stains. You
 8 know, it would be his decision to, you know,
 9 if he's going to optimize those stains with
 10 the technologists. So in my opinion it was
 11 being handled. I think I might have spoken to
 12 Dr. Ejeckam and maybe Dr. Cook, also, in-I
 13 mean, Dr. Ejeckam was fairly new. I think I
 14 might have just made a comment that, you know,
 15 "If you're going to do this and stop testing,
 16 you really should at least inform the clinical
 17 chief or the program director that"--we found
 18 out after he had already sent this memo out.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, so you think you spoke to him to tell
 21 him that "Next time something like this comes
 22 up -
 23 MR. GULLIVER:
 24 A. Yeah, just -
 25 CHAYTOR, Q.C.:

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1 Q. - at least give us a heads up."
 2 MR. GULLIVER:
 3 A. Yes, yeah.
 4 CHAYTOR, Q.C.:
 5 Q. But to ask him any questions about what do you
 6 mean by "unreliable" "erratic" and "unhelpful
 7 for diagnostic purposes," did you ask him what
 8 that meant and what his concerns were?
 9 MR. GULLIVER:
 10 A. At that time, no.
 11 CHAYTOR, Q.C.:
 12 Q. At any time?
 13 MR. GULLIVER:
 14 A. Well, we will talk about it later on when he
 15 puts the testing back in place.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, so you talked to him later about it.
 18 But at the time when this happens, in April of
 19 '03, you go to him and say, "Well, the proper
 20 protocol would be, you know, come and talk to
 21 me and Dr. Cook and let us know you're going
 22 to do this." But you weren't consulted
 23 beforehand on the testing shutting down?
 24 MR. GULLIVER:
 25 A. No.

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1 CHAYTOR, Q.C.:
 2 Q. And did you ask him why these eight stains out
 3 of the approximate 100 that we're doing,
 4 what's with these stains?
 5 MR. GULLIVER:
 6 A. Again, as you've heard in my testimony, you
 7 know, the medical laboratories which I'm
 8 director of, we perform 10 million tests a
 9 year, you know, it's 10 million. And through
 10 all of our divisions we have divisional
 11 chiefs, clinical leaders. You know, this is
 12 not, you know, an uncommon occurrence within
 13 medical laboratory practice that you may be
 14 reviewing certain testing, certain protocol,
 15 certain procedures that you perform to either
 16 optimize them. So this is, you know, it's
 17 not, you know, as a laboratory profession this
 18 is not something that would strike me as like,
 19 oh, this is the first time it's ever happened
 20 within labs that we're going to review some of
 21 our testing or try to put new testing in place
 22 or improve current testing.
 23 CHAYTOR, Q.C.:
 24 Q. So I take it the answer to my question is no,
 25 you didn't ask him why these eight stains?

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1 MR. GULLIVER:
 2 A. No.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And you're telling me it's not uncommon
 5 for a pathologist, a fairly new pathologist,
 6 as you say, to your institution, to write a
 7 memo, shut down the testing with respect to
 8 eight stains and write that the stains have
 9 remained "unreliable, erratic, and therefore
 10 unhelpful for diagnostic purposes."
 11 MR. GULLIVER:
 12 A. No, not -
 13 CHAYTOR, Q.C.:
 14 Q. That's not an uncommon occurrence?
 15 MR. GULLIVER:
 16 A. Not in pathology. I'm saying this happen to
 17 be in pathology. I mean, within laboratory
 18 medicine overall.
 19 CHAYTOR, Q.C.:
 20 Q. So that's not an uncommon occurrence?
 21 MR. GULLIVER:
 22 A. Whether it's biochemistry, it could be
 23 cytology, could be genetics, it could be
 24 different parts of the lab where -
 25 CHAYTOR, Q.C.:

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1 Q. So you've received similar memos? Not
 2 uncommon to receive such memos?
 3 MR. SIMMONS:
 4 Q. Commissioner, moments ago when answering that
 5 question initially, he didn't say that it was
 6 common to receive such memos. He said it was
 7 common throughout the laboratory for there to
 8 be instances where testing was reviewed. The
 9 questions that are being put now are as if he
 10 said something very specifically here as
 11 opposed to what Mr. Gulliver's answer actually
 12 was.
 13 COMMISSIONER:
 14 Q. You're saying Mr. Gulliver didn't say he got
 15 messages, he just said that these things
 16 happen?
 17 MR. SIMMONS:
 18 Q. Right. And I mean, he can certainly be asked,
 19 you know, what the similarities were. The
 20 questions are being put as if he had just said
 21 that he'd encountered exactly the same set of
 22 circumstances -
 23 COMMISSIONER:
 24 Q. Well, let's find out if he did.
 25 MR. SIMMONS:

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

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1 ongoing activity for test validation,
 2 etcetera, etcetera, and receiving a memo of
 3 the nature of the one you got from Dr. Ejeckam
 4 which uses language like "unreliable, erratic"
 5 etcetera, etcetera.
 6 MR. GULLIVER:
 7 A. Well, okay, put it this way: if Dr. Ejeckam
 8 had to write a memo to say that we are
 9 shutting down the IHC lab and all 120 or 30 or
 10 40 antibodies that are performed in that lab,
 11 certainly, to me, that would be an absolutely
 12 huge event. But Dr. Ejeckam is saying of the
 13 130, 140 antibodies that we offer in the IHC
 14 lab, there are several of them that I would
 15 like to review and do some testing and
 16 optimize that staining. Can you -
 17 CHAYTOR, Q.C.:
 18 Q. Except that's not what his memo said.
 19 MR. GULLIVER:
 20 A. He's saying they're "unreliable" and
 21 "erratic".
 22 CHAYTOR, Q.C.:
 23 Q. Yes.
 24 MR. GULLIVER:
 25 A. So as a lab person reading this here,

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1 "erratic" means that probably from week to
 2 week he's probably not seeing the same
 3 intensity of staining on these antibodies.
 4 CHAYTOR, Q.C.:
 5 Q. Yes. And did you ask him what he meant?
 6 MR. GULLIVER:
 7 A. At this point in time, no.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. Mr. Gulliver, he also says "have
 10 remained unreliable, erratic and therefore
 11 unhelpful for diagnostic purposes." Did you
 12 ask him how long this has been a problem?
 13 MR. GULLIVER:
 14 A. I don't remember asking him and I don't
 15 remember him even telling me anything.
 16 CHAYTOR, Q.C.:
 17 Q. And did you ask him whether any investigation
 18 had been undertaken to determine how long it
 19 had been a problem?
 20 MR. GULLIVER:
 21 A. Well, he was, this is what he was doing right
 22 now at this point in time.
 23 CHAYTOR, Q.C.:
 24 Q. Okay.
 25 MR. GULLIVER:

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1 A. To my knowledge there was no prior
 2 investigation.
 3 CHAYTOR, Q.C.:
 4 Q. And was there any investigation or any
 5 question asked as to whether an investigation
 6 may be necessary to determine whether or not
 7 tests happening prior to April, 2003 may need
 8 to be repeated?
 9 MR. GULLIVER:
 10 A. That was never discussed on this memo or the
 11 one following or the one in June that follows.
 12 CHAYTOR, Q.C.:
 13 Q. So that wasn't anything that--you didn't pose
 14 that question and nor did anyone else?
 15 MR. GULLIVER:
 16 A. And no one posed it back to me either, no.
 17 CHAYTOR, Q.C.:
 18 Q. And it's not something you thought of at the
 19 time?
 20 MR. GULLIVER:
 21 A. No.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. So other than Mr. Dyer bringing you
 24 this and then you spoke to Dr. Ejeckam to
 25 speak about the appropriateness of informing

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1 you directly of such activities, when did you
 2 next hear anything about the fact that these
 3 stains had been shut down, they're being
 4 reviewed, when did you next hear anything
 5 about this?
 6 MR. GULLIVER:
 7 A. I guess maybe a few weeks later when they were
 8 putting them back in place.
 9 CHAYTOR, Q.C.:
 10 Q. And at that point in time did Dr. Ejeckam then
 11 share with you the memo that he wrote in May?
 12 MR. GULLIVER:
 13 A. I think he may have copied me on that one, Ms.
 14 Chaytor; I'm not sure.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. We can look at that one then.
 17 MR. GULLIVER:
 18 A. And that's the one where he's giving sort of
 19 fixation protocols -
 20 CHAYTOR, Q.C.:
 21 Q. Yes, that's right.
 22 MR. GULLIVER:
 23 A. - interpretation guidelines and things?
 24 CHAYTOR, Q.C.:
 25 Q. That's correct.

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1 MR. GULLIVER:
 2 A. I don't know if I received that one at the
 3 time.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. So if we could look then first at P-
 6 1572, and I'll bring you back to that.
 7 Because this meeting happens in the interim.
 8 And it's April 15th, 2003. And you're not in
 9 attendance. It's the surgical pathology
 10 review committee. But if we come down through
 11 here, there's reference to the ER/PR issue.
 12 And "Dr. Ejeckam stated that ER and PR
 13 receptors are not being performed for the next
 14 six weeks due to a technical problem. If a
 15 solution cannot be found, these tests will be
 16 sent outside St. John's." Now, do you recall
 17 any discussion about the potential of having
 18 to send the tests outside of St. John's?
 19 MR. GULLIVER:
 20 A. No, no.
 21 CHAYTOR, Q.C.:
 22 Q. "He stated it is being considered to send one
 23 or two technologists to Halifax or Toronto for
 24 training." Was there any discussion with you
 25 or did you become aware of any discussion as

Page 24

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

Page 25

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

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

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1 standardized fixation and tissue preparation
 2 protocols.
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 MR. GULLIVER:
 6 A. And that may alleviate some of the variability
 7 that you're seeing from batch to batch.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, and so DAKO, in essence, is suggesting
 10 that the variability in staining is likely due
 11 to variability in the tissue preparation?
 12 MR. GULLIVER:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. And was that issue brought to your attention
 16 back in April of 2003?
 17 MR. GULLIVER:
 18 A. In 2003, no.
 19 CHAYTOR, Q.C.:
 20 Q. And when was that issue first brought to your
 21 attention?
 22 MR. GULLIVER:
 23 A. Again, I don't know if it was like 2005 or, as
 24 you said, '06 or '07, but since, you know,
 25 we've started the whole ER/PR retesting and

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1 been dealing with this issue, at some point
 2 during that time frame, certainly long after
 3 2003.
 4 CHAYTOR, Q.C.:
 5 Q. So you've spoken then again with Barry and
 6 suggested that he get in touch with DAKO. Did
 7 you then get any further feedback on how
 8 things were going or how they were
 9 progressing, and what, if any, involvement did
 10 you have in terms of keeping an eye on things
 11 while Dr. Ejeckam is undergoing the review?
 12 MR. GULLIVER:
 13 A. I had no involvement.
 14 CHAYTOR, Q.C.:
 15 Q. If we could look then, please, back to P-0113?
 16 And if I just take you here to page two, it's
 17 the May 2nd, 2003 memo, and this is sent to
 18 pathologists, St. Clare's and out of --HSC,
 19 St. Clare's and out-of-town hospitals, from
 20 Dr. Ejeckam, May 2nd, 2003, and it's copied to
 21 the site chief at the Health Science and St.
 22 Clare's and Barry Dyer and all technical
 23 staff. So do you know whether or not you
 24 received this memo?
 25 MR. GULLIVER:

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1 A. I think Barry probably showed it to me at the
 2 time.
 3 CHAYTOR, Q.C.:
 4 Q. So you became aware through the memo that the
 5 staining, at least for ER/PR, had been -
 6 MR. GULLIVER:
 7 A. Well, yes, I knew it was put back in place,
 8 yes.
 9 CHAYTOR, Q.C.:
 10 Q. So you knew this was--it had been put back in
 11 place?
 12 MR. GULLIVER:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. And Mr. Dyer informed you of that?
 16 MR. GULLIVER:
 17 A. And I think it was Barry, yeah.
 18 CHAYTOR, Q.C.:
 19 Q. And in terms of the content of the memo, you
 20 knew the staining was put back in place, but
 21 did you--were you told at the time, the issues
 22 that had been identified by Dr. Ejeckam such
 23 as, in paragraph one, the issue regarding
 24 fixation, the mention of internal controls,
 25 which reporting of ER/PR, different formula in

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1 the literature. This section here in
 2 paragraph five -
 3 MR. GULLIVER:
 4 A. Well, he's really giving the pathologists some
 5 guidelines on interpretations and guidelines
 6 on, you know, sort of pitfalls or watch out
 7 for this or watch out for that.
 8 CHAYTOR, Q.C.:
 9 Q. Yes, and that certain tumours would be
 10 expected to be ER positive. So the content
 11 itself, were you aware of that or was it just
 12 the testing has resumed?
 13 MR. GULLIVER:
 14 A. Just testing has resumed, you know. I'm not a
 15 pathologist so that wouldn't--most of this
 16 would not be directly related to me in
 17 practising.
 18 CHAYTOR, Q.C.:
 19 Q. Did you, at the time--when did you become
 20 aware about the other--these are two of the
 21 stains. What about the other six stains? Did
 22 you become aware whether or not they in fact
 23 had resumed?
 24 MR. GULLIVER:
 25 A. I was just made aware that whatever Dr.

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

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

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1 with, you know, with that memo and he and I
 2 and Barry would sit in my office and we'd
 3 just, you know, pretty well just chat about
 4 it.
 5 CHAYTOR, Q.C.:
 6 Q. Yes, and I'll take you to that in a minute.
 7 I'm just wondering about at this point in time
 8 then, what discussions or follow up you had
 9 with him. The identification of fixation as a
 10 potential issue or potential factor on the
 11 results of the immunostains, was that the
 12 first time that anyone had raised with you any
 13 concern about fixation?
 14 MR. GULLIVER:
 15 A. No, certainly not.
 16 CHAYTOR, Q.C.:
 17 Q. And so in what other context had the issue of
 18 fixation been raised as a concern?
 19 MR. GULLIVER:
 20 A. You mean just at this point in time or you
 21 mean in general in pathology?
 22 CHAYTOR, Q.C.:
 23 Q. Prior, prior to--no, prior to Dr. Ejeckam
 24 sending out this memo and his intervention,
 25 had anyone raised with you that there was a

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1 problem or a perceived problem or any
 2 potential problem with fixation of your
 3 specimens?
 4 MR. GULLIVER:
 5 A. I mean, certainly. I mean, it's a large
 6 volume pathology lab where you have multiple
 7 pathologists practising, you know. I've been
 8 there, I worked in pathology as a technologist
 9 from 1980 to '87 and I was the manager from
 10 '87 to 2001. Certainly I've had issues of
 11 fixation come to me before from the
 12 technologist. You seen yesterday, you know, a
 13 lecture that I would give and at times, other
 14 senior techs would give the new pathology
 15 residents, talking about the importance of
 16 fixation and a lot of the times, the issue
 17 wasn't that specimens were not put in
 18 fixative. Don't get that wrong. The
 19 specimens were put in fixative and either they
 20 weren't left long enough or they were left too
 21 long. Most importantly, at the gross bench,
 22 that when the pathologists were grossing, they
 23 really were not cutting their sections thin
 24 enough to allow for the full penetration of
 25 the formalin fixation.

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1 CHAYTOR, Q.C.:
 2 Q. Okay, so those -
 3 MR. GULLIVER:
 4 A. And that was an issue on different occasions
 5 multiple times.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and so what prior to Dr. Ejeckam sending
 8 out his memo then, on May 2nd, 2003, what on
 9 those prior occasions happened to prevent that
 10 from being an ongoing issue?
 11 MR. GULLIVER:
 12 A. What would happen at the time, at the time
 13 when there--if there was an issue and
 14 generally, you know, in your routine processes
 15 in pathology, once your tissue has been, you
 16 know, fixed and grossed, go through the
 17 processing cycle, the next day when the
 18 technologist are doing the paraffin embedding
 19 and the cutting of the slides and the routine
 20 staining of the slides, that's where a fair
 21 bit of time you would notice if the specimen
 22 had not been fixed properly, the technologist
 23 would pick it up and they would go directly
 24 back to the submitting pathologist, you know,
 25 and say to them, "look, we're having

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1 difficulty even cutting H & E's on this case
 2 because it's not fixed properly."
 3 CHAYTOR, Q.C.:
 4 Q. Was there ever any discussion to bring in any
 5 kind of policy procedure or protocol to
 6 standardize fixation?
 7 MR. GULLIVER:
 8 A. I don't know if there was a policy to
 9 standardize fixation. There was certainly a
 10 lot of discussion, even when I was there as
 11 manager, which you know, predates 2001,
 12 discussion about trying to standardize
 13 grossing practices. Again, you know, I'm
 14 going to go back to even that small
 15 presentation I gave to all new residents in
 16 talking about the importance of fixation and
 17 proper fixation, proper thickness of tissues.
 18 It's not something that people were not
 19 informed of, and when issues arose, it was
 20 brought back to the particular pathologist who
 21 had prepared that sample.
 22 CHAYTOR, Q.C.:
 23 Q. Yes, and was that a presentation that you gave
 24 every time a new batch of residents came in?
 25 MR. GULLIVER:

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1 A. It went on for--yeah, for a long time.
 2 CHAYTOR, Q.C.:
 3 Q. Went on -
 4 MR. GULLIVER:
 5 A. Yeah.
 6 CHAYTOR, Q.C.:
 7 Q. And was it ever changed or is it just that one
 8 version that we have there?
 9 MR. GULLIVER:
 10 A. You know, it's pretty well that one version,
 11 but you know, it's--like the foundation of
 12 pathology is the specimen that comes in, most
 13 importantly, it is fixed properly, because
 14 everything else you do from that specimen,
 15 it's critical to make sure the specimen is
 16 preserved in as lifelike manner as possible
 17 and is preserved properly.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, and that's critical, as you say?
 20 MR. GULLIVER:
 21 A. And that's just basic pathology foundation.
 22 CHAYTOR, Q.C.:
 23 Q. But no--even though this was discussed and the
 24 importance and it being critical was
 25 acknowledged, there was no standardized

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

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1 A. I don't think I asked him and I don't think he
 2 even came and offered up anything.
 3 CHAYTOR, Q.C.:
 4 Q. And did you, at this point in time, then
 5 inquire of him as to whether or not the
 6 problems he had discovered could have impacted
 7 upon the tests that had been done in the past?
 8 MR. GULLIVER:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. And why not?
 12 MR. GULLIVER:
 13 A. Why would I ask him has it impacted in the
 14 past?
 15 CHAYTOR, Q.C.:
 16 Q. Yes.
 17 MR. GULLIVER:
 18 A. Rightly or wrongly, I would assume that he's a
 19 physician, a pathologist, every slide that
 20 came out of that lab is reviewed and signed
 21 out by a pathologist, so if they had issues,
 22 then I'm assuming I would have heard about it
 23 long before this, and if he had issues or
 24 concerns, I would expect that he would express
 25 them. You can see Dr. Ejeckam, the way he

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

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1 positive result, but it's weak, it stained
 2 weaker.
 3 CHAYTOR, Q.C.:
 4 Q. And what effect might weak staining have on a
 5 patient who is a low expressor?
 6 MR. GULLIVER:
 7 A. I'm really not qualified to answer that.
 8 CHAYTOR, Q.C.:
 9 Q. So if the staining is erratic, wouldn't you
 10 think there might be slides that are not
 11 staining at all that should perhaps be
 12 staining because the person is a low
 13 expressor?
 14 MR. GULLIVER:
 15 A. I guess it could be possible.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, but that didn't cross your mind at the
 18 time?
 19 MR. GULLIVER:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and it wasn't discussed with anyone
 23 within -
 24 MR. GULLIVER:
 25 A. I mean, we're talking 2003. At that time, I

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1 would have no idea what a low expressor is.
 2 CHAYTOR, Q.C.:
 3 Q. And if we could look then, please, continuing
 4 on with actually this exhibit, and it's page--
 5 well, perhaps I can do this, page five of the
 6 exhibit. So this is June 19th, 2003. So Mr.
 7 Gulliver, you're saying that between the May
 8 memo and the letter to you or memo to you of
 9 June 19th, 2003, you had somewhat of a casual
 10 conversation with Dr. Ejeckam and asked him if
 11 there is anything else that may be required?
 12 MR. GULLIVER:
 13 A. Pretty well, yeah.
 14 CHAYTOR, Q.C.:
 15 Q. And is that what you understand to be the
 16 reason why then you received this memo dated
 17 June 19th?
 18 MR. GULLIVER:
 19 A. Yeah.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and if I could just take you through
 22 this. So is it a situation where you actually
 23 invited this from Dr. Ejeckam?
 24 MR. GULLIVER:
 25 A. Well, I can't say I invited it from him. You

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1 know, I had a casual conversation with him. I
 2 pretty well said to Dr. Ejeckam, like you
 3 know, he hadn't been here a long time, that
 4 for example, in our--in that part of our
 5 pathology lab at the time, the IHC testing was
 6 still being performed sort of the back bench
 7 of pathology. You know, we were--had for a
 8 long time planned--needed physical space freed
 9 up, needed some renovations from facilities
 10 management to move IHC into its own lab. I
 11 talked to him about, you know, the senior
 12 techs that were doing the testing at one point
 13 in time. The pathologists wanted those
 14 technologists trained to do the gross bench,
 15 the small specimens. So I just pretty well
 16 gave him some of the history of what had gone
 17 on in our IHC part of our lab and you know,
 18 said you know, if you got anything that you'd
 19 like to put--to come talk to me about or put
 20 in writing, you know, just do it.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. So you suggested that to him, if
 23 there's anything else, you could put it in
 24 writing?
 25 MR. GULLIVER:

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1 A. Yeah.
 2 CHAYTOR, Q.C.:
 3 Q. And why would you want that? Why would you
 4 want him to put something in writing to you?
 5 MR. GULLIVER:
 6 A. Because in writing, you can follow it step by
 7 step and what's there and what you can do to
 8 respond to it. I also put it--I asked him, I
 9 think, you know, at the time, in my mind would
 10 be if it's something in writing and it's
 11 coming from a doctor, you know, it may lend a
 12 bit more weight to things that he may request
 13 or things he may suggest for that part of our
 14 laboratory.
 15 CHAYTOR, Q.C.:
 16 Q. So it would make it easier for you to go
 17 forward to your superiors to try and get put
 18 in place whatever it was that Dr. Ejeckam may
 19 be requesting?
 20 MR. GULLIVER:
 21 A. Well, and not necessarily for me to go
 22 forward, but it could be, if it's a clinical
 23 thing, Dr. Cook to go forward with.
 24 CHAYTOR, Q.C.:
 25 Q. Yes. If you have it committed to writing,

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1 then you were thinking that this might have a
 2 little, as you say, a little more weight and
 3 would give you something of substance to take
 4 forward, should it be something you need to
 5 take forward or Dr. Cook, whoever in the
 6 laboratory medicine program needed to go
 7 forward with it. Okay, and is that what--
 8 that's what you had in mind when you suggested
 9 to Dr. Ejeckam that he could put this in
 10 writing?
 11 MR. GULLIVER:
 12 A. That certainly was in the back of it, yes.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, and then having received it, Mr.
 15 Gulliver, who did you share this with?
 16 MR. GULLIVER:
 17 A. You know, what I remember, I think Dr. Ejeckam
 18 just walked over to my office and brought it
 19 in and gave it to me, and Barry came over and
 20 the three of us sat down and we just kind of
 21 reviewed it and, you know, we just went
 22 through the pieces of it that we felt that we
 23 could address, myself and Mr. Dyer.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. So you're saying that Dr. Ejeckam

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1 walked in and handed it to you?
 2 MR. GULLIVER:
 3 A. That's what I remember.
 4 CHAYTOR, Q.C.:
 5 Q. And then the three of you sat down, you and
 6 Dr. Ejeckam and Barry Dyer?
 7 MR. GULLIVER:
 8 A. And Barry, yeah.
 9 CHAYTOR, Q.C.:
 10 Q. Sat down and went through his memo?
 11 MR. GULLIVER:
 12 A. We went through, you know, the basic things,
 13 went through it. For example, the physical
 14 location of the facility is unsatisfactory.
 15 Well, that's not telling me anything new.
 16 CHAYTOR, Q.C.:
 17 Q. And if Dr. Ejeckam has told the Commissioner
 18 that he wrote this letter to you, stopped you
 19 afterwards to find out whether or not you had
 20 in fact received it, had a chat with you in
 21 the corridor to see whether or not you had
 22 even received it, was told that you would be
 23 responding to him and then never heard
 24 anything else from you on it, no response?
 25 MR. GULLIVER:

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1 A. Well, I didn't hear Dr. Ejeckam's testimony.
 2 I'm just telling you what I remember. I can
 3 clearly remember myself, him, and Barry, in my
 4 office, I have a small table, the three of us
 5 sitting there informally talking about this
 6 letter and myself and Barry going through with
 7 him and pretty well saying, yeah, we know
 8 about the facility, the physical space
 9 location is unsatisfactory.
 10 CHAYTOR, Q.C.:
 11 Q. So that's paragraph one.
 12 MR. GULLIVER:
 13 A. We have been working on trying to get
 14 dedicated space for the IHC part of pathology.
 15 We talked about workload and volumes. I had
 16 told Dr. Ejeckam at the time that I had
 17 recently been to a large conference where I
 18 had seen that vendors were coming out with new
 19 automated technology for IHC testing, i.e.
 20 this is how I first seen the Ventana System.
 21 He talked about at the time--I think at the
 22 time Mary, and I think Peggy may be still
 23 there, and Ken is new into the lab. You know,
 24 he wanted them to be full time working in IHC.
 25 CHAYTOR, Q.C.:

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1 Q. By June, I think--by this point in time, I
 2 think Peggy would have moved on?
 3 MR. GULLIVER:
 4 A. I think Peggy is gone.
 5 CHAYTOR, Q.C.:
 6 Q. Yes.
 7 MR. GULLIVER:
 8 A. And, you know, Ken was still fairly new, only
 9 had been there probably a year in IHC lab, and
 10 Les Simms has just moved over from St.
 11 Clare's. So he was saying that, you know,
 12 those staff needed to be dedicated to IHC to
 13 give them time to learn, give them time to
 14 read articles and read journals. Therefore,
 15 we kind of--those were the senior techs that
 16 were doing the grossing that the main body of
 17 the pathologists had asked for a couple of
 18 years prior without pathology assistants. So
 19 we had to put in processes to skill up or
 20 retrain other technologists to take over that
 21 biopsy grossing function in order to do this.
 22 So these are the kinds of things that we
 23 talked about, the kinds of things that we
 24 could do.
 25 CHAYTOR, Q.C.:

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1 Q. Okay, so first of all, it's the physical
 2 space, the physical location of this facility
 3 is unsatisfactory. "Immunohistochemical
 4 stains need to be housed in a separate room
 5 with proper humidity control. This is lacking
 6 in the corner of an open laboratory where
 7 procedures are carried out at the moment". So
 8 what was done in response to that particular
 9 concern?
 10 MR. GULLIVER:
 11 A. Well, shortly afterwards there--adjacent, and
 12 you've been in to, you've physically seen our
 13 lab when you came in for your tour.
 14 Physically adjacent to the pathology lab,
 15 there was other lab testing taking place, and
 16 I moved those staff out and moved them over to
 17 the main biochemistry lab. We had been
 18 waiting on with the Janeway moving and
 19 reopening, additional space was being
 20 renovated over in that part of the lab in
 21 order to move these people out, and then we
 22 started moving the IHC stuff into that part of
 23 the lab.
 24 CHAYTOR, Q.C.:
 25 Q. And when did that actually happen, when did

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1 that physical move happen?
 2 MR. GULLIVER:
 3 A. It happened, I think, by the end of '03. By
 4 the time we did--by late summer/fall of '03,
 5 you know, we do a tender where we're going to
 6 acquire the Ventana System. By the time the
 7 Ventana System comes into the physical plant,
 8 that new system is being set up in the
 9 dedicated space for IHC lab.
 10 CHAYTOR, Q.C.:
 11 Q. So was that spurred then--the change in the
 12 physical location brought on by Dr. Ejeckam's
 13 concerns back in June or was that brought on
 14 by the fact that you had acquired new
 15 technology and in December, 2003, then the
 16 move happens?
 17 MR. GULLIVER:
 18 A. It was brought on by neither.
 19 CHAYTOR, Q.C.:
 20 Q. Sorry?
 21 MR. GULLIVER:
 22 A. It wasn't brought on by Dr. Ejeckam and it
 23 wasn't brought on by Ventana. It's something
 24 that even I as the manager two years prior to
 25 this had wanted, however, we were waiting on

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1 facilities management to get things done.
 2 CHAYTOR, Q.C.:
 3 Q. So your response to Dr. Ejeckam was this is
 4 something I'm already working on and we'll get
 5 it done when we can?
 6 MR. GULLIVER:
 7 A. Well, working on, and frustrated with.
 8 CHAYTOR, Q.C.:
 9 Q. Yes.
 10 MR. GULLIVER:
 11 A. That we've been trying to get this done for a
 12 couple of years.
 13 CHAYTOR, Q.C.:
 14 Q. And what was it--sorry, Mr Gulliver, what was
 15 it you needed to have happen in order--if it's
 16 something you're frustrated with and something
 17 you've been trying to do for a while, what was
 18 it you needed for that to be able to happen?
 19 MR. GULLIVER:
 20 A. We needed renovations to take place in other
 21 parts of our laboratory program.
 22 CHAYTOR, Q.C.:
 23 Q. And what was the slow up in that happening?
 24 Was it a resource issue?
 25 MR. GULLIVER:

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1 A. It was facilities management, and prioritizing
 2 what needs to be done within the health care
 3 system. Before the Grace closed and Janeway
 4 closed, we're going back to 1999, the main
 5 pathology lab at the Health Sciences, we had
 6 done up detailed plans to renovate and upgrade
 7 the current space at the Health Sciences. We
 8 had also done detailed plans to upgrade our
 9 microbiology services at the Health Sciences
 10 to consolidate for one lab.
 11 CHAYTOR, Q.C.:
 12 Q. Yes.
 13 MR. GULLIVER:
 14 A. And here it is, 2008, and it still isn't done.
 15 CHAYTOR, Q.C.:
 16 Q. So did you -
 17 MR. GULLIVER:
 18 A. So when I'm talking about this here with Dr.
 19 Ejeckam, it's like it's so frustrating that
 20 maybe with a doctor putting this in writing,
 21 we might get some response.
 22 CHAYTOR, Q.C.:
 23 Q. Right. Okay, so now you've got your doctor
 24 has put it in writing. What do you do with
 25 it?

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1 MR. GULLIVER:
 2 A. Well, what happened was we're able to get
 3 space finished over in the extension of our
 4 chemistry lab.
 5 CHAYTOR, Q.C.:
 6 Q. So who did you go with this memo--armed with
 7 this memo, who did you take it to to make
 8 things happen?
 9 MR. GULLIVER:
 10 A. I didn't take this memo--no, I didn't take
 11 this memo to facilities management and say
 12 here.
 13 CHAYTOR, Q.C.:
 14 Q. Did you take it to Dr. Williams?
 15 MR. GULLIVER:
 16 A. I don't think I did. I addressed the parts in
 17 this here as the administrative director and I
 18 would have assumed if there was any clinical
 19 issues that Dr. Cook would have taken this up
 20 with Dr. Ejeckam and with Dr. Williams.
 21 CHAYTOR, Q.C.:
 22 Q. You report directly to Dr. Williams as well,
 23 though?
 24 MR. GULLIVER:
 25 A. Yes.

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1 CHAYTOR, Q.C.:
 2 Q. So you now have something committed in
 3 writing, you've been frustrated trying to have
 4 this happen yourself. So, how does having
 5 this put in writing by Dr. Ejeckam, what do
 6 you do, how do you use that to make it happen
 7 faster?
 8 MR. GULLIVER:
 9 A. Well, I think--it could be by coincidence. I
 10 think around this same time we knew that the
 11 renovations over in chemistry would be
 12 completed in the next few months, so we could
 13 move hormone chemistry testing out of the
 14 space adjacent to pathology, over with the
 15 main biochemistry, and then that space would
 16 be vacated and we could move the IHC testing
 17 into that part of our laboratory.
 18 CHAYTOR, Q.C.:
 19 Q. And how physically then does the move happen,
 20 who makes the move happen?
 21 MR. GULLIVER:
 22 A. Pretty well mostly Barry and the techs do it
 23 themselves.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. So they actually go in and move things,

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1 move the equipment, and it's Barry Dyer and
 2 his technologists?
 3 MR. GULLIVER:
 4 A. They went in and moved out parts of benches
 5 and made things a bit more ergonomic, as best
 6 they could, and put different tables in there.
 7 CHAYTOR, Q.C.:
 8 Q. And the idea that it be a separate room with
 9 proper humidity control, do you currently have
 10 that, do you have a separate room with proper
 11 humidity control?
 12 MR. GULLIVER:
 13 A. Well, it is a separate room, and proper
 14 humidity control now, I don't think is an
 15 issue because the Ventana System is the closed
 16 system. So the slides are on a closed system,
 17 they're not exposed to sitting in the bench in
 18 a petri dish or even the old DAKO autostainer,
 19 what the autostainer did was provide the
 20 humidity chamber for the slides during the
 21 incubation time. So, I mean, this is back in
 22 2003 before we got the Ventana System.
 23 CHAYTOR, Q.C.:
 24 Q. Yes, and up until, I guess, then December of
 25 '03, from June of '03 to December '03, you

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

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1 problem shooter and that can only materialize
 2 through thorough understanding of the
 3 subject". So just let me ask you about that
 4 piece, what happened in response to his
 5 concern here about the dedicated staff and
 6 need for dedicated staff?
 7 MR. GULLIVER:
 8 A. Well, I think Mr. Dyer started the process
 9 then of--there wasn't enough workload in the
 10 IHC part of pathology to justify or warrant
 11 those numbers of staff doing this testing
 12 every single day. What Dr. Ejeckam was saying
 13 was I understand that, however, we have new
 14 staff there--Les and Ken had just--Les was
 15 just there a few months and Ken a year, and
 16 they need to have time freed up to be able to
 17 sit down, read journals, and if Dr. Ejeckam
 18 wants to give them some lectures and those
 19 kinds of things, those staff were the senior
 20 pathology technologists and they were the
 21 staff that were doing the small biopsy
 22 grossing to help with the pathologists front
 23 end workload. So Barry had to take other
 24 technologists in the pathology lab and then
 25 skill them up to a certain level to take over

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1 the grossing function. Therefore, Les and
 2 Mary and Ken could then be freed up, more time
 3 to spend in the IHC part of the lab.
 4 CHAYTOR, Q.C.:
 5 Q. And when did that happen?
 6 MR. GULLIVER:
 7 A. It may have taken four or six months before it
 8 finally happened.
 9 CHAYTOR, Q.C.:
 10 Q. The idea that the staff were expected to be
 11 quite knowledgeable with respect to
 12 immunohistochemistry and should be reading
 13 upon it and should be able to problem shoot,
 14 what if any measures were taken to ensure that
 15 that was the case?
 16 MR. GULLIVER:
 17 A. Nothing that I took. You know, he's pretty
 18 well saying that the staff who are performing
 19 this testing should be able to understand the
 20 testing, and if he's the director of the IHC
 21 lab--I think Dr. Ejeckam also gave some basic
 22 lectures at the time to the new staff.
 23 CHAYTOR, Q.C.:
 24 Q. And he uses some strange language at the end
 25 of this paragraph where he's talking about the

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1 dedicated staff should cut and stain all cases
 2 while the assistant standby staff does that
 3 twice a week. "The designated staff uses this
 4 valuable time for housekeeping jobs in immuno.
 5 This will include dealing with order and
 6 titrating new antibodies. This ensures that
 7 the standby staff is in tune with the
 8 procedure and can produce acceptable results
 9 when the need arises. To do less would simply
 10 become a gamble where you may win or lose.
 11 This obviously will spell disaster". When you
 12 read that, Mr. Gulliver, and as you say you
 13 sat down and discussed this with Dr. Ejeckam,
 14 that's fairly strong language, did you
 15 understand what he meant by that, "how it
 16 could spell disaster"?
 17 MR. GULLIVER:
 18 A. Again he's not telling me anything new. He's
 19 talking about laboratory testing, you know. I
 20 could sit down and speak to the biochemist and
 21 he can come and say to me, you know, if we
 22 don't have this, this, and this, you realize
 23 it could be disaster for this particular
 24 testing or the outcome for the patient, it'
 25 just basic understanding, and this is the way

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1 Dr. Ejeckam spoke. You know, he put--the way
 2 he's writing here is the way he expressed
 3 himself. He never brought it as a major
 4 concern to me and I read this here to say,
 5 yeah, I mean, it's just -
 6 CHAYTOR, Q.C.:
 7 Q. So that doesn't--that's not bringing to you a
 8 major concern?
 9 MR. GULLIVER:
 10 A. He's not saying that we're gambling, he's not
 11 saying the staff aren't trained, he's not
 12 saying the staff are not qualified.
 13 CHAYTOR, Q.C.:
 14 Q. But to do less -
 15 MR. GULLIVER:
 16 A. He's just saying that we need to ensure that
 17 the staff have got enough time to be able to
 18 read and learn on the job.
 19 CHAYTOR, Q.C.:
 20 Q. And enough knowledge--enough time and enough
 21 knowledge to be able to do these things?
 22 MR. GULLIVER:
 23 A. Yes, and he never once said to me our staff
 24 did not have the knowledge or could not
 25 perform the testing.

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1 CHAYTOR, Q.C.:

2 Q. So when you -

3 MR. GULLIVER:

4 A. I think if you'll scroll down, I think he

5 actually says the reason why we have good

6 quality stains now is because of our

7 technologists.

8 CHAYTOR, Q.C.:

9 Q. It's a credit them.

10 MR. GULLIVER:

11 A. Somewhere there, yeah.

12 CHAYTOR, Q.C.:

13 Q. We'll come to that, but in terms of them being

14 able to be problem shooters and to knowledge,

15 I'm just wondering when you read this and when

16 you discussed it with Dr. Ejeckam, did you

17 take from this that he had any concern that up

18 to this point in time they perhaps did not

19 have sufficient knowledge?

20 MR. GULLIVER:

21 A. He never said--no, he didn't say. As a matter

22 of fact, he--well, I can't say that, I can't--

23 I was going to say, I mean, I think he kind of

24 praised the technologists that they're good

25 technologists, but I can't really swear that

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1 he said that, but that was generally the

2 conversation.

3 CHAYTOR, Q.C.:

4 Q. And you didn't take away from this that there

5 was any concern about their current level of

6 expertise?

7 MR. GULLIVER:

8 A. No, I didn't, no.

9 CHAYTOR, Q.C.:

10 Q. And he talks then in paragraph four about the

11 volume of immunohistochemical procedures

12 continuing to increase, every day more

13 diagnostic antibodies are added.

14 MR. GULLIVER:

15 A. And again, you know, he's saying every day

16 more diagnostic antibodies are being added.

17 We may have added an antibody every few

18 months, a new one.

19 CHAYTOR, Q.C.:

20 Q. "And each new antibody", he says, "poses its

21 own special problems that needs to be mastered

22 before reliable, reproducible, and consistent

23 results can be obtained. Since this is the

24 only centre in the province that performs this

25 test, there is enough case to be made for

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1 identifying the activity is special and

2 unique, therefore, requires financing and

3 staffing", and Mr. Gulliver, if it requires

4 financing and staffing, who would be

5 responsible for that?

6 MR. GULLIVER:

7 A. Well, it would be my main function.

8 CHAYTOR, Q.C.:

9 Q. And if you needed financing or other resources

10 to be able to carry out what Dr. Ejeckam is

11 seeking here, where would you have to go?

12 MR. GULLIVER:

13 A. Well, there's two avenues. We operate under

14 program management. There are times where

15 there were financial resources freed up for

16 various reasons in other parts of the lab that

17 I could actually move that money over to the

18 pathology budget, and other cases that

19 required a direct ASP (phonetic) through the

20 budget process, you know, within the Health

21 Care Corporation, but what he's saying here is

22 he's just reinforcing the fact, the staffing,

23 that we've got three staff who are trained in

24 immuno, so let's just keep them dedicated in

25 immuno. That means the staffing issue here is

Page 64

1 I need to get other technologists to backfill

2 the grossing function that those three techs

3 were doing in immuno. The financing piece of

4 it was pretty well saying that when we add new

5 antibodies to our arsenal, it will increase

6 the operating cost for the IHC part of our

7 lab, and never once to my knowledge in all the

8 years have we not ever purchased a new

9 antibody that a pathologist suggested that

10 should be in our protocols.

11 CHAYTOR, Q.C.:

12 Q. Did anything that you did in response to Dr.

13 Ejeckam's memo require extra resources?

14 MR. GULLIVER:

15 A. I'm thinking at the time and I don't know if,

16 like we put a fulltime tech to them. We used

17 to have, like Mary and Peggy and Ken would do

18 a weekly rotation at the gross bench and Barry

19 took one of the next senior technologists and

20 trained them in to do the grossing. And I

21 don't know if I sort of took money from

22 biochemistry hematology division and put it

23 over to pathology to fund that position, or we

24 just went right ahead and put that position in

25 place and I dealt with the budget deficit for

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1 that. But we put the fulltime -
 2 CHAYTOR, Q.C.:
 3 Q. So there was an actual position created,
 4 whether you reassigned within the program -
 5 MR. GULLIVER:
 6 A. Right, at this time, I don't think we got the
 7 position created, but it does come in the next
 8 year or so through the budget cycle.
 9 CHAYTOR, Q.C.:
 10 Q. So it's a year or so down the road through the
 11 next budget?
 12 MR. GULLIVER:
 13 A. But we do have a physical person who is now
 14 fulltime doing all the small biopsy grossing.
 15 CHAYTOR, Q.C.:
 16 Q. Right.
 17 MR. GULLIVER:
 18 A. A Technologist II.
 19 CHAYTOR, Q.C.:
 20 Q. And when was that put in place?
 21 MR. GULLIVER:
 22 A. Again, I don't know the exact date, you know.
 23 CHAYTOR, Q.C.:
 24 Q. Around the same time the space moved, the end
 25 of '03?

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

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1 with succession planning, that there will be a
 2 vacuum and another period of uncertainty.
 3 Sorry?
 4 MR. GULLIVER:
 5 A. No, I'm just reading this now, you know, again
 6 for--I haven't read it for awhile, but -
 7 CHAYTOR, Q.C.:
 8 Q. Was there something there though that you
 9 wanted to comment on?
 10 MR. GULLIVER:
 11 A. Well I just, you know, when he talks about
 12 this succession planning for the
 13 technologists, and yes, we were well aware
 14 that the staff who had left, like Peggy had
 15 left and you know, it wasn't an expected
 16 decision for Peggy to move to Nova Scotia for,
 17 other than her reasons.
 18 CHAYTOR, Q.C.:
 19 Q. I think she's gone, though, by this point in
 20 time.
 21 MR. GULLIVER:
 22 A. I know, but then the backfill of that, you
 23 know, we expected Peggy--she's still working
 24 in Nova Scotia, you know, I expected Peggy
 25 would be in the IHC lab until she decided to

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

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1 but they have numerous other duties, and what
 2 you're saying is that there was an extra
 3 position created sometime within the next
 4 year.
 5 MR. GULLIVER:
 6 A. No, before a year, it started, I think by the
 7 fall, once the summer holidays were over, I
 8 think Barry started training someone else to
 9 start doing all the grossing.
 10 CHAYTOR, Q.C.:
 11 Q. Okay.
 12 MR. GULLIVER:
 13 A. I think he might have trained two people.
 14 CHAYTOR, Q.C.:
 15 Q. And his last numbered paragraph, number six,
 16 "Finally it is pertinent to mention that
 17 results of immunostains are extremely
 18 important in histopathological diagnosis,
 19 especially where classification of lymphomas
 20 and determination of benign or malignancy on
 21 certain lesions. For example, in the prostate
 22 biopsies depend on crisp reliable and
 23 reproducible staining results. Diagnosis
 24 based on inappropriate immunostain will surely
 25 jeopardize patient care and may even expose

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1 the Health Care Corporation of St. John's to
 2 litigation. Therefore, it will be ill advised
 3 to operate an unreliable and erratic
 4 immunohistochemical procedures in our
 5 laboratory." And Mr. Gulliver, when you read
 6 this paragraph, and again there's fairly
 7 strong language used, did this cause you any
 8 concern and did you take this up with Dr.
 9 Ejeckam?
 10 MR. GULLIVER:
 11 A. No, you know, to me he's just, he's simply
 12 stating the facts and this is laboratory
 13 medicine, this is the practice and this
 14 happens to be potential outcomes, I guess if
 15 something were to go wrong in that part of the
 16 laboratory. But for him saying to me that
 17 this is important diagnostic testing and it's
 18 important for lymphomas, it's important for
 19 prostates, it's important for every pretty
 20 well cancer I know the pathologists use it
 21 for, I mean, he's not telling me something
 22 new.
 23 CHAYTOR, Q.C.:
 24 Q. And again, though, I take it happened -
 25 MR. GULLIVER:

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1 A. But we never ever discussed nothing like
 2 litigation and suing and, you know, that kind
 3 of stuff.
 4 CHAYTOR, Q.C.:
 5 Q. That wasn't discussed?
 6 MR. GULLIVER:
 7 A. No.
 8 CHAYTOR, Q.C.:
 9 Q. And to be told something like that in writing,
 10 how common would that be?
 11 MR. GULLIVER:
 12 A. More common in the last two or three years.
 13 CHAYTOR, Q.C.:
 14 Q. How about up to this point in time?
 15 MR. GULLIVER:
 16 A. Up to this point in time? Fairly uncommon.
 17 CHAYTOR, Q.C.:
 18 Q. But it wasn't the subject of anything that you
 19 and he discussed in your sit down after you
 20 received this?
 21 MR. GULLIVER:
 22 A. No, no.
 23 CHAYTOR, Q.C.:
 24 Q. And was it something that you--did you ask
 25 him, well Dr. Ejeckam, what about right now,

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1 you know, what are you telling me, is this
 2 something that I should be concerned about
 3 right now?
 4 MR. GULLIVER:
 5 A. I have to say I didn't ask him, Ms. Chaytor
 6 and you know, neither did Dr. Ejeckam, you
 7 know, say to me that, you know, we have
 8 erratic staining, he didn't say that we have
 9 poor staining, he complimented the staff, you
 10 know, and as you said in the one before he
 11 says, "we do have a good lab and we've got
 12 good staining there" and this is just a way
 13 Dr. Ejeckam spoke and did things. And I guess
 14 the thing that I would say, this is in 2003
 15 and Dr. Ejeckam, you know, eventually retires
 16 in 2006 and for the next three years, I don't
 17 hear one thing from him, either in writing or
 18 even verbally with any issue in the IHC part
 19 of our laboratory.
 20 CHAYTOR, Q.C.:
 21 Q. So he didn't come forward with any other
 22 requests once you took the measures that you
 23 took in response by the end of 2003, early
 24 2004.
 25 MR. GULLIVER:

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1 A. Yeah, I think he was very pleased that we were
 2 able to finally get things set up in a
 3 dedicated part of the laboratory, we were able
 4 to get some new refrigerators and things to
 5 keep all the reagents together. I think he
 6 was pleased that we were able to acquire
 7 through an operational lease -
 8 CHAYTOR, Q.C.:
 9 Q. Did he tell you that? Did he tell you that he
 10 was pleased with the response?
 11 MR. GULLIVER:
 12 A. Well, I don't know. But I'm thinking if he
 13 was displeased, he would have told me.
 14 CHAYTOR, Q.C.:
 15 Q. Was there anything--then he finishes by saying
 16 that, he advised that "you kindly take a hard
 17 look at the above and then commit the
 18 necessary resources, human and financial to
 19 this special all important and only service in
 20 the province." And you've indicated that one
 21 of the reasons that you had asked him or
 22 invited him to put this in writing is that it
 23 would, in essence, provide you with extra
 24 ammunition if it's coming from a physician and
 25 a physician feels strongly enough to dedicate

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1 it to writing. If you need additional
 2 resources, human and financial to have this
 3 happen, wouldn't you have to take it to Dr.
 4 Williams?
 5 MR. GULLIVER:
 6 A. It all depends on the magnitude of the
 7 additional resources. When myself and Dr.
 8 Ejeckam and Barry kind of reviewed this stuff,
 9 you know, the kinds of things that he was sort
 10 of suggesting here certainly were not new to
 11 us and like we knew that we were going to get
 12 our own space, we knew that was going to
 13 happen, it was just the timing and how long it
 14 was going to take. So that didn't require
 15 additional resources, it required the time to
 16 get that set up and we were--at the time in
 17 June '03, it wasn't until Barry did the tender
 18 to the marketplace looking for new equipment
 19 and new reagent contract with a vendor, it
 20 could have been DAKO, it could have been
 21 Ventana, it could have been Vision, there were
 22 several companies out there who provided
 23 automation and, you know, your antibodies and
 24 solutions to go with it. And luckily enough,
 25 the volumes of dollars that we were spending

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

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1 if I couldn't do that, either way we just put
 2 a staff person in place and just ran a
 3 deficit. I felt like as long as I could
 4 justify it at the end of the budget year why I
 5 was over budget in all our divisions, I felt
 6 comfortable enough in being able to do that.
 7 CHAYTOR, Q.C.:
 8 Q. And the other piece, though, in terms of the
 9 additional training for the staff and the
 10 staff--what about that, in terms of any monies
 11 expended on that?
 12 MR. GULLIVER:
 13 A. At the time I don't think there was any money
 14 spent directly on it, but there were two
 15 things, you know, I assumed Dr. Ejeckam, he
 16 seemed to be very enthusiastic and by this
 17 time, you know, he was pretty well in the lab
 18 with the technologists, working with them. I
 19 think the staff certainly appreciated his
 20 guidance and so did I. I think Dr. Ejeckam
 21 had indicated that, you know, he would be able
 22 to bring some books into the lab, some new
 23 textbooks or new materials coming out, so I
 24 thought Dr. Ejeckam would provide some of that
 25 training to the staff if he felt they needed

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1 it.

2 CHAYTOR, Q.C.:

3 Q. And the idea that we saw in the meeting, the

4 surgical pathology meeting in April of sending

5 perhaps one or -

6 MR. GULLIVER:

7 A. He never ever--I never seen that, Ms. Chaytor

8 -

9 CHAYTOR, Q.C.:

10 Q. And that didn't come up in the context of

11 this?

12 MR. GULLIVER:

13 A. And he never ever brought it up, no. But then

14 something else happened though, that in our--

15 when we went to the marketplace in the fall

16 for the tender for IHC lab, and you know, we

17 spend upwards of \$200,000 a year -

18 CHAYTOR, Q.C.:

19 Q. And why did you do that, because I mean, that

20 wasn't something that Dr. Ejeckam was looking

21 for? Why did you see the need to do that?

22 MR. GULLIVER:

23 A. Oh, he's talking about workload of volume

24 increases and at about six months prior, I had

25 seen at a trade show where laboratory vendors

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1 go and show their new chemistry equipment and

2 hematology equipment and pathology equipment -

3 CHAYTOR, Q.C.:

4 Q. Where was that?

5 MR. GULLIVER:

6 A. That was in New Orleans. It was at the CMLA

7 conference, which is a clinical lab managers

8 association for North America and I had seen

9 this company, there was two actually, Ventana

10 where they had their protocol of new

11 technology that would be coming to the

12 marketplace and there was a company from

13 Australia called Vision, and they had a

14 similar kind of automated platform coming out

15 that would replace just the basic DAKO

16 autostainer that was just pretty well a fluid

17 dispenser. So by this time, we know that

18 Ventana is coming out with a much more

19 automated system and it helps with workload

20 and volumes and those things, and we had said

21 to Dr. Ejeckam that, you know, and I'm kind of

22 thinking that we spent enough money through

23 that part of our lab, if we kind of pooled all

24 of those dollars, we could probably be able to

25 afford an operational lease that included new

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1 equipment and, you know, reagents all

2 inclusive type of thing. But in that

3 contract, we wrote and I had done contracts

4 similar to this much much larger, now, mind

5 you, like in biochemistry, we'd have like a

6 three million dollar a year reagent lease with

7 a large vendor that supplies both the

8 equipment and service and reagents. So I was

9 applying the same kind of theory that we used

10 in biochemistry to this part of our pathology

11 lab and in the Ventana contract, in the other

12 contracts I always write in and ask for is

13 there any staff education you can provide also

14 because we're going to give you all this

15 business, and Ventana came back and they said

16 that they would co-support one technologist

17 per year to attend the national histology

18 conference in the United States. So that

19 would be sort of a part--I would have a

20 resource for some dedicated funding to send

21 one of our IHC techs to that conference

22 annually.

23 CHAYTOR, Q.C.:

24 Q. So after, in essence, inviting Dr. Ejeckam to

25 state any issues that he had to put it in

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1 writing, you didn't--are you saying you didn't

2 go to Dr. Williams and raise these concerns

3 with him and use it for anyone in authority

4 for the purpose that you thought you would

5 need to use it originally?

6 MR. GULLIVER:

7 A. No, because what Dr. Ejeckam put in this

8 letter were pretty well most of the things we

9 had either already agreed upon, it was just

10 the timing to get things done and most of the

11 things that we needed for, if it was new

12 resources, we pretty well could find it within

13 the program and we could find them for the new

14 leasing for the new automated equipment.

15 CHAYTOR, Q.C.:

16 Q. Even if it meant further, running further

17 deficit?

18 MR. GULLIVER:

19 A. I didn't go to Dr. Williams ever time we

20 thought we were going to run a deficit in a

21 particular division. It's no different--I use

22 the same philosophy, for example, I mean, even

23 back in 2003 I think most of my budget deficit

24 was we didn't have--we don't have enough staff

25 to keep up with the daily outpatient blood

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1 collection demands. At St. Clare's we were
 2 seeing 300 patients a day and I gave the
 3 manager the approval to add two new lab
 4 assistants to improve the waiting time.
 5 CHAYTOR, Q.C.:
 6 Q. And, Mr. Gulliver, that's not my point, my
 7 point was -
 8 MR. GULLIVER:
 9 A. No, but it's the same philosophy.
 10 CHAYTOR, Q.C.:
 11 Q. But you asked for this because you thought
 12 this might give you something, some ammunition
 13 that you could go and say, well these are
 14 things I've been frustrated with for awhile,
 15 put it in writing, I've got a physician saying
 16 it and perhaps now this will make a
 17 difference, so in terms of then using the memo
 18 for the purpose for which you originally
 19 envisioned it, you didn't do that?
 20 MR. GULLIVER:
 21 A. Well I asked Dr. Ejeckam to put his concerns
 22 in writing. I had no idea what concerns he
 23 was going to put in writing, but the concerns
 24 he put in writing, we were able to address
 25 most of his concerns within the Laboratory

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1 Medicine Leadership Program. If Dr. Ejeckam
 2 had to put concerns in here that would
 3 involve, well I think we need to have four new
 4 additional staff for IHC lab, if he had to put
 5 in concerns here we need to have three
 6 pathology assistants for the lab, those things
 7 I would have had to have brought forward to
 8 Dr. Williams because we're talking about a
 9 large amount of new additional resources, and
 10 not either reallocating resources within the
 11 program.
 12 CHAYTOR, Q.C.:
 13 Q. And his concerns that the potential, his
 14 wording that "It will be ill advised to
 15 operate an unreliable and erratic
 16 immunohistochemical procedure in our
 17 laboratory" and his concerns for a potential
 18 litigation, were they anything that you
 19 thought needed to be brought forward?
 20 MR. GULLIVER:
 21 A. Again, I mean, he's telling me stuff that I
 22 already know, it's basic lab practice. It
 23 would be ill advisable to run a bad lab, yes.
 24 And if there was a clinical issue, I would
 25 assume Dr. Ejeckam would have brought that

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1 directly to Dr. Cook.
 2 CHAYTOR, Q.C.:
 3 Q. And do you know whether or not then your
 4 superior, Dr. Williams, would have been aware
 5 of the nature of Dr. Ejeckam's concerns?
 6 MR. GULLIVER:
 7 A. I don't think he was, no.
 8 CHAYTOR, Q.C.:
 9 Q. So you didn't tell him, you didn't bring it
 10 forward?
 11 MR. GULLIVER:
 12 A. No. And Dr. Ejeckam didn't ask to bring it
 13 forward. He never expressed any concern
 14 whatsoever to bring it forward to Dr.
 15 Williams.
 16 CHAYTOR, Q.C.:
 17 Q. So was there anything at all in his letter to
 18 you that you took issue with?
 19 MR. GULLIVER:
 20 A. You mean that I didn't support?
 21 CHAYTOR, Q.C.:
 22 Q. Anything that you--from what I'm hearing you
 23 say and correct me if I'm wrong, that for the
 24 most part, these were things that you were
 25 working on, anything in terms of his concerns

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1 as to what might be the outcome of doing
 2 things in less than an ideal way, all that was
 3 nothing new to you, so I'm wondering is there
 4 anything there that you did take issue with?
 5 MR. GULLIVER:
 6 A. I don't remember taking issue with anything in
 7 it, no.
 8 CHAYTOR, Q.C.:
 9 Q. Was there any reason that you didn't want Dr.
 10 Williams to see this memo?
 11 MR. GULLIVER:
 12 A. None whatsoever. It was an issue that was, in
 13 my opinion, was being handled very well by Dr.
 14 Ejeckam. He was the director of IHC lab and
 15 if he had any other major concerns, I would
 16 assume he would have brought it up to the
 17 clinical side of the program.
 18 CHAYTOR, Q.C.:
 19 Q. Now the memo or letter is copied to a number
 20 of other people, Dr. Robb, Dr. Cook, Dr. Parai
 21 and Mr. Dyer and you've told us about your
 22 discussions with Mr. Dyer. Did you discuss
 23 the memo with any of the physicians named?
 24 MR. GULLIVER:
 25 A. I think I didn't--I don't know if I discussed

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1 the memo with Dr. Cook, but I know myself and
 2 Don talked about it and pretty well just to
 3 give Don an update on, look, in the next few
 4 months, once the summer is over, here are the
 5 things that I think that we can do, you know,
 6 like moving the staff, setting the new lab up,
 7 we're going to go to tender and look for some
 8 new automation, we're going to retrain another
 9 senior tech to take over the grossing
 10 function, like those basic things to make sure
 11 that Don knew, was aware. But Dr. Cook and I
 12 never ever sat down and went through this
 13 memo, like paragraph by paragraph or line by
 14 line.
 15 THE COMMISSIONER:
 16 Q. And Drs. Parai and Robb, did you hear from
 17 them?
 18 MR. GULLIVER:
 19 A. I never heard anything from either one of
 20 them, no.
 21 CHAYTOR, Q.C.:
 22 Q. And I take it there was no written response to
 23 Dr. Ejeckam?
 24 MR. GULLIVER:
 25 A. No, we just pretty well went ahead and did

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1 what we said we were going to do.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, and if we could have, please, the
 4 transcript of Dr. Ejeckam's evidence, June
 5 3rd, 2008. And, Registrar, it's page 286.
 6 And Mr. Coffey was asking Dr. Ejeckam the
 7 questions about your June 19th memo and he
 8 says "By the time you came to write the June
 9 19th memo, one, the immediate problem of the
 10 eight stains was addressed? Yes. Did anyone
 11 ask you to write this? No. Okay, so it was
 12 your idea? Yes. Having written it, did you
 13 ever get any feedback or anybody ever ask you
 14 about it, any response? Not in terms of
 15 written feedback, but I remember after some
 16 days when I didn't get any reply, I ran into
 17 Dr. Robb in the corridor and I asked him if he
 18 got the letter. He said yes, I got it and I
 19 think it was a good letter and that he was
 20 going to have a meeting. Unfortunately he was
 21 ill and went off for January for surgery and
 22 didn't make it back. And then also the same
 23 process with Terry. I saw him in the lab and
 24 said did you get a letter? He said, yes, and
 25 he told me I am going to reply to you and that

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1 was the follow up that I had and that was all
 2 the response that I got from this. So you
 3 spoke to Dr. Robb and as you pointed out, he
 4 was going to get back to you. Dr. Robb
 5 unfortunately was ill and got iller and I
 6 gather died shortly thereafter? Yeah. And
 7 you also spoke to Mr. Gulliver? Yes. And he
 8 said he expected to act upon it and he would
 9 get back to you? Yes. And that was the last
 10 you heard from him about it? Yes. Did you
 11 ever hear from anybody else about it? No,
 12 well I know, I think Dr. Don Cook may have
 13 discussed it, but not written communication."
 14 So, Mr. Gulliver, I'm just wondering in terms
 15 of Dr. Ejeckam's recollection of your
 16 response, he's saying that--you're saying that
 17 you sat down with him and Mr. Dyer and
 18 discussed and went through his memo line for
 19 line or paragraph for paragraph?
 20 MR. GULLIVER:
 21 A. Pretty well paragraph by paragraph, yeah, and
 22 I mean, I don't know--well, you know, Ms.
 23 Chaytor, this inquiry has been ongoing for
 24 months and obviously I'm director of the
 25 program, one of the key witnesses, and I

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1 really don't follow other people's testimony
 2 and I've been prodded by people in Eastern
 3 Health to say, well I should be watching it
 4 and following it. Well I've got all to much
 5 work to do and my -
 6 CHAYTOR, Q.C.:
 7 Q. I just wanted to offer you an opportunity to
 8 respond if you haven't seen this -
 9 MR. GULLIVER:
 10 A. I know, but my response has been I don't want
 11 for me to read other people's testimony, so
 12 that would influence my testimony.
 13 CHAYTOR, Q.C.:
 14 Q. Yes.
 15 MR. GULLIVER:
 16 A. And I'm saying to you -
 17 CHAYTOR, Q.C.:
 18 Q. That's why I'm offering you an opportunity
 19 when I see a situation where your evidence is
 20 not the same as what we've heard from others,
 21 so I'm offering you an opportunity to respond.
 22 MR. GULLIVER:
 23 A. And when you read this here, he says he spoke
 24 to Dr. Robb in January. The memo was written
 25 in June and he's saying he spoke to Dr. Robb,

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1 but he went off on surgery in January. You
 2 see this right here?
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 MR. GULLIVER:
 6 A. You know, so is he saying he spoke to Dr. Robb
 7 six months after he wrote the memo. I guess,
 8 my point to you is that I clearly remember
 9 speaking to Dr. Ejeckam and Barry in my
 10 office, and, you know, that's--I can't say
 11 anything different. Whether Dr. Ejeckam
 12 remembers that or not, I don't know. I
 13 clearly remember speaking to him about this
 14 memo, going through it, and clearly indicating
 15 to him the things I can do within my own
 16 authority as director of the program to
 17 respond to some of those concerns in his memo.
 18 CHAYTOR, Q.C.:
 19 Q. Mr. Gulliver, who was prodding you to follow
 20 the evidence and what's the purpose in doing
 21 that?
 22 MR. GULLIVER:
 23 A. Oh, not prodding me to follow evidence. It's
 24 just that obviously you can understand within
 25 Eastern Health that this is webcast live all

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1 day long, and people have it on their
 2 computers, they have it on their computer
 3 screens. I'm not someone--I have never yet
 4 put it on my computer screen. Even though key
 5 witnesses have come here to testify that could
 6 have an impact on the laboratory, I still
 7 don't feel I want to watch their testimony
 8 directly unless it's been staff--you've seen
 9 me here in the back of the room when my
 10 manager and staff have been here. I felt to
 11 be here for support for them, but I don't want
 12 to read people's transcripts because I want to
 13 make sure what's in my mind is what's in my
 14 mind and what my memory is, what my belief is,
 15 and I'm afraid if I read someone else's
 16 testimony, it would be like, oh, I should
 17 change what I'm going to say and I don't want
 18 to do that.
 19 CHAYTOR, Q.C.:
 20 Q. So have you been an attendee at meetings at
 21 Eastern Health for the purpose of the inquiry?
 22 MR. GULLIVER:
 23 A. For the purpose of reading evidence or the
 24 testimony?
 25 CHAYTOR, Q.C.:

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1 Q. No, for talking about the inquiry.
 2 MR. GULLIVER:
 3 A. I generally don't go to those either.
 4 CHAYTOR, Q.C.:
 5 Q. Okay.
 6 MR. GULLIVER:
 7 A. I know there was a session set up for staff
 8 who are coming to the inquiry as more of
 9 support. I think it's more of a psychological
 10 support and group support. I've gone to
 11 several of those, but nothing is discussed
 12 about coming up at the inquiry, none of the
 13 details of the inquiry. It's more of as a
 14 support group mechanism.
 15 CHAYTOR, Q.C.:
 16 Q. And in terms of the manner in which you would
 17 give your evidence or things that you -
 18 MR. GULLIVER:
 19 A. Nothing whatsoever, no.
 20 CHAYTOR, Q.C.:
 21 Q. If we could have, please, P-2406. Before we
 22 leave that then, Mr. Gulliver, is there
 23 anything else around Dr. Ejeckam and his memos
 24 that you recall that would be important for us
 25 to know about?

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1 MR. GULLIVER:
 2 A. Again I mention to you that, you know, you can
 3 see the way Dr. Ejeckam writes and he spoke
 4 the same way, that he remained as director of
 5 our lab for three more years, he never ever
 6 wrote another concern, never wrote another
 7 concern to my level about the IHC lab, and as
 8 a matter of fact, I think it may have been
 9 last summer--as you know, Dr. Ejeckam retired
 10 in June of '06, and last summer he came back
 11 to Newfoundland and spent the summer as a
 12 locum in, I think, Gander or Grand Falls, and
 13 he sent all of his IHC tests in to the Health
 14 Sciences to get done while he was practising
 15 as a pathologist out in Gander or Grand Falls.
 16 So I take that to mean that he was pretty well
 17 happy with the service.
 18 CHAYTOR, Q.C.:
 19 Q. Well, would he have had any choice as a locum
 20 pathologist as to where his samples went?
 21 MR. GULLIVER:
 22 A. He could send them out to Toronto or send them
 23 anywhere. It's their decision.
 24 THE COMMISSIONER:
 25 Q. Could we go back to 113 or--yes, 113, for just

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1 a moment, page one. Mr. Gulliver, you've on
 2 two or three occasions during your testimony
 3 regarding this series of communications,
 4 referred to Dr. Ejeckam's way of speaking, and
 5 as an outsider when I read phrases like "have
 6 remained unreliable, erratic, and, therefore,
 7 unhelpful for diagnostic purposes", my
 8 reaction is that's serious stuff. You seem to
 9 say that's--what Dr. Ejeckam is talking about
 10 is nothing more than the normal adjustments
 11 one does in IHC, and you add that's the way he
 12 talks. Now are you suggesting that Dr.
 13 Ejeckam is apt to exaggerate?
 14 MR. GULLIVER:
 15 A. I don't think exaggerate is the correct term.
 16 THE COMMISSIONER:
 17 Q. Okay, do I discount what Dr. Ejeckam says
 18 because he speaks in a particular way that
 19 others don't? I'm not quite sure I'm
 20 understanding your response when you say,
 21 well, that's the way Dr. Ejeckam talks?
 22 MR. GULLIVER:
 23 A. Well, it is the way Dr. Ejeckam talks,
 24 however, it is a serious issue he's bringing
 25 forward here. Now in this memo, he's pretty

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1 well direct.
 2 THE COMMISSIONER:
 3 Q. Uh-hm.
 4 MR. GULLIVER:
 5 A. However, what he's saying here, Judge Cameron,
 6 is something that would not be uncommon
 7 practise in medical laboratories, that a part
 8 of your laboratory, a clinical physician,
 9 whether it's a pathologist, a biochemist, or
 10 microbiologist, they may decide to review some
 11 of the current testing and practises and put
 12 changes in place.
 13 THE COMMISSIONER:
 14 Q. I'm not having difficulty with the concept
 15 that my suspicion is it would be good practise
 16 to from time to time ensure that your
 17 practises are properly being followed, if
 18 there are variations that you note in your
 19 process, make sure that you are rigidly
 20 adhering to the proper protocols, determining
 21 whether, in fact, protocols should be changed
 22 for some reason or another because of perhaps
 23 a variable having changed that was not there
 24 when you originally determined your protocol.
 25 That to me is science. I really don't have

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1 any difficulty with the idea that in a
 2 laboratory sciences would from time to time
 3 make adjustments, check, double check, triple
 4 check, that's what they do, but the language
 5 used by Dr. Ejeckam of unreliable, erratic,
 6 and, therefore, unhelpful for diagnostic
 7 purposes, to somebody who does not live in
 8 that scientific world, causes me some concern
 9 and what I need to know from you is whether
 10 you have a similar view of this language, or
 11 are you telling me that in the world of
 12 science, when they use "unreliable, erratic,
 13 and, therefore, unhelpful for diagnostic
 14 purposes", that's just the normal day?
 15 MR. GULLIVER:
 16 A. And somewhere in between. You know, I -
 17 THE COMMISSIONER:
 18 Q. Well, see, I need to know two things; whether
 19 that's really normal, or you're telling me it
 20 was a normal situation and Dr. Ejeckam has a
 21 tendency to up the level of the language, and
 22 don't worry about it, or should I be concerned
 23 that Dr. Ejeckam, who everybody has come here
 24 has indicated is a person who had an interest
 25 in IHC, had a knowledge that was greater than

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1 other people in the general area at the time,
 2 took great pains to deal with the subject
 3 within the lab, communicated very well with
 4 the technologists--I got the impression from
 5 the technologists who came through here that
 6 they were most appreciative of the opportunity
 7 to learn side by side with him, and he says,
 8 "unreliable, erratic, and, therefore,
 9 unhelpful for diagnostic purposes", so I'm
 10 wondering what's the situation? There seems
 11 to be a disconnect between what I, as an
 12 outside person would view that statement as
 13 being, and how you see it, and I need to
 14 understand why you don't see it the same way I
 15 would.
 16 MR. GULLIVER:
 17 A. I don't know if it's because of my 28 years in
 18 laboratory, whether it's--you know, anything
 19 in the laboratory could be unreliable or
 20 erratic, you know, that could happen. I guess
 21 my main point would be when this came across--
 22 well, it didn't come across my desk, I was
 23 informed from Barry, and all the pathologists,
 24 no one raised any red flags to say, hold on
 25 here, what are you saying to us, Dr. Ejeckam,

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1 do we have to stop practice, do we have to go
 2 back and review what we did five years ago. So
 3 it's--within the lab environment, this was not
 4 a red flag that was raised where you had to
 5 stop everything you were doing and focus all
 6 of your attention, all your resources, on this
 7 particular issue. It was something that Dr.
 8 Ejeckam was saying to you, that you realize
 9 that if we have unreliable and erratic
 10 staining, it could lead to, and would be
 11 unhelpful for diagnostic purposes, and he's
 12 saying something to me that I know as a
 13 medical lab technologist, and as the former
 14 manager, that if these stains or any IHC
 15 stains are unreliable and erratic, it's not
 16 going to help the pathologist render a
 17 diagnosis or help them with their
 18 interpretations.
 19 THE COMMISSIONER:
 20 Q. Uh-hm.
 21 MR. GULLIVER:
 22 A. I don't know if I'm answering you correctly.
 23 THE COMMISSIONER:
 24 Q. Can I read what you're saying this way, Dr.
 25 Ejeckam was a person who spoke directly and

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1 plainly, and he was being honest and not
 2 exaggerating when he said his view was that
 3 these were unreliable, erratic, and,
 4 therefore, unhelpful for diagnostic purposes,
 5 but your perspective is that within a
 6 laboratory setting, that's life, that happens
 7 from time to time?
 8 MR. GULLIVER:
 9 A. It does.
 10 THE COMMISSIONER:
 11 Q. You deal with it.
 12 MR. GULLIVER:
 13 A. It does happen from time to time.
 14 THE COMMISSIONER:
 15 Q. And unless somebody like Dr. Ejeckam raised
 16 with you that this was a particularly unusual
 17 circumstances, you would read that as being
 18 normal adjustment being done within a
 19 particular division of the lab?
 20 MR. GULLIVER:
 21 A. I would have to say yes, yeah.
 22 THE COMMISSIONER:
 23 Q. All right, thank you.
 24 CHAYTOR, Q.C.:
 25 Q. Thank you, Commissioner.

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1 THE COMMISSIONER:
 2 Q. Now you wanted 2406.
 3 CHAYTOR, Q.C.:
 4 Q. Yes. Just before, though, we leave this, the
 5 ER and PR, we understand that is for
 6 prognostic purposes as opposed to diagnostic
 7 purposes. Did that make any difference to
 8 you, Mr. Gulliver, in your interpretation of
 9 what's being said here?
 10 MR. GULLIVER:
 11 A. It did not, no.
 12 CHAYTOR, Q.C.:
 13 Q. If we could have, please, 2406, and this is a
 14 division of anatomical pathologist meeting,
 15 September 1, 2004, and I'm thinking that's not
 16 the right number. Let's try 2404. Yes, this
 17 is the one, sorry about that. This is quality
 18 assurance document, Division of Anatomic
 19 Pathology, Health Care Corporation of St.
 20 John's, and it's, we understand, a draft
 21 document at that time, quality assurance in
 22 anatomic pathology, and if we just go through
 23 the document here, do you know anything about
 24 this, Mr. Gulliver, this document, and whether
 25 or not it was finalized?

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1 MR. GULLIVER:
 2 A. It's not something that I had seen.
 3 CHAYTOR, Q.C.:
 4 Q. So you're not involved in this?
 5 MR. GULLIVER:
 6 A. No.
 7 CHAYTOR, Q.C.:
 8 Q. If we could have 1867, please, page 50. This
 9 is another quality initiatives report. You'll
 10 recall I took you to one yesterday, and this
 11 one is for the time period, April 1st, 2003
 12 through March 31st, '04, submitted by yourself
 13 as program director, and if we look at your
 14 challenges that you've identified in your
 15 report on page 52, and then your achievements,
 16 when I look down through the challenges, you
 17 indicate, "Ongoing renovations of laboratory
 18 at General site, providing high quality
 19 laboratory services within existing
 20 resources", and dealing again with labour
 21 management issues, keeping abreast with new
 22 technology equipment, and implementation of
 23 the HAY operational report. When I look down
 24 through in terms of the fact that Dr. Ejeckam
 25 had to shut down the stains, those eight

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1 stains for that period of time, and the
 2 response that you had to make in this calendar
 3 year to that, or in this fiscal year to that,
 4 I don't see any indication of that under your
 5 challenges. Is there any reason for that?
 6 MR. GULLIVER:
 7 A. Well, actually, I think we were told we had to
 8 keep four or five bullets for challenges and
 9 achievements and I had to submit this for the
 10 laboratory medicine program, pathology being
 11 about ten percent of the program. Ninety
 12 percent of the program is not in pathology.
 13 And I guess at the time I don't think it was a
 14 major challenge to move the staff into a new
 15 space for IHC. We're able to operationalize
 16 the new reagent lease for the Ventana
 17 equipment without getting any new funding.
 18 So, I mean, it wasn't like it was a--we did it
 19 within our program. A lot of these things
 20 here are put on here for major challenge are
 21 things that would probably require outside the
 22 program and issues that are more than just the
 23 laboratory.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. So you didn't see it as being something

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1 that would make your list here at the end of
 2 the year?
 3 MR. GULLIVER:
 4 A. Obviously it didn't.
 5 CHAYTOR, Q.C.:
 6 Q. And achievements, "Increase workload by five
 7 percent; increase productivity; maintain
 8 cause/workload unit; ranked in top quartile
 9 for productivity; provide professional
 10 development for staff." You "improved
 11 technology equipment through capital purchases
 12 and/or negotiated reagent leases; increase
 13 laboratory revenue." Those were some of the
 14 achievements for the year?
 15 MR. GULLIVER:
 16 A. Um-hm.
 17 CHAYTOR, Q.C.:
 18 Q. And then your "Key Directive," "Key
 19 Directives/Objectives. Continue to improve
 20 operational efficiencies within the program:
 21 Consolidate technical Pathology services." So
 22 that's still under way. "Meet budget targets
 23 for 2004/05. Maintain HAY productivity
 24 benchmarks. Standardize specimen collection
 25 services within Health Care Corporation of St.

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1 John's." Again, in terms of setting up a
 2 separate IHC lab to address the concerns and
 3 having that become a dedicated space with
 4 dedicated staff, you wouldn't see that as
 5 something you would outline in your quality
 6 initiatives report?
 7 MR. GULLIVER:
 8 A. No, because if you go back here earlier where
 9 I said I set up a system where I met with each
 10 division manager to outline their goals,
 11 objectives, probably we discussed that at the
 12 manager's level and the accomplishments that
 13 were done within each--with each division or
 14 with each manager. And again, for example,
 15 we're currently, in this year, we are going to
 16 open up a new blood collection centre at
 17 Major's Path and we're moving our fertility
 18 testing lab to Major's Path. That will
 19 probably be under my list of achievements
 20 because it's a significant thing to move your
 21 service outside your building. In the
 22 pathology lab we moved IHC testing from the
 23 back bench right here, you open the door and
 24 walk into a separate room. It wasn't like a
 25 significant thing to have to go through and do

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1 that. It was like saying "Ms. Chaytor, you're
 2 going to go and question me over on the other
 3 side of the room this afternoon." You know,
 4 it's adjacent to each other. So I guess it
 5 wasn't significant enough to put it underneath
 6 the achievements for the lab program for that
 7 year. But again, if we had to move that to a
 8 brand new lab with new construction and new
 9 spaced, new square footage and new benches and
 10 all that stuff, it would probably be on our
 11 list of achievements.
 12 CHAYTOR, Q.C.:
 13 Q. And the directive for to ultimately become
 14 more than just a physical move a few feet away
 15 and to have it become an IHC lab with
 16 dedicated staff, that again is not seen as
 17 under you key objectives or directives?
 18 MR. GULLIVER:
 19 A. Um-um. And the staff, you're talking about
 20 dedicated staffing, the staff were always
 21 dedicated for IHC. We only had two or three
 22 staff who were trained for IHC testing,
 23 therefore we had dedicated staff for IHC
 24 testing. The issue was to take the other
 25 duties away from those staff so they're

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

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1 Q. Why it's not on the list.
 2 MR. GULLIVER:
 3 A. The directives there are big picture stuff
 4 that -
 5 CHAYTOR, Q.C.:
 6 Q. And you didn't see that as a big picture item?
 7 MR. GULLIVER:
 8 A. Well, we had already been denied that before.
 9 CHAYTOR, Q.C.:
 10 Q. If we could have, then, please, 1891? And
 11 this is your annual report then for the
 12 laboratory medicine program from April 1st,
 13 2003 through March 31st, '04. And it's you
 14 and Dr. Cook and Dr. Williams is the VP. And
 15 again, when I look down through here, there's
 16 a list of goals. And then you have a list of
 17 highlights for the year. Opportunities to
 18 acquire new technology; to offer new services;
 19 improve specimen collection; continue the
 20 implementation of your three-year strategic
 21 plan. This is going on then into '04, '05.
 22 And challenges, you had limited financial
 23 resources; dependency on facilities
 24 management. And your workload increase is
 25 identified coming up for the challenges of

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1 '04, '05. And outcome measures. And when I
 2 look through that document and I couldn't see
 3 any reference there, either, to the issues
 4 regarding IHC and the need for IHC staff and
 5 any measures that had been taken to address
 6 that in terms of it becoming more of a
 7 dedicated lab. And also couldn't see any
 8 reference to looking to have a quality
 9 management position. So is that also for the
 10 same reasons that we didn't see it in the
 11 quality initiatives report?
 12 MR. GULLIVER:
 13 A. Um-hm, I guess so. I mean, but if you look at
 14 this comprehensive report, there are a lot of
 15 things in there. And there's probably lots of
 16 other things you could put in there.
 17 CHAYTOR, Q.C.:
 18 Q. And if we could look, please, at 0912?
 19 MR. GULLIVER:
 20 A. You know, if Mr. Dyer had to submit a quality
 21 report for pathology division, you'd probably
 22 see that in there. As program director, you
 23 know, having to report up for the whole
 24 laboratory medicine program, you know, there's
 25 only so many things you can put in a report.

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

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1 efficient manner." And under "Pathology"
 2 again you have "Consolidation of the technical
 3 staff to the Health Sciences Centre; develop
 4 canned text for transcription." And then
 5 "Meet your budget targets," number five.
 6 Number six is "Utilization issues." And
 7 number seven, "Continue the development of the
 8 laboratory management team philosophy." And
 9 number eight, "Plan, design, monitor
 10 laboratory renovations." So those were your
 11 goals and objectives for that year?
 12 MR. GULLIVER:
 13 A. Well, this is the program's, not just mine.
 14 CHAYTOR, Q.C.:
 15 Q. Okay, so how would these be developed, then?
 16 This is not just something you submit. Who
 17 would sit down and who would come up with
 18 those?
 19 MR. GULLIVER:
 20 A. Well, as I mentioned to you, we had sort of a
 21 final planning day exercise around, I think it
 22 was March of '03. But for about three or four
 23 months leading up to that exercise I sat down
 24 with the division managers, division chiefs,
 25 we talked about, you know, the next three

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

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1 And that was a full-day exercise and we had it
 2 facilitated with, I think, one of our, I think
 3 Janet Laidley was our facilitator internally.
 4 But it was a lot of work went into preparing
 5 this. From that three-year plan I then
 6 developed a sort of a template like this where
 7 on a quarterly or, a quarterly basis I would
 8 sit down with Dr. Williams and say for the
 9 first year of our plan here are the things
 10 within our divisions that we are going to
 11 work towards and hopefully achieve. We did
 12 the same thing for year two, year three. I
 13 then sat down and made a same template. I
 14 would meet with my managers every six months
 15 and say, "Okay, you're goals for your division
 16 this year, where are we? what are you doing?
 17 Give me an update. And is there some reason
 18 why we're not meeting this target or achieving
 19 this target?" So that's--does that give you
 20 enough background on it?
 21 CHAYTOR, Q.C.:
 22 Q. Yes, to how they're developed, yes. Thank
 23 you. Now, under the goals for pathology, we
 24 saw back here the intent to acquire new
 25 technology for immunopathology. Is that the -

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1 MR. GULLIVER:
 2 A. That would be, I guess, the Ventana.
 3 CHAYTOR, Q.C.:
 4 Q. The Ventana machine.
 5 MR. GULLIVER:
 6 A. Yeah.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. And also the issue then of the
 9 consolidation. Come down here under number
 10 four, "Consolidation of technical staff to the
 11 Health Sciences Centre." And I take it that's
 12 something that had long been a goal for you?
 13 MR. GULLIVER:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. But you're saying that was actually
 17 having it articulated here, it was that's a
 18 program goal, that's something everybody by
 19 2003 and '04, for that year, everybody has
 20 agreed upon?
 21 MR. GULLIVER:
 22 A. Oh, not saying everyone is in agreement upon.
 23 I'm saying that the general consensus is this
 24 is a goal within that division.
 25 CHAYTOR, Q.C.:

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1 Q. And during this calendar--or this, I should
 2 say, fiscal year, then as you move forward, is
 3 there--and beyond there in terms of trying to
 4 achieve that goal, do you take part in
 5 meetings regarding the consolidation of the
 6 technical services?
 7 MR. GULLIVER:
 8 A. I do, yes.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. And did you have--did you run into any
 11 particular challenges or obstacles in trying
 12 to achieve that goal?
 13 MR. GULLIVER:
 14 A. Well, as you can see there, well, first of
 15 all, for my three-year plan some of these
 16 things were goals that each division could
 17 attain within their own division. It may be
 18 change practice, change procedure or do
 19 something differently. Some of these
 20 objectives were big objectives, like the off-
 21 site blood collection centre for adult walk-in
 22 for St. John's. This is, I'm saying this is
 23 2003 and five years later we're going to move
 24 to Major's Path. The -
 25 CHAYTOR, Q.C.:

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1 Q. But in terms of the pathology -
 2 MR. GULLIVER:
 3 A. The actually moving pathology from St. Clare's
 4 to Health Sciences was a bigger issue than
 5 within the pathology division. So some of
 6 these goals had to go to executive team for
 7 approval or not approval. For example, the
 8 off-site blood collection centre had to go to
 9 executive team to give us permission to work
 10 towards that goal. The pathology
 11 consolidation was one of those issues that
 12 also went up to executive team.
 13 CHAYTOR, Q.C.:
 14 Q. And did you, in fact, have any--and I guess in
 15 terms of it having to go up to the executive
 16 team, why would certain things have to go to
 17 the executive team as opposed to the program
 18 itself working it out?
 19 MR. GULLIVER:
 20 A. It could be either/or, it could be -
 21 CHAYTOR, Q.C.:
 22 Q. Well, what about in this case, for pathology
 23 consolidation?
 24 MR. GULLIVER:
 25 A. For example, the off-site blood collection

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1 would cost significant new dollars.
 2 CHAYTOR, Q.C.:
 3 Q. Right. But what about -
 4 MR. GULLIVER:
 5 A. This one here, the program leadership team
 6 didn't agree upon the goal, so because we
 7 didn't have agreement within the program, then
 8 that would go to Dr. Williams, which he
 9 brought to executive.
 10 CHAYTOR, Q.C.:
 11 Q. So that's you and Dr. Cook didn't agree on
 12 this particular goal and objective, to
 13 consolidate the pathology services to Health
 14 Sciences?
 15 MR. GULLIVER:
 16 A. Pretty well.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And so Dr. Williams then became
 19 involved. And so what happened after that,
 20 did you have meetings with Dr. Williams on the
 21 issue?
 22 MR. GULLIVER:
 23 A. We talked about it several times, I think, in
 24 our monthly leadership meetings, and I think
 25 what eventually happened was, I guess within

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1 the pathology division, also Ms. Chaytor,
 2 there was, I guess, apprehension about, you
 3 know, consolidating pathologist services.
 4 While there was a fair bit of agreement to it,
 5 again, there was still some resistance to it,
 6 and what happened was myself and Dr. Cook, Dr.
 7 Williams invited myself and him to Mr.
 8 Tilley's office and we had a discussion with
 9 Mr. Tilley and Dr. Williams, myself, Dr. Cook,
 10 about this particular goal objective.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So with Mr. Tilley. What came out of
 13 that?
 14 MR. GULLIVER:
 15 A. Well, at -
 16 CHAYTOR, Q.C.:
 17 Q. Or what happened at the meeting I should ask
 18 you first?
 19 MR. GULLIVER:
 20 A. Well, at the meeting, it was, I guess, Mr.
 21 Tilley wanted to find out firsthand, you know,
 22 why am I in favour and why is Dr. Cook not in
 23 favour, and we both--you know, we both did
 24 sort of a presentation to George and Dr.
 25 Williams pros and cons and went through that,

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

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

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

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

11 CHAYTOR, Q.C.:

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

25 MR. GULLIVER:

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

7 CHAYTOR, Q.C.:

8 Q. And what did you do following that?

9 MR. GULLIVER:

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

20 CHAYTOR, Q.C.:

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

22 MR. GULLIVER:

23 A. Well, you know, like St. Clare's were doing
 24 tissue processing, embedding, cutting,
 25

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

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1 pathology.
 2 CHAYTOR, Q.C.:
 3 Q. Did you have any concern that you wanted, by
 4 doing this, to move staff and move the
 5 technical staff over to the Health Science,
 6 were you trying to achieve standardized
 7 processing and grossing?
 8 MR. GULLIVER:
 9 A. I really can't say standardized grossing, no.
 10 CHAYTOR, Q.C.:
 11 Q. What about the processing?
 12 MR. GULLIVER:
 13 A. But certainly tissue processing then would be
 14 more standardized.
 15 CHAYTOR, Q.C.:
 16 Q. Okay, and -
 17 MR. GULLIVER:
 18 A. At this time, the grossing is still being
 19 performed by the pathologists.
 20 CHAYTOR, Q.C.:
 21 Q. Are you then, in terms of standardizing the
 22 processing, I just want to understand your
 23 reasons why this was so important to you to
 24 have the technical consolidation?
 25 MR. GULLIVER:

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1 A. Well, see, it's not--well, actually, you're
 2 not showing the full scope. It's not just
 3 staff. It's also the equipment. At St.
 4 Clare's, they were probably doing a couple 100
 5 slides a day. The Health Sciences were doing
 6 7-800-900 slides a day, and we had similar
 7 equipment. So they had a slide stainer, slide
 8 cover slippers at St. Clare's. The same
 9 equipment was over at the Health Sciences.
 10 The Health Sciences' volume warranted more
 11 than one piece of equipment. So we actually
 12 took the slide stainers and slide cover
 13 slippers and embedders from St. Clare's that
 14 were being under utilized and moved them to
 15 Health Sciences to make them better utilized
 16 and help with the volumes at the Health
 17 Sciences. So it's not just the technical
 18 staff that was important. The staff had to
 19 come with that in order to do it.
 20 CHAYTOR, Q.C.:
 21 Q. Yes, and was Dr. Cook consulted on that, and
 22 was he in agreement?
 23 MR. GULLIVER:
 24 A. I don't know if myself and Dr. Cook had a sort
 25 of dedicated meeting to talk about the

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1 technical side, but obviously at some point,
 2 Dr. Cook was okay with the technical piece
 3 moving to St. Clare's--from St. Clare's to
 4 Health Sciences.
 5 CHAYTOR, Q.C.:
 6 Q. So whether or not you discussed that with him
 7 beforehand or not?
 8 MR. GULLIVER:
 9 A. Oh, I know we discussed it. I don't know if
 10 we discussed it in a separate dedicated
 11 meeting, but we obviously had discussions over
 12 it. I think Dr. Cook was fine as long as he
 13 knew that St. Clare's still had support staff
 14 on site to respond for frozen sections, that
 15 there was technical staff on site to assist
 16 the pathologists in the gross bench. I think
 17 Dr. Cook's concerns were alleviated by that.
 18 CHAYTOR, Q.C.:
 19 Q. In terms of standardizing the processing,
 20 Barry Dyer is manager of both sites, Health
 21 Science -
 22 MR. GULLIVER:
 23 A. By this time, yes.
 24 CHAYTOR, Q.C.:
 25 Q. - yes, and St. Clare's, and why--and had been

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1 for a couple of years. Why wouldn't--if you
 2 have the same manager, why couldn't you have
 3 the same standardized processing happening at
 4 both sites?
 5 MR. GULLIVER:
 6 A. Well, and you could ask Barry that question,
 7 but I'm pretty sure that the processing cycle
 8 that was being operated on for each tissue
 9 processor at Health Sciences and St. Clare's
 10 was probably the same kind of schedule.
 11 However, there's more than just, you know, the
 12 processing cycle. You want to make sure that
 13 all the fluids on the tissue processor are
 14 being changed on a routine schedule, you know,
 15 those kinds of things that also go into
 16 maintaining the tissue processors.
 17 CHAYTOR, Q.C.:
 18 Q. But can't that be done through your standard
 19 operating procedures?
 20 MR. GULLIVER:
 21 A. I guess it could, yes.
 22 THE COMMISSIONER:
 23 Q. Ms. Chaytor, it's past the time when we
 24 normally take the break.
 25 CHAYTOR, Q.C.:

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1 Q. Sorry.
 2 THE COMMISSIONER:
 3 Q. So I suggest we do that.
 4 CHAYTOR, Q.C.:
 5 Q. Okay.
 6 THE COMMISSIONER:
 7 Q. Thank you. Take 15 minutes.
 8 (BREAK)
 9 THE COMMISSIONER:
 10 Q. Please be seated. Ms. Chaytor.
 11 CHAYTOR, Q.C.:
 12 Q. Thank you, Commissioner. Mr. Gulliver, we
 13 were talking about the consolidation of the
 14 technical services. Your meeting that you had
 15 with Mr. Tilley and Dr. Williams regarding
 16 that, did Dr. Williams express his view as to
 17 on the issue of consolidation?
 18 MR. GULLIVER:
 19 A. I don't remember Dr. Williams being either in
 20 favour or against. I think he was also, you
 21 know, listening to Mr. Tilley's assessment and
 22 I would assume that he agreed with that
 23 position.
 24 CHAYTOR, Q.C.:
 25 Q. And at any point prior to that meeting, this

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1 had been an issue back and forth between
 2 yourself and Dr. Cook within the program for
 3 some time, at any point in time, did Dr.
 4 Williams express his view?
 5 MR. GULLIVER:
 6 A. His view was that the leadership team should
 7 be in favour of it, and he never ever viewed
 8 that he was completely in favour or he was
 9 against. He was sort of on the fence.
 10 CHAYTOR, Q.C.:
 11 Q. But it was his view that the leadership team
 12 should be in favour of it?
 13 MR. GULLIVER:
 14 A. To do the full pathology consolidation, yeah.
 15 CHAYTOR, Q.C.:
 16 Q. So he was encouraging the consolidation to
 17 happen?
 18 MR. GULLIVER:
 19 A. I would have to say yes, yeah.
 20 THE COMMISSIONER:
 21 Q. Sorry, I'm confused now. Are you saying that
 22 Dr. Williams wanted you and Dr. Cook to be of
 23 the same view before it moved?
 24 MR. GULLIVER:
 25 A. Yes.

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1 THE COMMISSIONER:
 2 Q. It really didn't much matter what he thought,
 3 he just wanted the two of you to be in
 4 agreement? Is that it?
 5 MR. GULLIVER:
 6 A. He wanted the two of us to be in agreement.
 7 However, I don't think Dr. Williams would have
 8 wanted to make a decision one way or the other
 9 if both Dr. Cook and I were not in full
 10 agreement.
 11 THE COMMISSIONER:
 12 Q. Okay.
 13 MR. GULLIVER:
 14 A. To consolidate all pathology services.
 15 THE COMMISSIONER:
 16 Q. So he wasn't going to force the issue.
 17 MR. GULLIVER:
 18 A. Exactly.
 19 THE COMMISSIONER:
 20 Q. Whatever his personal view was, he wasn't
 21 going to force the issue, and his--you had the
 22 impression that Dr. Williams felt that you and
 23 Dr. Cook had to be on the same page?
 24 MR. GULLIVER:
 25 A. Exactly.

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1 THE COMMISSIONER:
 2 Q. Okay.
 3 CHAYTOR, Q.C.:
 4 Q. And you mentioned your monthly leadership
 5 meeting. So those meetings were with Dr.
 6 Cook, Dr. Williams and yourself, I take it?
 7 MR. GULLIVER:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And those happened fairly regularly, once a
 11 month?
 12 MR. GULLIVER:
 13 A. Yeah.
 14 CHAYTOR, Q.C.:
 15 Q. In those monthly leadership meetings, did you
 16 ever speak to Dr. Williams and raise with Dr.
 17 Williams, Dr. Ejeckam's concerns? So back in
 18 April, May, June of 2003.
 19 MR. GULLIVER:
 20 A. I don't think so, Ms. Chaytor, no.
 21 CHAYTOR, Q.C.:
 22 Q. So even though those meetings would have been
 23 taking place on a regular basis, April, May,
 24 June, it never came up for discussion with Dr.
 25 Williams that there's been some issues that

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

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

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

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1 process. When the technologists are cutting
 2 slides and putting tissue samples on a glass
 3 slide, some pathologists were coming back and
 4 saying that oh, there was a floater on one
 5 slide or there was a fold or a wrinkle in the
 6 tissue, and then they may go back and ask for
 7 recuts to get other H & E's. This had nothing
 8 to do with the IHC part of pathology.
 9 CHAYTOR, Q.C.:
 10 Q. And you specifically recall that and recall
 11 the discussion?
 12 MR. GULLIVER:
 13 A. I can remember meeting with Don and Barry
 14 talking about that and that was, it was just a
 15 general pathology main--the routine
 16 laboratory.
 17 CHAYTOR, Q.C.:
 18 Q. And did it have anything to do with fixation
 19 issues?
 20 MR. GULLIVER:
 21 A. No.
 22 CHAYTOR, Q.C.:
 23 Q. If we could see, please, 2946? And this is
 24 one of your leadership meetings, December
 25 19th, 2003. So I take it it's your monthly

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1 meeting for December 2003 between yourself,
 2 Doctors Cook and Dr. Williams, and it's
 3 indicated here that, under budget, "November
 4 saw a surplus of \$18,000. However, the
 5 program is still \$400,000 over budget. Terry
 6 presented Dr. Williams with a detailed
 7 analysis of the budget to March 31st, 2004."
 8 So Mr. Gulliver, in terms of, at this point in
 9 time, as of December 2003, into your fiscal
 10 year, I guess by three-quarters, you're
 11 \$400,000 over budget at that point in time.
 12 Did that have any--did the fact that you were
 13 running a deficit of that magnitude have any
 14 bearing on whether or not you spoke to Dr.
 15 Ejeckam about--or sorry, spoke to Dr. Williams
 16 about the issues raised by Dr. Ejeckam and
 17 looking for any additional resources that may
 18 be available?
 19 MR. GULLIVER:
 20 A. I can't say that it did, Ms. Chaytor, and the
 21 submission to Dr. Williams was trying to
 22 project to the end of the fiscal year, would
 23 the laboratory be in a balanced position or
 24 would we still be in a deficit position, and
 25 even though it states \$400,000 over budget,

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1 that's probably maybe two percent of the lab
 2 program budget, you know. I mean, our annual
 3 budget is close to \$40 million. So by that,
 4 after nine months, so it's probably a two
 5 percent deficit in our lab program budget.
 6 CHAYTOR, Q.C.:
 7 Q. So that wasn't considered to be a particularly
 8 bad year?
 9 MR. GULLIVER:
 10 A. That's a normal year.
 11 CHAYTOR, Q.C.:
 12 Q. That's a normal year.
 13 MR. GULLIVER:
 14 A. For lab.
 15 CHAYTOR, Q.C.:
 16 Q. And if we could have then--well, I guess, from
 17 there on, you look at this is the end of '03.
 18 MR. GULLIVER:
 19 A. And you can see the next items here. Just
 20 before the break, we talked about it.
 21 CHAYTOR, Q.C.:
 22 Q. Your lab plan.
 23 MR. GULLIVER:
 24 A. Where microbiology services moved from St.
 25 Clare's to Health Sciences and consolidated

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1 and then Ms. Predham is doing a review about
 2 the pathology technical consolidation.
 3 CHAYTOR, Q.C.:
 4 Q. Right, and I take it there wasn't anything in
 5 Ms. Predham's review detected that would have
 6 warned against any pathology technical
 7 consultation?
 8 MR. GULLIVER:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. So moving on then into 2004, the end of
 12 2003/2004, we understand the Ventana machine
 13 was acquired. Was there any particular reason
 14 why you went with the Ventana system?
 15 MR. GULLIVER:
 16 A. Well, it wasn't me in particular. I mean,
 17 it's for the pathology division. I mean, my
 18 role as program director for all of our
 19 divisions is to ensure that we have the
 20 financial capacity to implement such new
 21 technology as I had done for biochemistry
 22 hematology, other parts of the program.
 23 CHAYTOR, Q.C.:
 24 Q. So who would have made the decision as to it
 25 being Ventana, if it's not you, who did, who

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

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

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1 CHAYTOR, Q.C.:
 2 Q. But what I'm getting at Mr. Gulliver is what
 3 is it about--you had a response from DAKO.
 4 You had your current system in place. I take
 5 it there was nothing wrong with your current
 6 system. Your machine was functioning
 7 properly, was it?
 8 MR. GULLIVER:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. Yes, okay. So what is it, why did you go
 12 looking for a new system and why is it that
 13 the DAKO system and DAKO's response to your
 14 initial tender wasn't acceptable? What
 15 additional--what were you looking for?
 16 MR. GULLIVER:
 17 A. Well, I think the DAKO would have been
 18 acceptable if it was the only thing on the
 19 marketplace. But we had seen--I mentioned to
 20 you earlier, I had seen and we had gotten
 21 information about the new Ventana automated
 22 system, which you know, and again, you know,
 23 I'm the program director for all the
 24 laboratories, but because my background is in
 25 pathology, you know, I'm better able to

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

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1 antibodies, did you have any concerns
 2 regarding antigen retrieval that was currently
 3 taking place on the DAKO system and the use of
 4 other than pre-diluted antibodies? Had there
 5 been concerns brought to your attention
 6 regarding those?
 7 MR. GULLIVER:
 8 A. No concerns had been brought to my attention,
 9 either as the pathology manager years ago when
 10 testing first went in place with Dr. Khalifa,
 11 and neither for the last, the years I was
 12 program director. It's just--you know, it's a
 13 no-brainer that you got two choices. You can
 14 manually take your slides and put them on a
 15 hot plate and boil them or you can put them on
 16 the instrument and the instrument would do
 17 each slide individually.
 18 CHAYTOR, Q.C.:
 19 Q. Did you consult with Dr. Ejeckam, in terms of
 20 your--to get his opinion on which system to
 21 acquire?
 22 MR. GULLIVER:
 23 A. I don't remember if I did it personally. I'm
 24 sure Barry had talked to Dr. Ejeckam and the
 25 staff in the lab. I know Dr. Parai, I think

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1 at the time, was site chief. He would be
 2 informed and involved that we're hoping to get
 3 new technology, and again, even though you're
 4 acquiring new technology, in all these
 5 contracts and tenders, there still is an
 6 evaluation process that needs to take place
 7 once it comes into your laboratory, that
 8 there's an out clause that if you find it
 9 doesn't meet your needs or it's not what you
 10 expected, that you don't have to finalize the
 11 agreement.
 12 CHAYTOR, Q.C.:
 13 Q. So you didn't personally consult with Dr.
 14 Ejeckam and do you know then whether or not
 15 anyone consulted with Dr. Ejeckam to get his
 16 advice? He's, at this point in time, the
 17 person who's looking after IHC.
 18 MR. GULLIVER:
 19 A. Well, once the equipment is in, Dr. Ejeckam is
 20 the one who spends several months, you know,
 21 correlating and validating the Ventana
 22 instrument.
 23 CHAYTOR, Q.C.:
 24 Q. So whether he was consulted beforehand, you
 25 don't know?

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1 MR. GULLIVER:
 2 A. I can't tell you directly, no.
 3 CHAYTOR, Q.C.:
 4 Q. And what about Dr. Cook, would that be
 5 something that you would speak to Dr. Cook and
 6 consult Dr. Cook regarding?
 7 MR. GULLIVER:
 8 A. I think for Dr. Cook, it would be more like an
 9 FYI, like for your information, as we would do
 10 for upgrading chemistry analyzers or
 11 hematology analyzers or other things like
 12 that.
 13 CHAYTOR, Q.C.:
 14 Q. Where did the funding come from to acquire the
 15 Ventana system?
 16 MR. GULLIVER:
 17 A. As I said, I mean, by that point in time, the
 18 growth we had seen in our IHC lab, the amount
 19 of dollars that we were spending currently in
 20 our pathology budget on reagents, antibodies,
 21 detection kits, slides, you know, all the
 22 things that go into it, you know, we did not
 23 know until the quotes came back. Would I have
 24 to go look for new dollars to add to the
 25 pathology budget to acquire this technology

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1 and do a reagent lease or do we have enough
 2 money already in our operating budget that
 3 we're spending with various companies that we
 4 could pool our resources and sort of give, you
 5 know, most of our money to Ventana to be an
 6 all-inclusive reagent lease? And pretty well,
 7 the vast majority of the dollars were in our
 8 budget.
 9 CHAYTOR, Q.C.:
 10 Q. If we could look, please, at P-1891.
 11 THE COMMISSIONER:
 12 Q. Ms. Chaytor, I just want to--on the matter of
 13 the acquisition of the Ventana, do I take it
 14 from what you said that the Ventana was
 15 acquired not because you were on some kind of
 16 a normal replacement program for your
 17 machinery, and not because you had any
 18 problems with the DAKO machine, but because
 19 you felt it potentially could be more
 20 efficient for your then workload?
 21 MR. GULLIVER:
 22 A. Actually, you just made a good point first.
 23 At this point in time, I think our DAKO
 24 contract was expiring.
 25 THE COMMISSIONER:

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1 Q. Okay.

2 MR. GULLIVER:

3 A. And it coincided with, you know, this is new

4 testing and new parts of pathology. It

5 happened to coincide with other vendors coming

6 out with newer technology.

7 THE COMMISSIONER:

8 Q. So you were going to have to have a new lease,

9 in any event.

10 MR. GULLIVER:

11 A. I think, in any event, yes, around late 2003.

12 THE COMMISSIONER:

13 Q. And what happened--does DAKO then come along

14 and take out the old machine and it goes back

15 to some machine space in the sky wherever old

16 DAKO machines go, or whatever?

17 MR. GULLIVER:

18 A. Actually, it all depends, Justice Cameron. We

19 have some reagent leasing contracts in

20 laboratories where at the end of the lease,

21 the vendor still owns the equipment and they

22 will come and take it and decommission it.

23 THE COMMISSIONER:

24 Q. Uh-hm.

25 MR. GULLIVER:

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1 A. We have other leases where at the end, the

2 equipment belongs to us, because pretty well

3 it's either they know its outlived its useful

4 life or it's now older technology.

5 THE COMMISSIONER:

6 Q. Uh-hm.

7 MR. GULLIVER:

8 A. The DAKO one, when it was finished, when we

9 bought the DAKO contract originally, it was

10 not really an operational lease, it was we

11 were purchasing the equipment and committing

12 to buy reagents from DAKO, and they were

13 letting us pay off the value of the equipment

14 over a five year period.

15 THE COMMISSIONER:

16 Q. So you were actually purchasing the DAKO?

17 MR. GULLIVER:

18 A. Originally, we did. We were paying, I think,

19 like \$12,000.00 a month toward the purchase

20 cost of the equipment, so we owned the

21 equipment when it was done.

22 THE COMMISSIONER:

23 Q. So your lease wasn't expiring, you were

24 actually getting a piece of equipment?

25 MR. GULLIVER:

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1 A. At the beginning, we did, but then by '03, we

2 had a five year commitment to purchase

3 reagents from DAKO at a certain value a month.

4 THE COMMISSIONER:

5 Q. Your commitment to purchase the reagents was

6 expiring?

7 MR. GULLIVER:

8 A. It was expiring, yes.

9 THE COMMISSIONER:

10 Q. It wasn't--yeah, okay.

11 MR. GULLIVER:

12 A. Yeah.

13 CHAYTOR, Q.C.:

14 Q. But you actually owned the machine at that

15 point?

16 MR. GULLIVER:

17 A. By that time we owned the machine, yes.

18 CHAYTOR, Q.C.:

19 Q. You had spent enough to own it?

20 MR. GULLIVER:

21 A. Right.

22 CHAYTOR, Q.C.:

23 Q. And that was--I took you to that lease, I

24 believe, last day. That's the lease that was

25 \$65,000.00, I believe, was the cost of the

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1 machine?

2 MR. GULLIVER:

3 A. Yeah, yeah.

4 THE COMMISSIONER:

5 Q. So at that point, you had to either get a new

6 contract for reagents -

7 MR. GULLIVER:

8 A. For DAKO.

9 THE COMMISSIONER:

10 Q. Or purchase -

11 MR. GULLIVER:

12 A. Or do an all inclusive.

13 THE COMMISSIONER:

14 Q. Or purchase on a wider basis and get a new -

15 MR. GULLIVER:

16 A. Right.

17 THE COMMISSIONER:

18 A. All right.

19 CHAYTOR, Q.C.:

20 Q. And you did a cost benefit analysis or some

21 sort of feasibility study and made the

22 determination that it was more cost effective

23 to go out and purchase a new machine?

24 MR. GULLIVER:

25 A. Well, by this time, we had--well, we wanted to

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1 get the tenders first to see what we would be
 2 offered, and, you know, to see if we could
 3 afford to acquire new technology and update
 4 our current technology, in conjunction with
 5 maintain our reagent base.
 6 CHAYTOR, Q.C.:
 7 Q. So did you do that, did you figure out that it
 8 was just as cost effective to have a new piece
 9 of machinery and enter into a new reagent
 10 lease as it was to continue on with your piece
 11 of equipment that you now owned and enter into
 12 a reagent -
 13 MR. GULLIVER:
 14 A. I don't know if Barry did an exact feasibility
 15 study. However, I do realize that overall the
 16 Ventana System would probably cost us a bit
 17 more than operating the DAKO autostainer in
 18 conjunction with the DAKO reagents, but we
 19 were able to--as you can see, all the benefits
 20 of the Ventana System compared to the manual
 21 method, are part of the thing you also would
 22 look at was that the Ventana instrumentation
 23 would reduce technical time on the bench,
 24 doing tasks that the instrument could do, and
 25 that also would be sort of a savings, a

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1 technologist savings in the lab. So,
 2 therefore, staff can be able to spend more
 3 time, as Dr. Ejeckam had mentioned, more time
 4 reading journals and learning IHC as opposed
 5 to performing the test on the DAKO. So it was
 6 much more efficient also.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, P-1891, and this is your annual report
 9 then for the laboratory program, and it's fro
 10 the fiscal year ending March 31st, '04, and
 11 under number three, we look at, "Negotiated a
 12 five year reagent lease for immuno pathology
 13 services. This provided new equipment that
 14 improves quality and turnaround times". I
 15 take it, Mr. Gulliver, that's reference to the
 16 acquisition of the Ventana machine?
 17 MR. GULLIVER:
 18 A. Ventana.
 19 CHAYTOR, Q.C.:
 20 Q. Okay. And in terms of the new equipment
 21 improving the quality, what specifically do
 22 you believe was improved by the purchase of
 23 the Ventana machine?
 24 MR. GULLIVER:
 25 A. Well, again quality, I'm talking about overall

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1 quality of the service. Quality could include
 2 the fact that you have on board antigen
 3 retrieval; therefore, you reduced or minimize
 4 the opportunity for tissues to boil off the
 5 slides. Quality would mean that the Ventana
 6 System operates under pre-diluted and sort of
 7 pre-optimized antibodies when they come in.
 8 Therefore, you minimize the risk of manually
 9 having to make your own antibody dilutions and
 10 titrations on the bench. Quality also means
 11 that the Ventana System bar coded all the
 12 reagents, so when you put your reagents on the
 13 instrument, the instrument read the bar codes
 14 to ensure that the slide matched the reagent
 15 and those things, so it's just--it's all
 16 inclusive, and -
 17 CHAYTOR, Q.C.:
 18 Q. If we could have--sorry.
 19 MR. GULLIVER:
 20 A. And I would say then during the process where
 21 the instrument was being assessed before it
 22 was put in full operation, I know that--I
 23 mean, I spoke to many pathologists and
 24 technologists and their view was the overall
 25 quality of the slide itself was better.

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1 CHAYTOR, Q.C.:
 2 Q. If we could have 1903, please. This is your
 3 leadership meeting and it's for the month of
 4 January, 2004, yourself and Drs. Cook and
 5 Williams, and it indicates here, "A tender has
 6 been awarded for a six year reagent lease for
 7 immuno pathology, which includes new
 8 equipment. Also pathology awarded the tender
 9 for purchase of an automated stainer.
 10 Currently working through awarding tender for
 11 automated slide and cassette labellers".
 12 What's being referred to there, Mr. Gulliver?
 13 MR. GULLIVER:
 14 A. Well, again this is the--this would be the
 15 Ventana contract, and when we're going forward
 16 with the IHC part of the lab, Ventana also has
 17 an automated stainer that you can use for the
 18 histochemical staining, not just
 19 immunohistochemical staining, and they would
 20 be some of the routine stains in the main part
 21 of pathology, so we actually committed, I
 22 think, to a six year agreement and then
 23 included and piggybacked the bigger agreement
 24 for IHC to be able to put some automation into
 25 the routine part of pathology.

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1 CHAYTOR, Q.C.:

2 Q. So this is two pieces of equipment?

3 MR. GULLIVER:

4 A. I think there was three. There were two for

5 the IHC part of our lab, and then there was

6 another stainer that came in to do routine

7 histochemical staining.

8 CHAYTOR, Q.C.:

9 Q. Okay, and all through Ventana?

10 MR. GULLIVER:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. Through the same -

14 MR. GULLIVER:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. Through the same negotiations?

18 MR. GULLIVER:

19 A. Through the same contract.

20 CHAYTOR, Q.C.:

21 Q. If we could have, please, 1913, and this is a

22 meeting of site chiefs and divisional manager,

23 and Dr. Cook, Parai, and Robb are in

24 attendance. It's March 31st, 2004. 4.2,

25 there we go, under new technology, "The

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1 immunoperoxidase stainer appears to be working

2 generally well, however, there continues to be

3 some problems with estrogen and progesterone

4 receptors". Mr. Gulliver, do you know what at

5 the end of March, 2004, what problems were

6 continuing with ER/PR?

7 MR. GULLIVER:

8 A. I have no idea.

9 CHAYTOR, Q.C.:

10 Q. That wasn't discussed with you at the time?

11 MR. GULLIVER:

12 A. No.

13 CHAYTOR, Q.C.:

14 Q. And if we could have, please, P-2325, and this

15 is June 15th, 2004, and it's a meeting of

16 laboratory division managers and yourself, Mr.

17 Dyer, Ms. Wade, are in attendance, amongst

18 others, and the program--it's indicated here

19 the program has ended, it's '03/'04, with a

20 \$609,000.00 deficit. "Terry has no indication

21 of the '04/05 budget at this point". So in

22 terms of finishing off your year that year,

23 your budget is \$609,000.00 deficit, and so I

24 take it based on your remarks earlier, that

25 would not be unusual for your program?

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1 MR. GULLIVER:

2 A. I think that might have been our worst year, I

3 don't remember, but again in '03/04 or '02/03,

4 our budget was cut multiple times before this,

5 and actually when we were going through budget

6 preparations for the next fiscal year, I used

7 to argue to our financial people that the big

8 issue with the laboratory being in deficit all

9 the time is that you don't give us enough

10 money to start the year off with. Like, you

11 under fund us to begin the year, and you

12 expect us to balance the budget at the end of

13 the year, but you know full well, and I know

14 full well that it ain't going to happen,

15 because lab services as such that we cannot

16 control demands, we cannot control volumes.

17 At the same time, in my first couple of years,

18 the biggest piece of our budget that were

19 going in deficit was in our blood collection

20 staffing, that we didn't have enough blood

21 collectors to do in-patient out-patient

22 collection for all the facilities. We were

23 constantly paying overtime, constantly putting

24 on extra staff, to try to reduce patient wait

25 times, and I'm thinking this year, I think

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1 about \$400,000.00 of that deficit was simply

2 in blood collection services.

3 CHAYTOR, Q.C.:

4 Q. Okay, so if we could have then, please, P-

5 3113. I just want to follow along with a

6 couple of more exhibits and finish off the

7 2004 year. I take it, once the Ventana came

8 in in 2004, you didn't hear any complaints

9 about the product or the quality of the slides

10 after that?

11 MR. GULLIVER:

12 A. I didn't hear, not one.

13 CHAYTOR, Q.C.:

14 Q. And this is an exhibit I took you through

15 yesterday, just the memo part of it. It was

16 the accreditation of 2004, and you gave your

17 views on that in terms of it being somewhat of

18 a superficial -

19 MR. GULLIVER:

20 A. I mean, what they're asking is, like, where do

21 you have services, what services do you have

22 on what sites, those kinds of questions.

23 CHAYTOR, Q.C.:

24 Q. Okay.

25 MR. GULLIVER:

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1 A. And this is the list of questions I submitted,
 2 I gave Dr. Williams a copy of.
 3 CHAYTOR, Q.C.:
 4 Q. Okay, yes, so this is what would have been -
 5 MR. GULLIVER:
 6 A. Given to the surveyors.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, so the survey guidelines, this would be
 9 given to you, I take it, and then the list of
 10 questions, these would be your answers, is
 11 that right, or is that -
 12 MR. GULLIVER:
 13 A. And I actually think either myself of Lynn
 14 Wade probably worked on these.
 15 CHAYTOR, Q.C.:
 16 Q. Okay.
 17 MR. GULLIVER:
 18 A. Even though Lynn wasn't quality manager at the
 19 time, she was client services manager, but I'm
 20 thinking myself and Lynn did most of this.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. So, for example, at page seven, where
 23 we have under areas to improve, "Many
 24 specimens collected by other health care
 25 providers in the hospital are delivered by a

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

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1 MR. GULLIVER:
 2 A. Well, for tissue specimens, they were brought
 3 down from the OR and from the day surgery, and
 4 when they came to the lab, the lab had a
 5 logbook to document every surgical specimen
 6 that came into the lab.
 7 CHAYTOR, Q.C.:
 8 Q. This says, "Presently there is no provision
 9 for documentation on receipt in the lab at the
 10 delivery time, only at processing time".
 11 MR. GULLIVER:
 12 A. That's blood specimen.
 13 CHAYTOR, Q.C.:
 14 Q. So blood specimen. You're saying that was, in
 15 fact, in place. There was a procedure in
 16 place for pathology?
 17 MR. GULLIVER:
 18 A. In pathology--when pathology specimens came
 19 down, there was a logbook where the porter who
 20 brought them down had to sign, the
 21 technologist who received the specimen signed,
 22 and it's a book kept in the gross room.
 23 CHAYTOR, Q.C.:
 24 Q. So was it timed then, Mr. Gulliver?
 25 MR. GULLIVER:

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

1 CHAYTOR, Q.C.:

2 Q. And if we could have, please, P-1583? And the

3 area of improvement that Ms. Wade noted

4 regarding the blood collection, do you know

5 was that remedied at the time that it was

6 brought up in 2004?

7 MR. GULLIVER:

8 A. As far as I know it was. What, and what we

9 put in place for most of the bloods collected

10 in the system, are collected by laboratory

11 staff, so we have a process in Meditech where

12 you actually have to go in there and receive

13 the sample and bar code--wand it in, and who

14 the collector was. The main issue that Ms.

15 Wade was talking about there were the hundreds

16 of bloods a day collected by nurses and

17 doctors that didn't follow the same protocol

18 that laboratory staff would follow. What the

19 staff did, I think, on the power processor

20 which is the automated equipment that would do

21 it, they enabled some of the function there to

22 record the time when it first came to the pre-

23 analytical part of the lab and then the

24 instrument that performs the test recorded the

25 time that the blood got to the instrument.

1 Q. Okay, and were you in favour of that approach?

2 MR. GULLIVER:

3 A. Of hiring pathology assistants?

4 CHAYTOR, Q.C.:

5 Q. Of having Dr. Robb approach Dr. Williams

6 directly?

7 MR. GULLIVER:

8 A. Oh sure, I mean, at the time I think Dr. Robb

9 had become the chairman of the University

10 Chair, as opposed to our clinical chief and,

11 you know, I felt that Dr. Robb was also a

12 practising pathologist, he's someone who, from

13 everyone in the program respected and felt

14 that if Dr. Robb can weigh in on the issue and

15 put his support behind it, it can only help

16 us.

17 CHAYTOR, Q.C.:

18 Q. And the idea of taking the \$100,000.00 and

19 somehow allocating a certain amount of that

20 towards the expenditure, is that something

21 that you could do or was that something that

22 had to go through Dr. Williams?

23 MR. GULLIVER:

24 A. It's a can of worms you opened up there

25 because laboratory medicine is one of the

1 CHAYTOR, Q.C.:

2 Q. P-1583 is a meeting, minutes of a meeting,

3 Division of Anatomical Pathology Pathologists'

4 meeting at the General Health Site on November

5 2nd, 2004, and there's a number of doctors in

6 attendance, as well as Mr. Dyer and on page 3

7 under "New Business: Pathologist assistants.

8 Much discussion on this issue. It is agreed

9 by the pathologists that the issue should be

10 brought to the attention of the vice-president

11 of Medical Services. Dr. D. Robb, chairman of

12 the discipline, will write to Dr. Williams

13 recommending pathologist assistants as per the

14 Royal College recommendation. It is also

15 pointed out that the anatomical pathology

16 division is earning over \$100,000.00 per year

17 by billing for the technical work. It is

18 expected that some of the money should be

19 given to the pathology budget to hire

20 pathologist assistants." Mr. Gulliver, was

21 this discussed with you at the time and that

22 Dr. Robb would write directly to Dr. Williams?

23 MR. GULLIVER:

24 A. Yes.

25 CHAYTOR, Q.C.:

1 programs, if you look at laboratory service is

2 the United States, everything is fee for

3 service, so laboratories are revenue

4 generating in their health care system. In

5 our system, you know, lab services are free to

6 the patient; however, our laboratory provided

7 specialty services to many other labs in

8 hospitals in the province and for certain

9 things, we had approval to bill for the

10 technical component. In chemistry we billed

11 for--we used to bill for B12's and folates and

12 different kinds of tests. And our lab program

13 would generate over a million dollars a year

14 in revenue. I think right now we're at 1.5

15 million in revenue. That money goes into

16 general revenue for the Health Care

17 Corporation. It goes right now to general

18 revenue for Eastern Health. The lab has no

19 say in how that money is distributed

20 throughout the organization. We have on many,

21 many occasions over the years proposed to VPs,

22 not just Dr. Williams, but prior to Dr.

23 Williams and prior to him, that if the lab is

24 generating this much revenue, we should be

25 able to access a part of that revenue, either

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1 for staff education, for out-of-province
 2 travel or for other services in the program
 3 and we've never ever gotten a yes on it.
 4 CHAYTOR, Q.C.:
 5 Q. Even though you've looked for it, that's never
 6 came to fruition.
 7 MR. GULLIVER:
 8 A. And I think from an organizational
 9 perspective, I think it will be, well if they
 10 do it for the lab, they have to do it for all
 11 parts of the organization that generate
 12 revenue. I think the organization relied upon
 13 this revenue to help with the shortfall of
 14 funding overall for the health care
 15 organization.
 16 CHAYTOR, Q.C.:
 17 Q. And they allocated it back, I take it, in
 18 terms of whatever the priorities was seen fit
 19 by the management?
 20 MR. GULLIVER:
 21 A. Right.
 22 CHAYTOR, Q.C.:
 23 Q. Under "New Business" then on page 4, 4.5 "New
 24 Tissue Processor: Pathologists are asked to
 25 get familiar with the new work station and cut

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1 the specimen at certain thickness to be
 2 processed in the new tissue processor." Mr.
 3 Gulliver, is that the Sakura Express?
 4 MR. GULLIVER:
 5 A. It would be, yes.
 6 CHAYTOR, Q.C.:
 7 Q. And where did the money come from to acquire
 8 the Sakura Express?
 9 MR. GULLIVER:
 10 A. That came direct funding from our capital
 11 equipment funding from the organization to the
 12 lab program.
 13 CHAYTOR, Q.C.:
 14 Q. So that was acquired some time in 2004?
 15 MR. GULLIVER:
 16 A. I think it was 2004, Ms. Chaytor.
 17 CHAYTOR, Q.C.:
 18 Q. And do you recall how much that piece of
 19 equipment cost?
 20 MR. GULLIVER:
 21 A. I think it was between two hundred and fifty
 22 thousand dollars.
 23 CHAYTOR, Q.C.:
 24 Q. And has that tissue processor ever been used?
 25 MR. GULLIVER:

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1 A. Has it ever been used? Yes.
 2 CHAYTOR, Q.C.:
 3 Q. Is it currently in use?
 4 MR. GULLIVER:
 5 A. No.
 6 CHAYTOR, Q.C.:
 7 Q. And for how long was it used?
 8 MR. GULLIVER:
 9 A. It was, when it first came in, you know, Barry
 10 and pathologists at the Health Sciences and
 11 staff, they were processing a lot of small
 12 biopsy specimens through the new tissue
 13 processor cycle, doing their routine H&E
 14 stains, did some IHC stains and it went on for
 15 a period of maybe six months, you know, trying
 16 it out and testing it and seeing, comparing
 17 what a slide looks like going through the old
 18 tissue processor or the old way of doing
 19 things, verses the new tissue processor which
 20 is a microwave processing cycle.
 21 CHAYTOR, Q.C.:
 22 Q. And whose decision was it to acquire the
 23 Sakura Express?
 24 MR. GULLIVER:
 25 A. It was a part of my decision, a part of

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1 Barry's, Dr. Sushil Parai was in favour of it.
 2 Again, when the instrument came in, we had
 3 sort of an outlet clause that if we felt that
 4 it didn't meet our needs, that we didn't have
 5 to complete the purchase. But at the Health
 6 Sciences it was generally supportive that this
 7 will be good to get this new way of processing
 8 our tissue.
 9 CHAYTOR, Q.C.:
 10 Q. And we've heard Ms. Wegrynowski express some
 11 concerns about the use of this type of a
 12 processor, given that it uses, I understand
 13 it's alcohol base, as opposed to your normal
 14 fixatives would have been done, your normal
 15 fixative would have been formalin and so, for
 16 example, your control bases, your control
 17 tissue has to be treated in the same manner as
 18 your patient tissue.
 19 MR. GULLIVER:
 20 A. Oh yes.
 21 CHAYTOR, Q.C.:
 22 Q. Were you aware of that at the time you
 23 acquired the Sakura Express?
 24 MR. GULLIVER:
 25 A. Well at the time Sakura, myself and Mr. Dyer,

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

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

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1 proposing to treat the patient tissue?
 2 MR. GULLIVER:

3 A. And that would apply, I would assume, to the
 4 controls being used in the IHC part of the
 5 lab, that if you are going to do IHC testing
 6 on tissue that is microwave processed, that
 7 your control tissue would have to be replaced
 8 and go through the same processes that your
 9 patient tissue would.
 10 CHAYTOR, Q.C.:

11 Q. And so you were aware that that would have to
 12 be done at the time the machine was acquired?
 13 MR. GULLIVER:

14 A. Well again, I'm not the pathology manager, Ms.
 15 Chaytor, I'm the director. This is something
 16 that I would not be involved in.
 17 CHAYTOR, Q.C.:

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

24 A. I can't answer for him.
 25 CHAYTOR, Q.C.:

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1 Q. So it wasn't discussed between you and Mr.
 2 Dyer that it may involve additional work for
 3 your technologists then if you have to create
 4 new controls?
 5 MR. GULLIVER:

6 A. I'm assuming it was discussed with Mr. Dyer
 7 and the pathologists who were doing the
 8 validation on this new microwave processing.
 9 CHAYTOR, Q.C.:

10 Q. Do you know that?
 11 MR. GULLIVER:

12 A. I said I assumed it was discussed amongst
 13 them.
 14 CHAYTOR, Q.C.:

15 Q. Okay, so it wasn't discussed with you and do
 16 you know whether or not it was discussed with
 17 anyone?
 18 MR. GULLIVER:

19 A. I don't know.
 20 CHAYTOR, Q.C.:

21 Q. So, Mr. Gulliver, this cost about a quarter of
 22 a million dollars and it was used for a six-
 23 month period?
 24 MR. GULLIVER:

25 A. I think they were about six months into

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

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1 and it took an hour and fifteen minutes to
 2 process a tissue sample as opposed to 14
 3 hours. So you could do same time turn-around
 4 time for urgent cases for pathology and that's
 5 what it was being used for in the University
 6 of Miami.
 7 CHAYTOR, Q.C.:
 8 Q. Yes.
 9 MR. GULLIVER:
 10 A. They had three of these in Miami. They had
 11 one of these processors actually in their
 12 cancer centre and a patient who came in for
 13 biopsy, the patient would not go home until
 14 that same day, the lab processed the tissue,
 15 cut and stained it and a pathologist read it
 16 and gave the result back to the oncologist, so
 17 they could decide what to do with that patient
 18 before the patient left.
 19 CHAYTOR, Q.C.:
 20 Q. And so what was the problem with implementing
 21 this process in your lab?
 22 MR. GULLIVER:
 23 A. Well again, it meant changing our practises.
 24 One of the critical pieces for microwave
 25 tissue processing is the thickness of the

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1 tissue that the pathologist would cut at the
 2 gross bench, and as you've heard through this
 3 inquiry, there has been many instances where
 4 the thickness of the tissue being dissected
 5 was too thick for the normal tissue
 6 processing; therefore, specimens weren't
 7 properly fixed. This required tissues to be
 8 even cut thinner because you're going to do an
 9 hour and fifteen minute processing cycle. So
 10 there was a whole new grossing board we bought
 11 with the instrument for pathologists and they
 12 had special dissecting instruments to ensure
 13 that they cut a nice even thin piece of tissue
 14 to be submitted into the tissue block. And
 15 that was very difficult to get the
 16 pathologists actually to change--that's not
 17 true, some pathologists embraced it, other
 18 pathologists did not embrace it.
 19 CHAYTOR, Q.C.:
 20 Q. What about discussion with Dr. Cook then,
 21 clinical chief before the machine was
 22 acquired, if it's going to have ramifications
 23 as to how the pathologists are doing their
 24 work.
 25 MR. GULLIVER:

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1 A. Well Dr. Cook is well aware that we were in
 2 the process of acquiring this piece of
 3 equipment, he was well aware, it was there on
 4 our capital equipment request list seeking
 5 funding and obviously when the instrument did
 6 come in, Dr. Cook would be part of the group
 7 of pathologists who would have to give their
 8 view point in their assessment. Dr. Cook
 9 never expressed any concerns before the
 10 instrument was bought and brought in.
 11 CHAYTOR, Q.C.:
 12 Q. And how about afterwards?
 13 MR. GULLIVER:
 14 A. I think Dr. Cook's concern was having to
 15 change their schedule and change their work
 16 practices.
 17 CHAYTOR, Q.C.:
 18 Q. And the six month period in which the machine
 19 or the process was used -
 20 MR. GULLIVER:
 21 A. But it wasn't used, it was being--in that
 22 timeframe you were taking side-by-side samples
 23 of specimens and being processed traditionally
 24 and processed -
 25 CHAYTOR, Q.C.:

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1 Q. So it was like a validation process?
 2 MR. GULLIVER:
 3 A. It's like a validation process.
 4 CHAYTOR, Q.C.:
 5 Q. So the machine has never been used to actually
 6 test patients.
 7 MR. GULLIVER:
 8 A. I don't think it was ever ever used on a
 9 current patient that gave a current diagnosis,
 10 no.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And so why didn't the machine go back
 13 or be resold or -
 14 MR. GULLIVER:
 15 A. Well I don't think there was ever a decision
 16 decided that we would never have the machine
 17 or ever use it. Unfortunately by the time the
 18 validation process is ongoing and Sakura, they
 19 brought in one of their expert pathologists
 20 that spend a couple of days with our
 21 pathologists to talk about the importance of
 22 the thickness of tissues being grossed and
 23 sectioned and pretty well saying, look, you
 24 know, once you get used to this here, I think
 25 that you would really embrace it and you'll

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1 really like it. By the time we get to that
 2 point, Ms. Chaytor, we're almost starting down
 3 the path of ER/PR retesting.
 4 CHAYTOR, Q.C.:
 5 Q. So what happened instead, if you needed a new
 6 tissue processor have you since had to acquire
 7 or--because this one then wasn't put into use,
 8 did you acquire a new tissue processor
 9 instead?
 10 MR. GULLIVER:
 11 A. We just got two new ones back in December of
 12 '07 which are the traditional way of tissue
 13 processing.
 14 CHAYTOR, Q.C.:
 15 Q. And why was that decision made to stick with
 16 the traditional way?
 17 MR. GULLIVER:
 18 A. Well because the two we currently have were
 19 getting fairly old and they were in need of
 20 replacement and we were having some mechanical
 21 issues with them and I asked directly to Dr.
 22 Howell and Louise Jones for funding to
 23 purchase two processors and they granted it
 24 and we got them.
 25 CHAYTOR, Q.C.:

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1 Q. And it was two processors that were replaced
 2 in the past year?
 3 MR. GULLIVER:
 4 A. Well we have two anyway because for volume,
 5 you need to have at least two.
 6 CHAYTOR, Q.C.:
 7 Q. But they were both replaced is my question?
 8 MR. GULLIVER:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. And so you were having some mechanical
 12 problems, was that with both processors or?
 13 MR. GULLIVER:
 14 A. I would say yes, and again, the ones before
 15 that replaced them, we had them for 10, 12
 16 years, you know, they're mechanical
 17 instruments, they're going to break down, just
 18 like your car is going to break down, whether
 19 it's a Cadillac or whether it's a -
 20 CHAYTOR, Q.C.:
 21 Q. So it was a regular replacement schedule for -
 22 MR. GULLIVER:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. Pretty much?

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1 MR. GULLIVER:
 2 A. Yeah.
 3 CHAYTOR, Q.C.:
 4 Q. What's the general live of a tissue processor?
 5 A car I would know about, a tissue processor I
 6 wouldn't.
 7 MR. GULLIVER:
 8 A. Oh, tissue processors, they're usually about
 9 anywhere from 10 to 15 or could be longer. If
 10 you look at Carbonear, we have a tissue
 11 processor in Carbonear, the same technology,
 12 however, they process maybe 40 or 50 blocks a
 13 day, so the usage they have will extend the
 14 life of the instrument. The Health Sciences
 15 processes at full capacity every single day,
 16 therefore you will reduce the life expectancy
 17 of your equipment.
 18 CHAYTOR, Q.C.:
 19 Q. So the two that were replaced, how old were
 20 they?
 21 MR. GULLIVER:
 22 A. I would say about ten years, probably.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And you said it's the traditional way
 25 that you've been doing tissue processing all

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1 along as opposed to what the Secure Express
 2 would have been introducing?
 3 MR. GULLIVER:
 4 A. Well, traditional, sorry, in 1987 is when the
 5 automated tissue processing came in place.
 6 Before that we processed on the bench.
 7 CHAYTOR, Q.C.:
 8 Q. Yes. But in terms of the new machines that
 9 came in, were they any different than what the
 10 technologists were using before, was there any
 11 difference or are these just replacement with
 12 new same machines?
 13 MR. GULLIVER:
 14 A. Replacement with just a few new software
 15 additions.
 16 CHAYTOR, Q.C.:
 17 Q. And did the technologists require any training
 18 on the new machines?
 19 MR. GULLIVER:
 20 A. No. The company comes in, they set them up,
 21 they check them out, verify them and you do
 22 like a dummy run, make sure they're working
 23 fine overnight and then they're ready to go.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. And in terms of any maintenance or

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1 anything on the machines, would that be shown
 2 by the people selling the machine or how would
 3 the technologists know that?
 4 MR. GULLIVER:
 5 A. Well, on the two new ones?
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 MR. GULLIVER:
 9 A. Well, the same maintenance records and logs
 10 required on the old ones would be the same on
 11 the new ones.
 12 CHAYTOR, Q.C.:
 13 Q. So no change?
 14 MR. GULLIVER:
 15 A. There's no change there, no.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. Mr. Gulliver, then I guess we're into
 18 2005. And tell us then when and how you first
 19 heard of what has become known as the ER/PR
 20 issue?
 21 MR. GULLIVER:
 22 A. Thank you. I guess I first heard about it and
 23 you've heard, you know, testimony here prior
 24 to me back in the summer, I was first made
 25 aware of the index case, at the time I didn't

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1 know it was the index case, by Mr. Dyer, the
 2 pathology manager.
 3 CHAYTOR, Q.C.:
 4 Q. So Mr. Dyer brought it to your attention. And
 5 what did he tell you and how had he heard
 6 about it?
 7 MR. GULLIVER:
 8 A. Well, he had just come from a meeting, he told
 9 me he just came from a meeting with Don, Don
 10 Cook and Bev Carter, and he said a couple of
 11 oncologists and they talked about, you know, a
 12 patient that was retested and came back
 13 negative and for--you know, for the ER/PR.
 14 And that's the first time I ever heard about,
 15 you know, a change in result for ER/PR. It
 16 turned out to be Ms. Peggy Deane, as we all
 17 refer to her as the index case when this
 18 started.
 19 CHAYTOR, Q.C.:
 20 Q. And we've heard from Mr. Dyer that he attended
 21 such a meeting with Doctors Cook and Carter,
 22 McCarthy and Laing on May 17th, 2005. So
 23 would that be the meeting that you're
 24 referring to?
 25 MR. GULLIVER:

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1 A. That's the one, yes.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, and that was you hadn't heard of the
 4 issue prior to that?
 5 MR. GULLIVER:
 6 A. No.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. And would that be unusual for Mr. Dyer
 9 to be called to that meeting as opposed to,
 10 for example, yourself?
 11 MR. GULLIVER:
 12 A. I don't think it's unusual because if there
 13 was an issue in pathology, you know, we've had
 14 Barry will go to meetings if there's an issue
 15 in the perioperative program with maybe
 16 specimens or something like, that. I thought
 17 it was strange that, you know, that Dr. Cook
 18 was there as our clinical chief and that I
 19 wasn't asked as the program director to be at
 20 the meeting.
 21 CHAYTOR, Q.C.:
 22 Q. Well, perhaps that's, yeah.
 23 MR. GULLIVER:
 24 A. I did, yes.
 25 CHAYTOR, Q.C.:

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1 Q. Whether, you know, to have him there -
 2 MR. GULLIVER:
 3 A. I didn't know the meeting was taking place.
 4 CHAYTOR, Q.C.:
 5 Q. - instead of you, probably you would not be
 6 there, you know?
 7 MR. GULLIVER:
 8 A. Right.
 9 CHAYTOR, Q.C.:
 10 Q. So you would have expected that you would be
 11 there along with Mr. Dyer?
 12 MR. GULLIVER:
 13 A. I would have thought so, yes.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And did you raise that with anyone, did
 16 you ask Dr. Cook or anyone afterwards, well,
 17 why aren't--why wasn't I included and what's
 18 happening?
 19 MR. GULLIVER:
 20 A. I don't remember asking Dr. Cook why. I mean,
 21 if he called a meeting, maybe it was the
 22 oncologists who called the meeting, I'm not
 23 really sure. I don't know if they called the
 24 meeting on that same day and just got people
 25 together. I don't know if it was set up two

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1 weeks ahead of time. I just know I found out,
 2 Mr. Dyer came to my office, he was--and
 3 actually, he was quite upset that he told me
 4 about this particular issue. And I think he
 5 was upset of things that were said at the
 6 meeting.
 7 CHAYTOR, Q.C.:
 8 Q. And what did he tell you was said at the
 9 meeting?
 10 MR. GULLIVER:
 11 A. And, you know, I sat here and heard Barry's
 12 testimony and I really can't tell you 100
 13 percent exactly what he said to me in my
 14 office. I know that he was really upset. I
 15 know that he pretty well said that, you know,
 16 "and the doctors are blaming me for this."
 17 CHAYTOR, Q.C.:
 18 Q. Okay.
 19 MR. GULLIVER:
 20 A. He didn't say anybody's name. I can't
 21 remember him saying Dr. so and so or Dr. so
 22 and so, but I clearly remember that he was
 23 visibly upset.
 24 CHAYTOR, Q.C.:
 25 Q. And he told this to you immediately after

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1 having been at the meeting?
 2 MR. GULLIVER:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. And so at that point -
 6 MR. GULLIVER:
 7 A. I think he came straight from the meeting to
 8 my office to see if I was there.
 9 CHAYTOR, Q.C.:
 10 Q. And so what did you then do after Mr. Dyer has
 11 told you about the index case? First of all,
 12 were you told, were there any other cases, was
 13 it just the one at that point in time?
 14 MR. GULLIVER:
 15 A. As far as I remember, Ms. Chaytor, it was just
 16 the one.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And Mr. Dyer is upset. So what did you
 19 do?
 20 MR. GULLIVER:
 21 A. At that time I don't remember exactly what I
 22 did.
 23 CHAYTOR, Q.C.:
 24 Q. And you didn't go to Dr. Cook -
 25 MR. GULLIVER:

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1 A. I did not go to Dr. Cook, no.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. And why not, why?
 4 MR. GULLIVER:
 5 A. I just think I spoke to Barry and I think I
 6 just calmed Barry down to say, "You know,
 7 look," and I think I was probably saying to
 8 him, "Well, you sure they're saying that it's,
 9 you know, it's the lab's fault or what the
 10 issue is?" And I have no information in front
 11 of me, I have nothing here, so I really can't
 12 comment on anything at that point in time.
 13 CHAYTOR, Q.C.:
 14 Q. So when did you next then hear anything about
 15 the issue?
 16 MR. GULLIVER:
 17 A. It was probably awhile. It might have been a
 18 couple of weeks went by before, I think, Dr.
 19 Cook had any really direct sort of contact
 20 with me to sort of talk about the issue. I
 21 think that what he and Dr. Carter--well, what
 22 he and Dr. Carter, I'm assuming, were doing, I
 23 think were trying to assess to see, you know,
 24 really what the issue is and what the
 25 implications of this issue could be.

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1 CHAYTOR, Q.C.:
 2 Q. So a couple of weeks went by before you heard
 3 anything else about it?
 4 MR. GULLIVER:
 5 A. Yeah, I think he might have wrote Dr. Williams
 6 and copied me on it or something like that.
 7 CHAYTOR, Q.C.:
 8 Q. And you -
 9 MR. GULLIVER:
 10 A. But we never had no face-to-face sit-down talk
 11 about it.
 12 CHAYTOR, Q.C.:
 13 Q. And in the meantime you didn't make any
 14 inquiries of anyone?
 15 MR. GULLIVER:
 16 A. Not that I remember, no. Again, it's a
 17 pathology issue, it will be handled by the
 18 site chiefs, it'll be handled by the manager
 19 and it's being handled by the clinical chief.
 20 CHAYTOR, Q.C.:
 21 Q. But did you know that that was happening?
 22 MR. GULLIVER:
 23 A. Well, Barry told me that Don and Bev Carter
 24 were at this meeting, that they were dealing
 25 with it and talking to the oncologists.

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1 CHAYTOR, Q.C.:

2 Q. So when you heard that Mrs. Deane's test had -

3 MR. GULLIVER:

4 A. I didn't know who the patient was.

5 CHAYTOR, Q.C.:

6 Q. No.

7 MR. GULLIVER:

8 A. I just knew there was -

9 CHAYTOR, Q.C.:

10 Q. Well, we now know.

11 MR. GULLIVER:

12 A. They sent a patient off for a retesting.

13 CHAYTOR, Q.C.:

14 Q. Okay. And we assume it was her test. But

15 anyhow, you were told that a patient's test

16 had been repeated and had changed. Did that

17 cause you any concern yourself knowing how

18 that these tests were done, for example,

19 Fridays, you thought a lot of them were done

20 in batches on the same day of the week, did it

21 cause you to pause and say, "Well, what about

22 every other test that was done in that batch

23 with Peggy Deane's test?"

24 MR. GULLIVER:

25 A. No, I didn't, no.

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1 CHAYTOR, Q.C.:

2 Q. You didn't think about that?

3 MR. GULLIVER:

4 A. No, because, I mean, again, every slide that's

5 performed by the technologist, it is read and

6 interpreted and signed out by a pathologist.

7 And if the pathologist didn't have any concern

8 about it, I wouldn't think about, you know,

9 having a concern about it.

10 CHAYTOR, Q.C.:

11 Q. And so whether or not it was a technical issue

12 that may have caused her test to be different,

13 you weren't concerned that, well, what about

14 the other 10 or 12 cases that may have been

15 run with her case, that didn't dawn on you at

16 the time?

17 MR. GULLIVER:

18 A. Well, I didn't know who was run with her case,

19 when her case was done. I didn't know at that

20 point what where it was retested.

21 CHAYTOR, Q.C.:

22 Q. And could you even do that, if you wanted to

23 find out what other patients had their tests

24 run in the same batch as Peggy Deane's, could

25 you reconstruct that?

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1 MR. GULLIVER:

2 A. I think it would take a bit of time, I think

3 you could, because, I mean, you would have to

4 go back and look at the date her test was

5 performed and signed out and then you had to

6 do, like if you do a computer search and look

7 for that week, what ER/PRs were done during

8 that week, and to see if the procedures that

9 were performed and ordered are on the same

10 day. So you know, logically then you'd be

11 able to say, well, I can't swear 100 percent,

12 but, you know, if four patients are, got the

13 ER/PR on June 19th, then if it's--I would

14 pretty well assume those four were done in the

15 same day, on the same batch.

16 CHAYTOR, Q.C.:

17 Q. So what would you check, would you check the

18 requisitions?

19 MR. GULLIVER:

20 A. We wouldn't have requisitions that were three

21 or four years lying around.

22 CHAYTOR, Q.C.:

23 Q. What would you check, what would be in your

24 computer system?

25 MR. GULLIVER:

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1 A. We'd go into the Meditech system and look at

2 the patients' reports and look at, and search

3 for those patients done that week.

4 CHAYTOR, Q.C.:

5 Q. So those reports would be when the

6 pathologists signed off, though?

7 MR. GULLIVER:

8 A. Right.

9 CHAYTOR, Q.C.:

10 Q. Right. So anything that had been signed off

11 around the same time period might be -

12 MR. GULLIVER:

13 A. I think within a day of each other you can

14 probably assume it was probably in the same

15 batch that week.

16 CHAYTOR, Q.C.:

17 Q. And if the pathologist hadn't read the report

18 or read the slides, for whatever reason, for a

19 week later, there's no way to actually go in

20 and say, "Well, here's, Peggy Deane's test was

21 run on this date and these others were also

22 run."

23 MR. GULLIVER:

24 A. No, the system records different events when

25 you access a patient's record. So if a

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1 technologist did a batch, generally that
 2 technologist would complete the batch, they
 3 would go into each individual patient's report
 4 and say, "I've now done the ER/PR" and that
 5 date and time is there in the system. The
 6 pathologist might not read it and sign out for
 7 it a week or a day or they could be all
 8 different times signed out. But what I'm
 9 saying, under the procedure that was ordered
 10 and completed, if you've got four or five
 11 patients on the same day in the system
 12 recorded, then you can pretty well assume
 13 those patients were done in the same batch on
 14 the same day irregardless of the time the
 15 pathologist read them or signed them out.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. So it would be likely that they were
 18 done on the same day?
 19 MR. GULLIVER:
 20 A. Yeah, likely. You can't guarantee 100
 21 percent.
 22 CHAYTOR, Q.C.:
 23 Q. Right.
 24 MR. GULLIVER:
 25 A. But it would be more likely, yes.

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1 CHAYTOR, Q.C.:
 2 Q. So was that done, did anyone ever attempt to
 3 do that?
 4 MR. GULLIVER:
 5 A. Not to my knowledge, no.
 6 CHAYTOR, Q.C.:
 7 Q. And why not?
 8 MR. GULLIVER:
 9 A. I can't tell you, I don't know. The
 10 pathologists didn't ask for it, Dr. Cook
 11 didn't ask for it, Dr. Carter didn't ask for
 12 it who at this time were the two clinical
 13 people leading this for the laboratory. Well,
 14 and actually, I can't say if it was done or
 15 not done. I'm saying to me no one ever came
 16 and asked me could it be done or should we do
 17 it.
 18 CHAYTOR, Q.C.:
 19 Q. Okay.
 20 COMMISSIONER:
 21 Q. Ms. Chaytor, when you can find a convenient
 22 spot, we'll take the luncheon break.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. So using Meditech, can you ascertain
 25 for a given date what procedures were done by

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1 a particular technologist on that date?
 2 MR. GULLIVER:
 3 A. That's much more difficult because, I mean, in
 4 general practice if it was Mary doing the
 5 batches this week or Peggy doing it this week,
 6 because, I mean, by this time, you know, from
 7 '97 up until Les comes, we've only got Mary
 8 and Peggy doing the batches. One can only
 9 assume that if Mary goes into the computer and
 10 she's the one saying the procedures are
 11 completed, you would assume Mary is the one
 12 that ran the batch. But that didn't happen
 13 all the time. Sometimes the workload didn't
 14 get inputted until several days later and
 15 maybe by that time Peggy's on the bench and
 16 she puts all the workload in for last week and
 17 this week, but that would not be the norm.
 18 But normally the technologist who did the
 19 batch would go and record it.
 20 CHAYTOR, Q.C.:
 21 Q. If I could have, please, P-2152? And page 8
 22 of the document, please, Registrar? Do you
 23 recognize what this document is, Mr. Gulliver?
 24 MR. GULLIVER:
 25 A. Not really.

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1 CHAYTOR, Q.C.:
 2 Q. No? This doesn't look familiar to you?
 3 MR. GULLIVER:
 4 A. I think I've seen in now in preparing for
 5 this.
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 MR. GULLIVER:
 9 A. But it's not something I would have seen back
 10 ten years ago.
 11 CHAYTOR, Q.C.:
 12 Q. And would this be something that is generated
 13 by the DAKO machine?
 14 MR. GULLIVER:
 15 A. I think that's probably where it would have
 16 come from.
 17 CHAYTOR, Q.C.:
 18 Q. Computer -
 19 MR. GULLIVER:
 20 A. It's probably like the protocol or something
 21 that they were using for antibody, but that's
 22 what it looks like to me.
 23 CHAYTOR, Q.C.:
 24 Q. Or would it be the computer records of the
 25 DAKO machine for a particular case, for

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1 example, here -

2 MR. GULLIVER:

3 A. It may have been, you know, when the staff or

4 technologist would do a run, they had to go

5 and tell the machine slide one is ER, slide

6 two is LCA, slide three, and they had a

7 template where they set it up.

8 CHAYTOR, Q.C.:

9 Q. Yes.

10 MR. GULLIVER:

11 A. The machine, I think, spit out like a piece of

12 paper with a bunch of circles and said, now,

13 when you put your reagents on, you put them in

14 slot number one, two, three, four, five, that

15 kind of template.

16 CHAYTOR, Q.C.:

17 Q. Yes.

18 MR. GULLIVER:

19 A. I never ever used the DAKO machine, so I can't

20 tell you, you know, exactly.

21 CHAYTOR, Q.C.:

22 Q. So this here in terms of the case number, this

23 looks like a surgical number, 1998.

24 MR. GULLIVER:

25 A. From Central Newfoundland.

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1 CHAYTOR, Q.C.:

2 Q. From Central Newfoundland. The doctor is Dr.

3 Khalifa and the technician is Peggy?

4 MR. GULLIVER:

5 A. Yeah.

6 CHAYTOR, Q.C.:

7 Q. Okay. And then we have slide, and the slot

8 numbers, I guess, would be 19 and 20?

9 MR. GULLIVER:

10 A. It's ER/PR.

11 CHAYTOR, Q.C.:

12 Q. Anti, the antibodies estrogen and

13 progesterone. And then we have the protocol

14 that was used?

15 MR. GULLIVER:

16 A. Yeah.

17 CHAYTOR, Q.C.:

18 Q. And then if this were information generated by

19 the DAKO computer, where would we get that

20 information today?

21 MR. GULLIVER:

22 A. Well, as you know, the DAKO computer, we don't

23 longer have it.

24 CHAYTOR, Q.C.:

25 Q. But where would this information have gone

Page 199

1 that was on the computer?

2 MR. GULLIVER:

3 A. I really can't give you, you know, 100 percent

4 answer. I know you've all been informed that

5 at some point in 2004, I think it was

6 November, that our main pathology lab, in

7 particular, the part of the lab that had been

8 used for IHC testing underwent a flood, ie,

9 all the ceiling tiles came out from the

10 ceiling. I've shown you-I've submitted

11 pictures of that.

12 CHAYTOR, Q.C.:

13 Q. Yes, and I'll take you to that when we have

14 more time after lunch.

15 MR. GULLIVER:

16 A. And I know when that event happened, it was in

17 the evening. Barry called me. It happened in

18 our microbiology lab also. That's the part of

19 the lab that were really affected. We went in

20 to work as soon as possible. We were trying

21 to cover up equipment with plastic and while

22 ceiling tiles were falling from our heads.

23 And -

24 CHAYTOR, Q.C.:

25 Q. And I will ask you about, but, Mr. Gulliver -

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1 MR. GULLIVER:

2 A. And I know after that a lot of material had to

3 be discarded in pathology because it was

4 asbestos contaminated.

5 CHAYTOR, Q.C.:

6 Q. Yes. And this gives us the date. There's a

7 date up here?

8 MR. GULLIVER:

9 A. Yeah. And this would be the log that the

10 computer would keep.

11 CHAYTOR, Q.C.:

12 Q. Yes.

13 MR. GULLIVER:

14 A. When the runs were being done, I think, yeah.

15 CHAYTOR, Q.C.:

16 Q. So are you able to tell the Commissioner where

17 are the logs from the computer?

18 MR. GULLIVER:

19 A. I can't, no, no.

20 CHAYTOR, Q.C.:

21 Q. Okay. We'll take the break there, please?

22 COMMISSIONER:

23 Q. All right, then. We'll meet again at ten

24 after two. Thank you.

25 (LUNCH BREAK)

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1 THE COMMISSIONER:
 2 Q. Ms. Chaytor.
 3 CHAYTOR, Q.C.:
 4 Q. Good afternoon, Commissioner. Good afternoon,
 5 Mr. Gulliver.
 6 MR. GULLIVER:
 7 A. Good afternoon, Ms. Chaytor.
 8 CHAYTOR, Q.C.:
 9 Q. We have two new exhibits this afternoon,
 10 Commissioner. P-3030 and P-3119, if I could
 11 have those entered?
 12 THE COMMISSIONER:
 13 Q. 3030 and 3119?
 14 CHAYTOR, Q.C.:
 15 Q. Yes.
 16 THE COMMISSIONER:
 17 Q. Entered.
 18 EXHIBIT ENTERED AND MARKED P-3030.
 19 EXHIBIT ENTERED AND MARKED P-3119.
 20 CHAYTOR, Q.C.:
 21 Q. Thank you. Now, Mr. Gulliver, before we broke
 22 for lunch I was asking you about the DAKO
 23 machine and what happened with the DAKO
 24 machine. And we were talking about
 25 documentation that was stored on the computer

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

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

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1 CHAYTOR, Q.C.:
 2 Q. Yes.
 3 MR. GULLIVER:
 4 A. I don't think we have pictures of the very
 5 back of the pathology lab.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. So, for example, this is not, this is
 8 not the -
 9 MR. GULLIVER:
 10 A. No, that's a microtome.
 11 CHAYTOR, Q.C.:
 12 Q. That's a mic, yeah.
 13 MR. GULLIVER:
 14 A. And that would be an embedding machine.
 15 CHAYTOR, Q.C.:
 16 Q. And that's not it, either?
 17 MR. GULLIVER:
 18 A. And that's the tissue processor in the gross
 19 room.
 20 CHAYTOR, Q.C.:
 21 Q. And so what about this tissue processor, was
 22 that salvageable?
 23 MR. GULLIVER:
 24 A. Oh, yes, yeah. I mean, when this happened, I
 25 put out an alert to several of my managers and

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1 staff, I don't know if it was a Friday night
 2 or a Sunday night, it was like late at night,
 3 where we came in and we tried to start
 4 covering as much of the big instruments as
 5 possible.
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 MR. GULLIVER:
 9 A. But there was a significant amount of damage
 10 done, as you can see. And there was a
 11 significant amount of, like, we lost reagents
 12 and paperwork, documentation. And the issue,
 13 the big issue was that the facilities
 14 management people called in this, you know,
 15 like a clean-up team immediately and they
 16 detected asbestos throughout all parts of the
 17 lab.
 18 CHAYTOR, Q.C.:
 19 Q. Okay.
 20 MR. GULLIVER:
 21 A. And from that point onwards no lab person was
 22 allowed in there until it was all cleaned up
 23 and finished. And that took about, I think,
 24 four, five, six weeks.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. So there's no photo, though, that would
 2 actually show the DAKO machine?
 3 MR. GULLIVER:
 4 A. I don't see it there, no.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. And so then you said this happened
 7 when, in late, was it 2004?
 8 MR. GULLIVER:
 9 A. I think this might have been like October,
 10 November, 2004.
 11 CHAYTOR, Q.C.:
 12 Q. Yes. And the DAKO machine you said was
 13 disposed of shortly thereafter. Where did it
 14 go?
 15 MR. GULLIVER:
 16 A. A gentleman who we had a long-term
 17 relationship with, Joe White, he's a local
 18 technical guy from lab--from a lab technical
 19 guy, our lab had used his services for
 20 repairing microtomes, microscopes, cryostats,
 21 various kinds of things and there were lots of
 22 occasions where if we were disposing of, like
 23 an old microscope that was 40 years old, he
 24 may--we may give it to him and he'd just take
 25 it and take it apart and use it for parts for

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1 repairing new scopes or something that was
 2 salvageable. Other times in the lab if we had
 3 equipment that was no longer of use, it would
 4 just go to the dump. Other times if the
 5 company still owned the equipment, the company
 6 would have to come in and take the equipment
 7 back and pay for the freight and transport.
 8 Other equipment in the labs, we would offer to
 9 CONA, the third year--the training program for
 10 med lab technologists and we would say to
 11 CONA, look, you know, we have an old chemistry
 12 analyzer, a hematology analyzer, you know,
 13 would you need it for training students for
 14 simulation labs up at CONA. Sometimes they
 15 would say yes and we'd, you know, pass the
 16 equipment on to them. So it was various means
 17 of disposing of--the DAKO machine that we
 18 owned it.
 19 CHAYTOR, Q.C.:
 20 Q. You owned it at that point?
 21 MR. GULLIVER:
 22 A. At that point, yes. I mean, it was end of
 23 lease and it was eight-years old and it was
 24 really our property. Generally I would either
 25 pop an e-mail or make a phone -

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1 CHAYTOR, Q.C.:
 2 Q. In 2004 it was eight-years old? You acquired
 3 it in '98?
 4 MR. GULLIVER:
 5 A. I think '96, '97, '98, so it was like six-
 6 years old.
 7 CHAYTOR, Q.C.:
 8 Q. Okay.
 9 MR. GULLIVER:
 10 A. Yeah. I would either pop an e-mail or make a
 11 phone call to our purchasing department, Bruce
 12 Gorman, and say, "Look, we have an old piece
 13 of equipment here. Do you know anybody wants
 14 it?" Or I would tell him that nobody wants it
 15 and that we're just going to give it away or
 16 throw it to the dump.
 17 CHAYTOR, Q.C.:
 18 Q. And so what happened in this particular
 19 situation, it was given, I take it then, to
 20 Mr. White?
 21 MR. GULLIVER:
 22 A. In this case Joe, I mean, who had been in our
 23 lab lots of times and, you know, fixing
 24 microtomes and microscopes and different
 25 things, odds and ends, he pretty well said,

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1 you know, if we're going to throw it out, you
 2 know, could he have it. And there was a
 3 process the Health Care Corporation had where,
 4 like, you call the purchasing, you know,
 5 someone could buy it for a dollar, like just
 6 to have something like that. And, Ms.
 7 Chaytor, I've looked for--I don't have any
 8 documentation where, you know, we actually
 9 sold it for a dollar to Mr. White.
 10 CHAYTOR, Q.C.:
 11 Q. So there's no paperwork that was -
 12 MR. GULLIVER:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. - completed regarding the disposal to Mr.
 16 White?
 17 MR. GULLIVER:
 18 A. No. Yeah. But that's where it ended up going
 19 to.
 20 CHAYTOR, Q.C.:
 21 Q. And before you would do that, though, why
 22 would you just give it away, was it--it was
 23 still operational when you stopped using it.
 24 That wasn't the reason you stopped using it.
 25 And you had acquired then the Ventana. And so

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1 why would just give it away, was there any
 2 kind of appraisal done to determine whether or
 3 not it had any value?
 4 MR. GULLIVER:
 5 A. Not to my knowledge, there was no--and it's
 6 like all--we have over 1000 pieces of
 7 equipment in the laboratories in Eastern
 8 Health.
 9 CHAYTOR, Q.C.:
 10 Q. This was a \$65,000 piece of equipment six
 11 years before.
 12 MR. GULLIVER:
 13 A. Six years before, yes.
 14 CHAYTOR, Q.C.:
 15 Q. And in terms of the depreciated value, do you
 16 know what it was worth in late 2004?
 17 MR. GULLIVER:
 18 A. No, I don't. Laboratory tech--laboratory
 19 medicine and technology is always changing.
 20 We have disposed of chemistry analyzers that
 21 were \$500,000 to buy or at least six years
 22 prior. By that point they've pretty well--
 23 technology has changed and really you would
 24 have to almost go to, I don't know, I won't
 25 say third world countries, but you wouldn't

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1 find a use for them in another large clinical
 2 lab anywhere.
 3 CHAYTOR, Q.C.:
 4 Q. But this DAKO system you would?
 5 MR. GULLIVER:
 6 A. No, I wouldn't, because the DAKO system, the
 7 only lab in Newfoundland that was using or
 8 doing this technology was the Health Sciences
 9 lab.
 10 CHAYTOR, Q.C.:
 11 Q. Yes.
 12 MR. GULLIVER:
 13 A. So if it was no longer of use to us, there was
 14 no sense calling Gander, Grand Falls or Corner
 15 Brook or St. Anthony and saying, "Would you
 16 like to have this used piece of equipment?"
 17 because they don't do the testing -
 18 CHAYTOR, Q.C.:
 19 Q. But it was in use in other places across the
 20 country?
 21 MR. GULLIVER:
 22 A. Oh, certainly would be, yes.
 23 CHAYTOR, Q.C.:
 24 Q. Yes, yes. Because you said acquiring the
 25 Ventana system was something fairly new and -

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1 MR. GULLIVER:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. - Newfoundland was one of the first to acquire
 5 that system. So I take it that the same
 6 machine or same type of machine was in use
 7 widespread across the country?
 8 MR. GULLIVER:
 9 A. I would assume so, yes.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. So there was nothing done in terms of
 12 determining what the value of the machine was?
 13 MR. GULLIVER:
 14 A. No.
 15 CHAYTOR, Q.C.:
 16 Q. Was the machine damaged in the -
 17 MR. GULLIVER:
 18 A. You mean dollar value?
 19 CHAYTOR, Q.C.:
 20 Q. Yes.
 21 MR. GULLIVER:
 22 A. Was the machine damaged, I really can't tell
 23 you for sure, Ms. Chaytor. You know, I know
 24 that, as you can see in some of those
 25 pictures, that pretty well all parts of the

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

11 CHAYTOR, Q.C.:

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

15 MR. GULLIVER:

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

25 CHAYTOR, Q.C.:

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1 Q. So was there an insurance claim?

2 MR. GULLIVER:

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

19 CHAYTOR, Q.C.:

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

22 MR. GULLIVER:

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

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

3 CHAYTOR, Q.C.:

4 Q. Okay, so the machine that -

5 THE COMMISSIONER:

6 Q. Sorry, PM'd?

7 MR. GULLIVER:

8 A. Oh, preventative maintenance.

9 THE COMMISSIONER:

10 Q. Thank you.

11 CHAYTOR, Q.C.:

12 Q. So the machine is in the back of the lab at
 13 the time of the flood, which is
 14 October/November you say, 2004. The Ventana
 15 had been up and operationalized since April,
 16 2004 we understand.

17 MR. GULLIVER:

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

20 CHAYTOR, Q.C.:

21 Q. And then there was a period, transition period
 22 which we understand both systems would have
 23 been used to do the validation. So by April,
 24 2004, the machine, the DAKO machine had not
 25 been in use, that's right?

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1 MR. GULLIVER:

2 A. (No audible response).

3 CHAYTOR, Q.C.:

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

7 MR. GULLIVER:

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

21 CHAYTOR, Q.C.:

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

24 MR. GULLIVER:

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

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

12 CHAYTOR, Q.C.:

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

16 MR. GULLIVER:

17 A. I can't remember.

18 CHAYTOR, Q.C.:

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

21 MR. GULLIVER:

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

25 CHAYTOR, Q.C.:

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

5 MR. GULLIVER:

6 A. No.

7 CHAYTOR, Q.C.:

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

15 MR. GULLIVER:

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

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

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

3 CHAYTOR, Q.C.:

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

7 MR. GULLIVER:

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

11 CHAYTOR, Q.C.:

12 Q. And how do you know that?

13 MR. GULLIVER:

14 A. Well I asked him.

15 CHAYTOR, Q.C.:

16 Q. When did you ask him that?

17 MR. GULLIVER:

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

20 CHAYTOR, Q.C.:

21 Q. And what did Mr. White tell you.

22 MR. GULLIVER:

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

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1 out in through all this clean up.
 2 CHAYTOR, Q.C.:
 3 Q. So Mr. White just in the past couple of weeks
 4 told you that he definitely did not take the
 5 computer that went along with the DAKO
 6 machine?
 7 MR. GULLIVER:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And so the computer portion itself then and
 11 the records that were stored on the computer,
 12 what happened to those?
 13 MR. GULLIVER:
 14 A. I'm just assuming that the asbestos clean up
 15 team who came in for that four to six week
 16 period the lab was closed down, that those
 17 things would have been discarded.
 18 CHAYTOR, Q.C.:
 19 Q. Can the DAKO machine work without the
 20 computer?
 21 MR. GULLIVER:
 22 A. I guess so because it's just a mechanical
 23 device, it's just a dispenser.
 24 CHAYTOR, Q.C.:
 25 Q. The autostainer.

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

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

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1 damage.
 2 CHAYTOR, Q.C.:
 3 Q. Is there any policy in place to say what has
 4 to happen to any records that may be stored on
 5 a computer prior to its disposal?
 6 MR. GULLIVER:
 7 A. No. Our policy for recordkeeping is more of a
 8 Meditech system which keeps a record of every
 9 single procedure a patient has had done,
 10 whether it was done, the DAKO instrument, that
 11 information is transcribed into the patient's
 12 record as a permanent record and our records
 13 would be the permanent blocks and slides that
 14 were done by the lab.
 15 CHAYTOR, Q.C.:
 16 Q. Were you present when Mr. White removed the
 17 autostainer?
 18 MR. GULLIVER:
 19 A. No.
 20 CHAYTOR, Q.C.:
 21 Q. Were you present when the computer was
 22 disposed of that went along with the
 23 autostainer?
 24 MR. GULLIVER:
 25 A. I didn't work in that lab, I -

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1 CHAYTOR, Q.C.:

2 Q. No, I'm just wondering if you were there.

3 MR. GULLIVER:

4 A. Nobody was there.

5 CHAYTOR, Q.C.:

6 Q. So nobody knows what happened to the computer?

7 MR. GULLIVER:

8 A. After the flood we were given, I think Mr.

9 Dyer was the only one, we were given a day to

10 go in and identify what equipment has to stay

11 there that we can probably, that we're still

12 using and can be usable afterwards. After

13 that, the whole place was sealed off and there

14 were people in there, you know, working with

15 the gas masks and the white clothing and they

16 pretty well discarded what they--anything they

17 thought that could have been contaminated with

18 asbestos.

19 CHAYTOR, Q.C.:

20 Q. So wherever the computer ended up and whatever

21 records were on it -

22 MR. GULLIVER:

23 A. I don't know.

24 CHAYTOR, Q.C.:

25 Q. You don't know.

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1 MR. GULLIVER:

2 A. I can't say, no.

3 THE COMMISSIONER:

4 Q. Did I understand you correctly, Mr. Gulliver,

5 that the policy regarding records for Eastern

6 Health covers only Meditech?

7 MR. GULLIVER:

8 A. No, no, no, the record that we have is in

9 Meditech every single patient individual

10 report with whatever procedures are performed

11 and tests are performed and the interpretation

12 and results -

13 THE COMMISSIONER:

14 Q. I understood that, but is there not a policy

15 regarding disposing of equipment that might

16 contain records related to patients, like the

17 computer?

18 MR. GULLIVER:

19 A. I'm not aware of one. It could be, Justice

20 Cameron, it could be an organizational policy.

21 THE COMMISSIONER:

22 Q. All right, thank you.

23 CHAYTOR, Q.C.:

24 Q. So you're not aware of anything in the way of

25 a policy that has to do with preservation of

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1 records?

2 MR. GULLIVER:

3 A. Well, again records, if you're talking about

4 blocks and slides, there's policies, but

5 you're talking about records that may be on a

6 PC.

7 CHAYTOR, Q.C.:

8 Q. Yes.

9 MR. GULLIVER:

10 A. I don't know. Any PCs--generally any PCs that

11 are being replaced, IT are the ones who come

12 and take them away and replace them. So what

13 they do with any permanent records on them, I

14 don't know, but most of the--understand that

15 in pathology at this point in time, that's

16 probably the only PC we had that was used only

17 for the DAKO autostainer.

18 CHAYTOR, Q.C.:

19 Q. So you're not even to this day aware of any

20 policy that would pertain to the preservation

21 of records, such as what we're seeing here in

22 P-2152?

23 MR. GULLIVER:

24 A. Not that I'm aware of, no.

25 CHAYTOR, Q.C.:

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1 Q. Or anything at all that would have information

2 that may pertain to a patient's care?

3 MR. GULLIVER:

4 A. Well, this doesn't pertain to the patient's

5 care. There's no patient identification here.

6 CHAYTOR, Q.C.:

7 Q. We have a surgical number.

8 MR. GULLIVER:

9 A. I know, and that's non-identifier. All you

10 have here is the protocols that were run on

11 the instrument. It's not patient care

12 records.

13 CHAYTOR, Q.C.:

14 Q. So for this type of a record, you're saying

15 there's no policy in place in terms of -

16 MR. GULLIVER:

17 A. Not to my knowledge, there could be.

18 CHAYTOR, Q.C.:

19 Q. And what about the practice that you said has

20 developed in terms of the disposal of

21 laboratory equipment over the years, is there

22 any policy or procedure in place pertaining to

23 acceptable disposal of equipment?

24 MR. GULLIVER:

25 A. There is a policy that's from the purchasing

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1 department where you have to follow through,
 2 and if you're going to dispose of a piece of
 3 equipment, you know, it can be sold off for a
 4 dollar. Like, that's the exchange, but
 5 internally in the lab -
 6 CHAYTOR, Q.C.:
 7 Q. So if it's a piece of equipment that's deemed
 8 to have no value, or do you have to have
 9 anything -
 10 MR. GULLIVER:
 11 A. Well, it has no value to us any more. If
 12 we're finished using it, then it has no more
 13 value to us on a daily basis to use it. We do
 14 make phone calls to the college, which I do,
 15 have done regularly, and offer equipment to
 16 the college. Now that we are Eastern Health,
 17 for example, we have upgraded equipment in the
 18 last two years in hematology chemistry, and
 19 we've actually taken equipment from Carbonear
 20 and put it down in Old Perlican and vice versa
 21 to extend the life of the equipment and offer
 22 better testing in those sites, but if that's
 23 no longer possible, then it's disposed of or
 24 just sold for a dollar.
 25 CHAYTOR, Q.C.:

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1 Q. Did Mr. White do anything or offer any
 2 services in exchange for the machine?
 3 MR. GULLIVER:
 4 A. Actually, while you're asking me, I'm thinking
 5 that. I think Joe may have come in on a
 6 Saturday and Sunday and serviced most of the
 7 microtomes in the pathology lab, just to do a
 8 routine maintenance cleaning and checking on
 9 them, almost like in lieu of taking away the
 10 old autostainer.
 11 CHAYTOR, Q.C.:
 12 Q. So like a barter system?
 13 MR. GULLIVER:
 14 A. Something like that, yeah.
 15 CHAYTOR, Q.C.:
 16 Q. And in terms of the decision to allow the
 17 equipment to leave the laboratory, who
 18 ultimately made that decision?
 19 MR. GULLIVER:
 20 A. Probably myself.
 21 CHAYTOR, Q.C.:
 22 Q. And would you have had to have any approval
 23 from anyone else?
 24 MR. GULLIVER:
 25 A. Again I think I'll probably just call Bruce

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1 over in purchasing and say, Bruce, we have an
 2 old stainer here, it's of no use to anyone
 3 else in the province, no one else does the
 4 testing, and we're going to throw it to the
 5 dump or I'm going to give it to Joe White. I
 6 think I probably made the phone call and did
 7 that.
 8 CHAYTOR, Q.C.:
 9 Q. And this would have been then some time after
 10 you flood. So some time after
 11 October/November '04. Do you know exactly
 12 when it was, Mr. Gulliver?
 13 MR. GULLIVER:
 14 A. I don't know, Ms. Chaytor.
 15 CHAYTOR, Q.C.:
 16 Q. Could it have been early on into 2005?
 17 MR. GULLIVER:
 18 A. I don't know. It could have been--I mean, the
 19 flood was November '04. It could have been
 20 January '05, it could have been February '05,
 21 because the lab was really unaccessible for
 22 four to six weeks. I can't give you an exact
 23 date.
 24 CHAYTOR, Q.C.:
 25 Q. So then this issue of the ER/PR arises in the

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1 spring of 2005--well, April is Peggy Dean's
 2 test.
 3 MR. GULLIVER:
 4 A. Really July '05.
 5 CHAYTOR, Q.C.:
 6 Q. And May 17th is the first time you learn of it
 7 in 2005. I'm sorry, why would you say that
 8 the issue arose in July?
 9 MR. GULLIVER:
 10 A. We covered May of '05 is when I was made aware
 11 that there was one patient who retested and
 12 was negative went to positive.
 13 CHAYTOR, Q.C.:
 14 Q. Yes.
 15 MR. GULLIVER:
 16 A. It's really not until early July before I'm
 17 actively involved in it.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, but the issue itself certainly has arisen
 20 and you've been part of meetings then after
 21 that. Within two weeks, you told us earlier
 22 this morning, you were -
 23 MR. GULLIVER:
 24 A. No, I think within two weeks, I receive a copy
 25 of a memo from Dr. Cook or Dr. Williams showed

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1 me a memo that was written to Dr. Williams.
 2 CHAYTOR, Q.C.:
 3 Q. Yes.
 4 MR. GULLIVER:
 5 A. Talking about several more cases.
 6 CHAYTOR, Q.C.:
 7 Q. And then in June, you're involved in meetings?
 8 MR. GULLIVER:
 9 A. Yeah.
 10 CHAYTOR, Q.C.:
 11 Q. So I'm just wondering then, when it comes up
 12 in the spring and summer of 2005, and we see
 13 in some of the documentation that there's
 14 concern is this a machinery issue, is this an
 15 equipment issue, is it because of the change
 16 from the new to the old system, did anyone ask
 17 where's the old system, where's the machine?
 18 MR. GULLIVER:
 19 A. I don't think so, because we had been using
 20 the Ventana by this time, '05, for a year and
 21 - almost a year and a half.
 22 CHAYTOR, Q.C.:
 23 Q. So nobody thought to ask that, you know,
 24 where's the piece of equipment that we were
 25 using?

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1 MR. GULLIVER:
 2 A. Not to my knowledge, no.
 3 CHAYTOR, Q.C.:
 4 Q. And did you think about that? Did you think
 5 about, well, if we're thinking it may have
 6 been something with the old DAKO system, maybe
 7 I should contact Mr. White and ask do you
 8 still have it?
 9 MR. GULLIVER:
 10 A. No, because I did never think it was the old
 11 DAKO system.
 12 CHAYTOR, Q.C.:
 13 Q. You never thought that?
 14 MR. GULLIVER:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. You never thought it was the equipment?
 18 MR. GULLIVER:
 19 A. It's--it's a liquid dispenser. It doesn't
 20 perform the test. It aids in performing the
 21 test, so I never thought the DAKO instrument
 22 was at fault and where is the old instrument
 23 to. That wasn't my thinking.
 24 CHAYTOR, Q.C.:
 25 Q. So in terms of it being explained through any

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1 difference in the equipment, what were you
 2 thinking?
 3 MR. GULLIVER:
 4 A. What exactly are you asking?
 5 CHAYTOR, Q.C.:
 6 Q. And maybe I misunderstood you last day when we
 7 were talking about this, but did you at all
 8 think there was any--that any of this could
 9 have been attributable to the fact that you
 10 had gone from the DAKO system to the Ventana
 11 System?
 12 MR. GULLIVER:
 13 A. No, at the time what I thought was the new
 14 Ventana System, which you've asked and we've
 15 seen now, the new Ventana System with the on
 16 board antigen retrieval, with the minimizing
 17 the human interaction in performing the
 18 procedure, that the new system was giving us
 19 positive results, I didn't think it was giving
 20 us positive results because the old system
 21 wasn't working, it was giving us better
 22 results because the new system was a better
 23 system.
 24 CHAYTOR, Q.C.:
 25 Q. But if the new system is better, and the old

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

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1 MR. GULLIVER:
 2 A. I'm saying that that could be a possibility,
 3 yes.
 4 CHAYTOR, Q.C.:
 5 Q. And that's what you thought at the time?
 6 MR. GULLIVER:
 7 A. Yeah.
 8 THE COMMISSIONER:
 9 Q. So at no point did you think there was a
 10 deficiency or DAKO was causing a problem, or
 11 there were errors in DAKO?
 12 MR. GULLIVER:
 13 A. I never did.
 14 THE COMMISSIONER:
 15 Q. You just thought--you just upgraded and this
 16 new system is calling things better?
 17 MR. GULLIVER:
 18 A. Right, and, I mean, we shouldn't even say the
 19 DAKO System and compare it to Ventana System.
 20 The Ventana System in my opinion is a system
 21 that it automates the antigen retrieval, it
 22 automates your slide during the procedure, you
 23 have your pre-optimized diluted antibodies,
 24 it's under a much more controlled environment.
 25 The DAKO was a machine, it wasn't a system.

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1 It was a machine that you took your slides off
 2 the bench, you put them on the machine, and
 3 you programmed the machine and it dispensed
 4 the liquids that you already made up yourself
 5 and made your own dilutions. That's all it
 6 did. So I never once thought the DAKO machine
 7 was something wrong with it and was
 8 malfunctioning for six years.
 9 CHAYTOR, Q.C.:
 10 Q. And you had no maintenance records, I take it,
 11 that would have suggested that, that there had
 12 been something wrong or something -
 13 MR. GULLIVER:
 14 A. Nothing major, just routine mechanical things.
 15 maybe the pump had to be replaced, or a tubing
 16 replaced, because it's just a mechanical
 17 instrument, but nothing to alert us to say
 18 that the DAKO machine wasn't functioning
 19 properly for an extended period of time or for
 20 a long period of time.
 21 CHAYTOR, Q.C.:
 22 Q. Or for any period of time?
 23 MR. GULLIVER:
 24 A. Or for an period of time.
 25 CHAYTOR, Q.C.:

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

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1 able to obtain such a system at this time to
 2 retest on that method", and do you remember
 3 that, Mr. Gulliver?
 4 MR. GULLIVER:
 5 A. Probably.
 6 CHAYTOR, Q.C.:
 7 Q. And did you, in fact, advise that it would be
 8 unlikely to be able to obtain such a system?
 9 MR. GULLIVER:
 10 A. I think so. I mean, this is summer of '05 and
 11 you know, the DAKO autostainer we had in '98,
 12 I think by this time DAKO has--you know, they
 13 have the new improved, the DAKO autostainer
 14 two. So the exact one that we had, I knew
 15 that it was gone.
 16 CHAYTOR, Q.C.:
 17 Q. And you made no inquiries of Mr. White to see
 18 whether or not he still had it?
 19 MR. GULLIVER:
 20 A. No, I didn't, no.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and you made no inquiries of anywhere
 23 else to find out who else may, in fact, be
 24 using that system?
 25 MR. GULLIVER:

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1 A. The exact system, no, I didn't call every lab
 2 in Canada and ask them what system are they
 3 using.
 4 CHAYTOR, Q.C.:
 5 Q. And if we could have P-0075, please? So you
 6 take--you don't take exception with that, and
 7 that is accurate of what you would have told
 8 Dr. Williams at the time?
 9 MR. GULLIVER:
 10 A. Yeah, I can see myself saying that, yeah.
 11 CHAYTOR, Q.C.:
 12 Q. And that ends up in the briefing note that
 13 goes to Minister Ottenheimer on July 20th or
 14 July 21st, I believe it was given to him. So
 15 we see that same paragraph here. So when Dr.
 16 Williams is making the inquiry about the
 17 possibility of repeating the negative tests on
 18 the old system and you tell him that, well,
 19 it's unlikely you're going to be able to
 20 obtain such a system, you don't have any
 21 discussion with him about "well, it's only
 22 been two or three months or four months or
 23 however, how long since Mr. White walked out
 24 of here with the system. Maybe I'll make some
 25 inquiries and see what we can do"?

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1 MR. GULLIVER:
 2 A. No, I did not, and the system we're talking
 3 about, the machine we're talking about, as you
 4 see in the flood, I had no idea what the--if
 5 it was still operational, not operational,
 6 what condition it was in when it left. It had
 7 not been used for months and months and
 8 months. It was sitting in the back of the
 9 lab. It's been just sitting there unused and
 10 what I did suggest is that we would contact
 11 Montreal University Health Network. I knew
 12 Montreal had a DAKO system and maybe we should
 13 send some of our cases out to another site and
 14 ask them to retest on their DAKO system to
 15 compare results. That would be my best
 16 suggestion, as opposed to us trying to find
 17 another mechanical instrument somewhere and
 18 having it flown into St. John's to see if we
 19 could retest to see if it was the system.
 20 CHAYTOR, Q.C.:
 21 Q. And the first time then that you do contact
 22 Mr. White is in the past couple of weeks after
 23 we made further inquiry regarding the
 24 location?
 25 MR. GULLIVER:

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1 A. Pretty well, yeah, just to verify that yes, he
 2 was the--his company is the one that actually
 3 took away the instrument.
 4 CHAYTOR, Q.C.:
 5 Q. And if we could have, please, P-3109 again?
 6 This is the exhibit with the photographs, but
 7 on the first page we have a letter and
 8 Registrar, if you could just increase that,
 9 please? It's a letter signed by Joe White,
 10 general manager of General Technical Services,
 11 dated September 17th, 2008. Mr. Barry Dyer,
 12 pathology manager, Eastern Health. "Hi,
 13 Barry. In response to your inquiry regarding
 14 the DAKO Autostainer, I removed the instrument
 15 from the Health Sciences Complex somewhere in
 16 the general time frame of late 2004, early
 17 2005 with the permission of lab director, Mr.
 18 Terry Gulliver." And so why do you understand
 19 that Mr. White provided this letter at this
 20 time?
 21 MR. GULLIVER:
 22 A. Oh, well, we were being asked by, you know,
 23 here, during this Inquiry, you know, where is
 24 the old machine to and who--how did we dispose
 25 of it. So I was asked to provide--to contact

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1 Mr. White at General Technical Services and
 2 you know, ask him to verify that he indeed is
 3 the one that took away the old machine.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, and did you have any other conversations
 6 then with Mr. White about this?
 7 MR. GULLIVER:
 8 A. I think I asked him about the old computer and
 9 he said there was definitely no computer.
 10 That was already gone.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, and -
 13 MR. GULLIVER:
 14 A. See, the machine sat, Ms. Chaytor, in the lab.
 15 The computer was on this bench and the machine
 16 was on a separate table over here. So most of
 17 what's on the benches, all the tiles fell
 18 mostly where the computer was to.
 19 CHAYTOR, Q.C.:
 20 Q. And did he tell you what he did with the
 21 machine?
 22 MR. GULLIVER:
 23 A. Well, I asked him what he did with it.
 24 CHAYTOR, Q.C.:
 25 Q. Yes.

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

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1 the PM, the diagnostics and fixed it up, and I
 2 think he said that it went to the Bahamas or
 3 Bermuda or somewhere like that.
 4 CHAYTOR, Q.C.:
 5 Q. Or maybe the United States?
 6 MR. GULLIVER:
 7 A. No, the Bahamas is what sticks out in my mind.
 8 CHAYTOR, Q.C.:
 9 Q. And if we could have, please, 3110? And do
 10 you know whether or not, Mr. Gulliver, the
 11 machine is still in existence working
 12 anywhere?
 13 MR. GULLIVER:
 14 A. Say it again?
 15 CHAYTOR, Q.C.:
 16 Q. Do you know whether or not the machine -
 17 MR. GULLIVER:
 18 A. I think it's--well, he told me, he said he
 19 thinks it's still in operation somewhere in
 20 Bahamas.
 21 CHAYTOR, Q.C.:
 22 Q. And 3110 and this is e-mail exchange between
 23 myself and Mr. Simmons about the location of
 24 the machine, and then on September 18th, 2008,
 25 Mr. Simmons provides to me and Mr. Coffey "a

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

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

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1 White, General Technical Services. Mr. White
 2 has dropped off a letter indicating that he
 3 indeed took away the old instrument." The
 4 dates of December '04, January 2005, where do
 5 you get those?
 6 MR. GULLIVER:
 7 A. That's just my recollection. That's all.
 8 CHAYTOR, Q.C.:
 9 Q. That's your own recollection?
 10 MR. GULLIVER:
 11 A. Yeah.
 12 CHAYTOR, Q.C.:
 13 Q. "The old computer with the DAKO machine, along
 14 with a fair bit of paper documentation was
 15 discarded during the clean up of the flood,"
 16 and again, we've talked about that.
 17 MR. GULLIVER:
 18 A. That's the best of my knowledge, yeah.
 19 CHAYTOR, Q.C.:
 20 Q. Best of your knowledge, but--and you've made
 21 inquiries, I take it, and nobody knows where
 22 the actual computer ended up?
 23 MR. GULLIVER:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. Nor the records from the computer?
 2 MR. GULLIVER:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. Is that correct?
 6 MR. GULLIVER:
 7 A. Yeah.
 8 CHAYTOR, Q.C.:
 9 Q. "The pathology laboratory, Barry Dyer was
 10 given permission then to enter the area to
 11 identify equipment that could be saved, and
 12 Mr. White has confirmed that he only took the
 13 DAKO instrument and not the old PC. There
 14 were no records kept with the DAKO machine's
 15 hard drive." And what does that mean?
 16 MR. GULLIVER:
 17 A. Well, on the machine itself, I mean, there was
 18 no hard drive on the -
 19 CHAYTOR, Q.C.:
 20 Q. On the autostainer.
 21 MR. GULLIVER:
 22 A. - on the autostainer, right.
 23 CHAYTOR, Q.C.:
 24 Q. There were also no records, disks, from the
 25 old PC anywhere in the lab, and what inquiries

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1 have you made, Mr. Gulliver, to be able to
 2 assert that?
 3 MR. GULLIVER:
 4 A. Well, it's over in the lab. I mean, Mary
 5 Butler, the technologist, and Les Simms and
 6 Ken Green and Barry have searched to provide
 7 documents for this Inquiry, started at year
 8 ago, and they were not able to find--whatever
 9 we found, we passed it in. But in that part
 10 of the lab where IHC used to take place, there
 11 were multiple large drawers and they would
 12 keep their paper records and requisitions and
 13 those things in there and pretty well most of
 14 that stuff was gone.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. So in terms of we received some new
 17 documents from you yesterday that you found in
 18 an old filing cabinet. I'm just wondering was
 19 there any--is this any new information.
 20 MR. GULLIVER:
 21 A. Oh no, no, no.
 22 CHAYTOR, Q.C.:
 23 Q. Was there a new search done?
 24 MR. GULLIVER:
 25 A. No.

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1 CHAYTOR, Q.C.:
 2 Q. So this is whatever was done -
 3 MR. GULLIVER:
 4 A. Back done a year ago.
 5 CHAYTOR, Q.C.:
 6 Q. Yes. "We can only assume then that when the
 7 PC was discarded after the flood, any disk,
 8 paper records went with it." And then on page
 9 three of the exhibit, a couple of days later,
 10 September 22nd, 2008 and Mr. Simmons again e-
 11 mails to us with your reply to the question
 12 about what Joe White did with the DAKO
 13 autostainer. "When Joe came in with the
 14 letter, I asked him that question. He said
 15 that when he took it, he cleaned it up, did a
 16 few minor repairs, performed diagnostic check
 17 and preventive maintenance. At some point, he
 18 sold it to a surplus equipment place and he
 19 thinks it is in Bermuda or Bahamas." And Mr.
 20 Gulliver, in terms of--you had a chat, I take
 21 it, when Mr. White dropped off the letter?
 22 MR. GULLIVER:
 23 A. Just for a few minutes, yes.
 24 CHAYTOR, Q.C.:
 25 Q. And what does it mean to perform a diagnostic

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1 check? How do you do that?

2 MR. GULLIVER:

3 A. I don't know. I mean, it's a technical

4 services kind of thing that they do.

5 CHAYTOR, Q.C.:

6 Q. And do you know whether or not you need to

7 have -

8 MR. GULLIVER:

9 A. I think he's just saying to see if the thing

10 is still operational, you know, just the

11 mechanical parts function, I would assume.

12 CHAYTOR, Q.C.:

13 Q. Do you know if you need a computer to be able

14 to do that?

15 MR. GULLIVER:

16 A. I seriously doubt it.

17 CHAYTOR, Q.C.:

18 Q. So is there any other information that you

19 have or anything about the whereabouts of the

20 DAKO machine or how it, in fact, left Eastern

21 Health?

22 MR. GULLIVER:

23 A. That's--everything I've told you is the best

24 knowledge I have about it.

25 CHAYTOR, Q.C.:

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1 Q. And has there been any subsequent inquiries--

2 because when we began asking about this, it

3 was not just the machine itself, not the

4 autostainer, but we were looking for records

5 related to the disposal of the machine and

6 related computer and data from the machine and

7 the computer. So since when this was received

8 obviously efforts were made and inquiries made

9 in terms of the disposal of the machine

10 portion, but what inquiries were undertaken in

11 terms of what happened to the computer that

12 accompanies the machine and any data on the

13 computer?

14 MR. GULLIVER:

15 A. I did nothing new two weeks ago when this was

16 asked for. I'm just restating that we had

17 done this when this Inquiry started and we

18 knew that the computer was gone. We knew that

19 that part of the lab, most of the things there

20 were thrown away, and I'm just restating what

21 we had said a year ago.

22 CHAYTOR, Q.C.:

23 Q. So in terms of making any other inquiries as

24 to the location of the computer portion of the

25 machine, there hasn't been any further

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1 inquiries?

2 MR. GULLIVER:

3 A. No.

4 CHAYTOR, Q.C.:

5 Q. And to your knowledge, you're unable--you

6 don't know where the computer ended up?

7 MR. GULLIVER:

8 A. No.

9 CHAYTOR, Q.C.:

10 Q. Nor its records?

11 MR. GULLIVER:

12 A. And I would say, if you check Robin Hood Bay,

13 it's probably down there somewhere. That's

14 where probably most of this stuff went to.

15 CHAYTOR, Q.C.:

16 Q. Okay, Mr. Gulliver, take you back then to the

17 ER/PR and what's happening in the spring and

18 summer of 2005, and perhaps you can tell the

19 Commissioner what your involvement was in

20 terms of trying to get at the root of the

21 problem and identify patients who may need

22 retesting?

23 MR. GULLIVER:

24 A. Well, I guess, you know, by the time I start

25 doing the computer searches to identify

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1 patients who required retesting, up to that

2 point, there's sort of an escalation, where I

3 really, at the very beginning, with Dr. Cook

4 and Dr. Carter who were pretty well the main

5 laboratory people involved in this issue with

6 the oncologists, I really don't get drawn

7 into--I think it might be end of June, early

8 July, and I think I was drawn into it at that

9 point because Barry Dyer, who was our

10 pathology manager, who would have been the

11 person dealing with this directly, had just

12 started vacation leave. So because I had a

13 pathology background, that's why I think they

14 came to me to talk about this pathology issue.

15 So I guess, you're going to have to separate

16 out what events you'd like me to talk about

17 first, because there's a lot of events at that

18 -

19 CHAYTOR, Q.C.:

20 Q. Well, why don't you just tell us? Tell us

21 what you were involved in.

22 MR. GULLIVER:

23 A. Well, again, I mean, I got involved in the

24 issue. It was after Dr. Cook and Dr. Carter

25 had confirmed that there was more than one

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1 patient who had--and it was that point
 2 actually that I realized that they had had
 3 several patients retested on our new Ventana
 4 system, where they were originally reported as
 5 negative in 2002 and they retested positive in
 6 2005 on the Ventana system. Up to that point,
 7 like May 17th, I didn't realize that they had
 8 that woman retested in house first.
 9 CHAYTOR, Q.C.:
 10 Q. You thought it had been done elsewhere?
 11 MR. GULLIVER:
 12 A. I thought it had been done outside elsewhere
 13 first.
 14 CHAYTOR, Q.C.:
 15 Q. So then you become aware of a number of
 16 others?
 17 MR. GULLIVER:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And how many others at that point in time?
 21 MR. GULLIVER:
 22 A. I think by that time, there might have been
 23 five or six that they originally did, and then
 24 I knew that Dr. Cook and Dr. Carter, and these
 25 patients were--I think these patients were

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1 given to them by the oncologists and these
 2 patients had to have been--they were in the
 3 year 2002 and to my understanding, Dr. Cook
 4 and Dr. Carter then were reviewing all
 5 negative cases that were reported in 2002 and
 6 were going to have them retested.
 7 CHAYTOR, Q.C.:
 8 Q. And did you understand that--what did you
 9 understand negative meant at that time?
 10 MR. GULLIVER:
 11 A. To me, negative was always zero, zero.
 12 CHAYTOR, Q.C.:
 13 Q. And were you asked to be involved in
 14 identifying any of those patients or pulling
 15 slides, blocks for those patients?
 16 MR. GULLIVER:
 17 A. The original ones, no.
 18 CHAYTOR, Q.C.:
 19 Q. In 2002 bunch?
 20 MR. GULLIVER:
 21 A. No.
 22 CHAYTOR, Q.C.:
 23 Q. And we understand there was, I believe, an
 24 original 57 patients or thereabouts.
 25 MR. GULLIVER:

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1 A. I think there were five first. Then they
 2 added 57 more on doing the big picture for
 3 2002.
 4 CHAYTOR, Q.C.:
 5 Q. Yes, and where did you understand those 57
 6 were tested or retested, I should say?
 7 MR. GULLIVER:
 8 A. To my knowledge, I thought Dr. Carter was
 9 having them sent to Mount Sinai to get them
 10 retested.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So even at that point in time, when you
 13 become involved in this, you thought those
 14 original 2002 cases were all sent away for the
 15 first retest?
 16 MR. GULLIVER:
 17 A. The first five I knew -
 18 CHAYTOR, Q.C.:
 19 Q. Were done in house.
 20 MR. GULLIVER:
 21 A. - were retested in house.
 22 CHAYTOR, Q.C.:
 23 Q. Yes.
 24 MR. GULLIVER:
 25 A. The next 57 were to be sent to Mount Sinai,

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1 because she had contacts with people in Mount
 2 Sinai.
 3 CHAYTOR, Q.C.:
 4 Q. And you weren't aware that they were done in
 5 house?
 6 MR. GULLIVER:
 7 A. At that time, no.
 8 CHAYTOR, Q.C.:
 9 Q. And when did you become aware of that?
 10 MR. GULLIVER:
 11 A. I can't tell you the exact time. It might
 12 have been two months after, three months
 13 after. I'm not really sure.
 14 CHAYTOR, Q.C.:
 15 Q. And so go ahead then, what do you get involved
 16 with? What are you asked to do?
 17 MR. GULLIVER:
 18 A. Well, I guess then, you know, I think by this
 19 time, Dr. Carter and Dr. Cook have been doing
 20 this, dealing with the oncologists and I think
 21 Dr. Cook had been keeping Dr. Williams
 22 informed up to that point, and then it comes
 23 up to our program leadership discussion with
 24 myself, Dr. Cook, Dr. Williams, and I think by
 25 this time, Dr. Cook has indicated that there's

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1 been more--there's been multiple patients
 2 retested and they've retested from negative to
 3 positive, and that could be early July, Ms.
 4 Chaytor. I'm not sure of the exact date time,
 5 because there was--there might have been 75
 6 meetings in the month of July, once this
 7 started.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. Well then, I'll take you through a
 10 couple of them, might help with your memory.
 11 If we could look at P-0492, please? And this
 12 is mid June, June 14th, 2005, and it's a memo
 13 that Dr. Cook sends out to all lab directors,
 14 and -
 15 MR. GULLIVER:
 16 A. And that's not--wouldn't be me.
 17 CHAYTOR, Q.C.:
 18 Q. No, you're not involved in this part. But
 19 were you aware then that this memo was being
 20 sent out across the province?
 21 MR. GULLIVER:
 22 A. I don't think I was made aware at the time,
 23 Ms. Chaytor.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, and you'll see here where Dr. Cook is

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1 asking them to send in--it says "most of these
 2 false negatives have occurred during the year
 3 2002." Had that been communicated to you at
 4 that point, that most of them were thought to
 5 have been -
 6 MR. GULLIVER:
 7 A. I knew the first four or five that they had
 8 done were 2002.
 9 CHAYTOR, Q.C.:
 10 Q. Okay, and "presently, we are in the process of
 11 retesting all negative ERs and PRs for that
 12 particular year." Was there anything
 13 communicated to you that there was a concern
 14 regarding 2002, and if so, why 2002?
 15 MR. GULLIVER:
 16 A. There was no particular concern relayed to me
 17 and I think it was Mr. Dyer who actually told
 18 me that what Don and Bev are doing now,
 19 they're going to go and get all the 2002 cases
 20 retested because the four or five patients the
 21 oncologists identified, including the index
 22 case, that's the year that they were
 23 originally tested in, and I guess Dr. Cook and
 24 Dr. Carter was thinking that if there was
 25 something that had not been picked up, was

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1 there something in particular for the year
 2 2002.
 3 CHAYTOR, Q.C.:
 4 Q. And it says "presently we're in the process of
 5 retesting all negative ERs and PRs for that
 6 particular year" and did you understand that
 7 was negative ERs, as well as negative PRs that
 8 were being tested?
 9 MR. GULLIVER:
 10 A. Well, I hadn't seen the memo. To my
 11 understanding, it was negative ER was the main
 12 one.
 13 CHAYTOR, Q.C.:
 14 Q. So when you get involved and you're asked to
 15 start identifying patients, what criteria did
 16 you understand? What were you asked to look
 17 for?
 18 MR. GULLIVER:
 19 A. Oh, so by the time I'm involved with this, a
 20 lot happens between this time and, as you
 21 know, between--by the end of July, the
 22 multiple, multiple, multiple, multiple
 23 meetings and discussions about this issue.
 24 When I start the process to do the review and
 25 identify patients through computer searches.

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1 By that time we've been instructed that there
 2 was a cutoff point, a clinical cutoff point
 3 versus a technical issue. In the lab side, we
 4 see a negative as being zero, zero, and the
 5 oncologists had informed that, well, how they
 6 practised for the earlier years, they were
 7 using a 30 percent or greater would receive
 8 treatment and then in 2001 it was a ten
 9 percent or greater for ER, you know, for the
 10 hormone receptors, actually, hormone therapy.
 11 And those are the cutoffs that I was
 12 instructed to use.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. So you never used negative ER and
 15 negative PR, you always looked at just the ER
 16 when you were identifying patients?
 17 MR. GULLIVER:
 18 A. Well, ER was the most critical one, yes.
 19 CHAYTOR, Q.C.:
 20 Q. Right. You weren't looking for people who
 21 were negative, negative. You were looking for
 22 anyone negative ER -
 23 MR. GULLIVER:
 24 A. Oh, no, no, no, no, no -
 25 CHAYTOR, Q.C.:

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1 Q. - regardless of PR?
 2 MR. GULLIVER:
 3 A. - negative, negative, number one. Zero, zero
 4 is negative, negative was number one.
 5 CHAYTOR, Q.C.:
 6 Q. Right. But you were looking for anyone who
 7 had a negative ER and negative was later
 8 defined for you in terms of the 30 percent and
 9 then 10 percent cutoff?
 10 MR. GULLIVER:
 11 A. Anything less than -
 12 CHAYTOR, Q.C.:
 13 Q. Regardless of what their PR -
 14 MR. GULLIVER:
 15 A. - 30 or less than 10 -
 16 CHAYTOR, Q.C.:
 17 Q. Regardless of their PR -
 18 MR. GULLIVER:
 19 A. - regardless of the PR.
 20 CHAYTOR, Q.C.:
 21 Q. Okay.
 22 MR. GULLIVER:
 23 A. Yeah.
 24 CHAYTOR, Q.C.:
 25 Q. If we could look at P-2357, please? Okay, so

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1 that's not the right document, 2357.
 2 MR. GULLIVER:
 3 A. This looks like your Ventana protocol or
 4 something, Ms. Chaytor.
 5 CHAYTOR, Q.C.:
 6 Q. Yeah, okay. All right, we'll come back to it.
 7 I was looking for, we have spreadsheets
 8 belonging to you and I'm not sure if they're
 9 somewhere in this. I don't think that's the
 10 right document at all. We'll come back to it.
 11 If we could have P-0497, please? I probably
 12 have my numbers backwards again, it might be
 13 2537. Okay. And this is a meeting then on
 14 July 8th. And this is Dr. Williams' notes.
 15 He says he "met earlier in the day with Dr.
 16 Cook and Mr. Gulliver. On review of this
 17 situation the problem appears to be--appears
 18 not to be confined to a few negatives that
 19 have converted to positives in one batch, but
 20 a larger problem." And were you involved at
 21 all in that, Mr. Gulliver, in determining the
 22 scope of the problem and whether it was
 23 confined to just -
 24 MR. GULLIVER:
 25 A. No, I think by this time, July 8th, I think

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

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1 MR. GULLIVER:
 2 A. Probably. For sure I would tell Dr. Williams
 3 that a part of the protocol for running IHC
 4 testing, in particular, ER/PR, that known
 5 positive controls must be run with every
 6 single time the procedure was run. And I
 7 guess documentation, it all depends on what
 8 your interpretation of documentation is.
 9 CHAYTOR, Q.C.:
 10 Q. Well, what would you have told Dr. Williams?
 11 MR. GULLIVER:
 12 A. I would have told Dr. Williams that the
 13 original slide, control slide should be with
 14 the patient's permanent record; that in most
 15 instances it would be documented in the
 16 computer system that there was a quality
 17 control slide run; and the documentation may
 18 exist in the pathologist's own--in the report
 19 if the pathologist documented I read and
 20 viewed the positive control.
 21 CHAYTOR, Q.C.:
 22 Q. And the control slide being put with the
 23 patient's slide, that would depend how many
 24 controls were run?
 25 MR. GULLIVER:

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1 A. That was only at a certain time period. We're
 2 talking about now over the whole time period.
 3 By and large -
 4 CHAYTOR, Q.C.:
 5 Q. There wasn't a -
 6 MR. GULLIVER:
 7 A. - I'm saying to him--yes.
 8 CHAYTOR, Q.C.:
 9 Q. - control slide for every patient, there
 10 wasn't a -
 11 MR. GULLIVER:
 12 A. At times there was a control slide for every
 13 patient; a times there was a control slide for
 14 every pathologist; at times there was a
 15 control slide just for the batch.
 16 CHAYTOR, Q.C.:
 17 Q. Yeah. And the fact that the runs had
 18 documented--or controls documented, that the
 19 only documentation that would exist on that
 20 would be what?
 21 MR. GULLIVER:
 22 A. Well, depending on the year that we're talking
 23 about. Again, the places where you could find
 24 documentation is, one, here's the control
 25 slide. So if there's the slide, to me that's

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1 documentation the slide, the control slide was
 2 run. If you're looking for further
 3 documentation, there were times when the
 4 pathologists would report in their report and
 5 document I've viewed and read the external
 6 control and it worked fine. In the Meditech
 7 system the technologist who performed the
 8 procedure, they would order an ER/PR and they
 9 would go into another piece of the computer
 10 system and say that they took quality control
 11 slides for immunohistochemistry today.
 12 CHAYTOR, Q.C.:
 13 Q. If we could have, please, P-0501? And this is
 14 another meeting. And I take it you don't have
 15 any independent recollection or anything, and
 16 if at any point you do have any recollection
 17 beyond what's in Dr. William's notes, by all
 18 means, let us know. This is July -
 19 MR. GULLIVER:
 20 A. I will.
 21 CHAYTOR, Q.C.:
 22 Q. Yes. July 12th, 2005. And it's Dr. Cook,
 23 yourself, Ms. Predham and Dr. Williams. And
 24 it's follow-up on the status. "Prior to 2004
 25 semi-automated, semiannual DAKO testing

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1 procedure" is referred to. And there was "A
 2 system of positive controls," it says.
 3 There's been--"October, 2003 the laboratory
 4 medicine program visited Ventana at the
 5 Montreal Jewish Hospital. January, '04 the
 6 Ventana system purchased." And it says, "We
 7 have pulled all cases in September, 2001 to
 8 review findings and retest. There was an
 9 issue of erratic staining in early 2003 and
 10 testing pulled for six weeks. Titration times
 11 and staining times were adjusted. Tests sent
 12 out for six weeks to other labs." And who
 13 would have been the source of that information
 14 in this meeting?
 15 MR. GULLIVER:
 16 A. I think, well, it's a combination. Either
 17 myself or Dr. Cook. And realize, this is July
 18 12th, '05. You know, this is an issue that,
 19 you know, the vice president is asking about
 20 and we're pretty well just giving him basic
 21 information on the history of the test and the
 22 changes in the laboratory over the--during the
 23 time period.
 24 CHAYTOR, Q.C.:
 25 Q. And were the tests sent out for six weeks to

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1 other labs, to your knowledge?
 2 MR. GULLIVER:
 3 A. This is talking about when Dr. Ejeckam stopped
 4 the testing. I don't, I actually don't think
 5 there was ever one sent out during that time
 6 frame. I think there was a hold on them, that
 7 Dr. Ejeckam said to the other regions, "If you
 8 have an urgent case, well, you're better off
 9 sending it out and have it done somewhere
 10 else" until his puts testing back in place. I
 11 think they just came in and they were held
 12 until he was fine to put them back in place
 13 and then did them.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And then it says, "For breast tissue
 16 samples, should be in formalin for 48 to 72
 17 hours. Controls are in formalin for optimal
 18 time." The idea of the breast tissue samples
 19 being in formalin for 48 to 72 hours, would
 20 that come from -
 21 MR. GULLIVER:
 22 A. That would be Dr. Cook, it wouldn't from me.
 23 CHAYTOR, Q.C.:
 24 Q. That would come from Dr. Cook?
 25 MR. GULLIVER:

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

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

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1 would you expect to see that should be
 2 positive versus negative on this procedure.
 3 Again, it's around this time, Ms. Chaytor,
 4 that, you now, I'm trying to explain to Dr.
 5 Williams and other people in the organization
 6 who are non-lab people, it's certainly a
 7 complicated issue for them to get their heads
 8 around. Myself and Dr. Cook would also be
 9 talking to Dr. Williams, telling him that we
 10 know, like, this procedure, this test, even
 11 when it's done perfectly, still has a false
 12 negative rate built into this procedure. So I
 13 guess knowing that, Dr. Cook had made
 14 inquiries asking about overall positivity--
 15 positive, negative rates by year. So that was
 16 -
 17 CHAYTOR, Q.C.:
 18 Q. And were you to then be involved in that?
 19 MR. GULLIVER:
 20 A. - this is the first thing that I was really
 21 started to do.
 22 CHAYTOR, Q.C.:
 23 Q. So that's what you started to do, look at
 24 positivity rates?
 25 MR. GULLIVER:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. And who asked you to do that, was that Dr.
 4 Williams?
 5 MR. GULLIVER:
 6 A. No, well, Dr. Williams, I would assume, yes.
 7 CHAYTOR, Q.C.:
 8 Q. What did it mean, number four, "Check out
 9 procedure versus DAKO standards."
 10 MR. GULLIVER:
 11 A. I think what Dr. Williams was--well, again, I
 12 can't speak for Dr. Williams, but when I'm
 13 reading this here, I think what Dr. Williams
 14 meant was ensure that we were following the
 15 procedure that DAKO had recommended.
 16 CHAYTOR, Q.C.:
 17 Q. And were you asked to go and check on that?
 18 MR. GULLIVER:
 19 A. I don't know if I was asked to go and check on
 20 it, but I do know, I mean, I spoke to Barry,
 21 the technologist and in particular Mary, that
 22 yes, I mean, the DAKO protocols is what we
 23 followed.
 24 CHAYTOR, Q.C.:
 25 Q. These spec sheets you mean, is it?

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

1 MR. GULLIVER:
2 A. Probably, and it might not have asked me
3 directly for this, it might have been
4 information Dr. Williams had received for me
5 over a period of maybe five meetings and two
6 days, I don't know, but certainly I would
7 probably be the main source for this
8 information.
9 CHAYTOR, Q.C.:
10 Q. And had it been determined that positive
11 controls were conducted every day?
12 MR. GULLIVER:
13 A. Well they were run every day. In IHC lab, you
14 run positive controls with your antibodies
15 every single day.
16 CHAYTOR, Q.C.:
17 Q. And what were you able to do to determine that
18 in fact had occurred?
19 MR. GULLIVER:
20 A. Because that's protocol, it's policy, it's
21 procedure, you run controls.
22 CHAYTOR, Q.C.:
23 Q. And what did you have to confirm that the
24 protocol and procedure had been adhered to?
25 MR. GULLIVER:

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

1 A. I guess I had faith in the technologists that
2 they did it and if there was no positive
3 controls gone to the pathologists over all
4 these years, I certainly would have heard
5 about it.
6 CHAYTOR, Q.C.:
7 Q. The results were read and documented daily by
8 pathologists and where would it be documented
9 that -
10 MR. GULLIVER:
11 A. Well that's the pathologists--I mean, how Dr.
12 Williams wrote this, I mean, I can't speak for
13 it. I think what he's saying is that the
14 results were then read by a pathologist and
15 the pathologist would have to document if
16 everything was okay.
17 CHAYTOR, Q.C.:
18 Q. And the process used by the technician being
19 those outlined in the DAKO procedure manual,
20 is there a DAKO procedure manual or is that
21 the spec sheets?
22 MR. GULLIVER:
23 A. Well there's a, the procedure manual, there
24 was a manual with the old instrument really on
25 how to operate the instrument.

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1 CHAYTOR, Q.C.:

2 Q. Yes.

3 MR. GULLIVER:

4 A. But pretty well the procedures are the

5 procedures that were used and the protocols

6 that were put into the DAKO templates, which

7 includes spec sheets, yes.

8 CHAYTOR, Q.C.:

9 Q. If I could have, please, P-0506? And these

10 are Dr. Williams' notes of July 15th, 2005 and

11 it looks like this is your leadership team.

12 It's yourself, Dr. Cook and Dr. Williams and

13 it says "reviewed meeting of July" -

14 MR. GULLIVER:

15 A. I don't think this--this was just still, just

16 separate ER/PR stuff.

17 CHAYTOR, Q.C.:

18 Q. Okay. So in addition to meeting for your

19 regular leadership monthly meetings, you would

20 be having separate meetings for ER/PR?

21 MR. GULLIVER:

22 A. Back in this time we might have met two and

23 three times a day, I can't remember, it was

24 just constant.

25 CHAYTOR, Q.C.:

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1 Q. And it says you reviewed meeting of July 14th,

2 re: "identifying all patients and getting

3 tests done as soon as possible. Plan: pull

4 one to two people to start process and assign

5 Mary to be assigned to cutting and testing

6 only. Dr. Cook is to contact pathologists in

7 other centres. Terry advises that each

8 patient slide was processed along a control

9 slide and the control slides were read and no

10 reporting done until all control read as

11 positive." And is that correct?

12 MR. GULLIVER:

13 A. Well that's what the pathologist was supposed

14 to do. They got the control slides, you know,

15 if the control slide didn't work, well the

16 pathologist is not going to sign the case out,

17 they're going to come back to the lab and say

18 repeat it or is there something going on here?

19 If the pathologist reports the case, one can

20 only assume that they read the positive

21 control and they were fine with it.

22 CHAYTOR, Q.C.:

23 Q. So I just want to be clear then, so you, in

24 advising of that, you would have been telling

25 Dr. Williams this is what is supposed to

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1 happen, that there's supposed to be a patient

2 slide and a control slide.

3 MR. GULLIVER:

4 A. A technical, the positive external control,

5 yes.

6 CHAYTOR, Q.C.:

7 Q. And were they being run, each patient slide

8 being processed along side a control slide and

9 the control slides then being read and no

10 reporting done until the control read is

11 positive. You're telling Dr. Williams that's

12 what's supposed to have happened.

13 MR. GULLIVER:

14 A. Right.

15 CHAYTOR, Q.C.:

16 Q. As opposed to, I can verify to you, Dr.

17 Williams, that in fact is what happened.

18 MR. GULLIVER:

19 A. That's what's supposed to happen and I would

20 hope that is what happened.

21 CHAYTOR, Q.C.:

22 Q. And that's what you were telling Dr. Williams?

23 MR. GULLIVER:

24 A. Yes.

25 CHAYTOR, Q.C.:

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1 Q. And do you recall any discussion, the last

2 bullet here is Dr. Cook to see if Dr. Laing

3 can provide article from Sloan-Kettering on

4 research and the change of ER/PR receptor

5 testing. Do you recall any discussion around

6 that?

7 MR. GULLIVER:

8 A. Not really, I just think Don was wondering,

9 you know, has someone else seen this in other

10 places.

11 CHAYTOR, Q.C.:

12 Q. And if we could have, please, P-0070? And

13 this is July 15th from Deborah Thomas to Susan

14 Bonnell. "Hi Susan, here's today's update

15 from Heather Predham." And there's a number

16 of bullets and your name comes up here.

17 "Terry G. says he has documentation that shows

18 positive controls were done daily (Heather yet

19 to see it)." And, Mr. Gulliver, did you in

20 mid July, 2005 advise that there was

21 documentation showing positive controls were

22 done daily?

23 MR. GULLIVER:

24 A. I don't think I said that directly, the way

25 you're interpreting it. I think I'm saying

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1 through all these meetings that positive
 2 controls were run with IHC testing,
 3 documentation was you had the procedure in the
 4 computer system, you went in and recorded that
 5 you did a QC control. The documentation is
 6 the actual slide is still there physically
 7 looking at you, there's your control slide, we
 8 still have it and another further level of
 9 documentation would be if the pathologist
 10 dictated that in their file or report. I
 11 don't think I ever said to them that oh, here
 12 is all the documentation that you're looking
 13 for for every control slide that was run.
 14 CHAYTOR, Q.C.:
 15 Q. Yes. Mr. Gulliver, did Ms. Predham ever come
 16 to you and ask you what documentation that you
 17 did have to show that positive controls were
 18 done?
 19 MR. GULLIVER:
 20 A. I think so and I think--this is what I just
 21 said to you is what I would have explained to
 22 Heather and relayed to Heather at this time.
 23 CHAYTOR, Q.C.:
 24 Q. And was there ever any suggestion or anything
 25 said to you in terms of any concern about

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1 inadequacy and documentation regarding
 2 controls?
 3 MR. GULLIVER:
 4 A. I certainly think so. I mean and again -
 5 CHAYTOR, Q.C.:
 6 Q. I'm sorry, I just want to be clear I asked
 7 whether or not there was anything indicated to
 8 you as to an inadequacy regarding the
 9 documentation around controls?
 10 MR. GULLIVER:
 11 A. I think from Heather, when these people were
 12 getting involved with the issue outside the
 13 lab, I think Heather probably did make
 14 statements that, from her risk management
 15 position, you know, the document--what she
 16 considers to be documentation is different
 17 than what our documentation was.
 18 CHAYTOR, Q.C.:
 19 Q. So she expressed concerns it wasn't what she
 20 was hoping or anticipating to see.
 21 MR. GULLIVER:
 22 A. I know, I think Heather expected to see a book
 23 that was eight years old where every single
 24 day there was something in there where a
 25 pathologist signed off and said, yeah, here's

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1 the control today, I signed it, read it and
 2 verified it and here's the date, time stamped
 3 and updated. We didn't have that kind of
 4 documentation. I think that's what Heather
 5 was expecting or would like to see.
 6 CHAYTOR, Q.C.:
 7 Q. Or perhaps similar to what Trish Wegrynowski
 8 was expecting to see.
 9 MR. GULLIVER:
 10 A. No, even that would be more than what Trish
 11 would see.
 12 CHAYTOR, Q.C.:
 13 Q. Heather's expectations were even higher,
 14 you're saying?
 15 MR. GULLIVER:
 16 A. Probably because she's used to dealing with
 17 the risk management issues and dealing with
 18 legal counsel and what legally people think
 19 documentation is and what they expect to see.
 20 CHAYTOR, Q.C.:
 21 Q. If we could have, please, P-1930? And this is
 22 an e-mail from Ms. Predham to Dr. Williams,
 23 Dr. Cook and yourself and its subject is
 24 "Update from Mr. Tilley, July 18th, 2005" and
 25 it's the update on the ER/PR document. And

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1 she says, "Hi, here's the update from Mr.
 2 Tilley, please review it and add anything you
 3 feel necessary. I'm not sure who this should
 4 go from, so I left it blank. It didn't
 5 include any information re: Dr. Ejeckam's
 6 memos should we? Thanks. Heather" and
 7 then when you see the document here, it's
 8 similar to the one that I showed you a few
 9 minutes ago. Do you recall receiving this e-
 10 mail Mr. Gulliver?
 11 MR. GULLIVER:
 12 A. I guess so.
 13 THE COMMISSIONER:
 14 Q. It doesn't sound exactly -
 15 MR. GULLIVER:
 16 A. I know, you're asking me something from three
 17 years ago where I -
 18 THE COMMISSIONER:
 19 Q. But the question is do you recall it? You may
 20 not recall it, if you don't -
 21 MR. GULLIVER:
 22 A. I don't recall it like specifically, but I
 23 can't say I didn't get it, you know, because
 24 there's probably been ten thousand e-mails,
 25 but at this particular time there's e-mails of

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

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

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1 letters", I think that should come from Dr.
 2 Williams or Dr. Cook. I mean, they're the
 3 clinical people.
 4 CHAYTOR, Q.C.:
 5 Q. So if we just scroll down the questions she
 6 had asked was--she didn't include the
 7 information re; Dr. Ejeckam's memo, should we,
 8 and her other question was, "I'm not sure who
 9 should this go from, so I left it blank". So
 10 your response, just explain that again because
 11 you responding saying "it looks fine to me",
 12 so I take it you had no trouble with the
 13 content?
 14 MR. GULLIVER:
 15 A. With the wording, the content that was in
 16 there, obviously.
 17 CHAYTOR, Q.C.:
 18 Q. "I would not include Dr. Ejeckam's letter. I
 19 think Dr. Williams or Dr. Cook should send the
 20 memo". So what is it that you're saying?
 21 MR. GULLIVER:
 22 A. I guess I'm saying, "I, Terry Gulliver, don't
 23 feel like I should give Dr. Ejeckam's letters
 24 to George Tilley, that that should come from
 25 Dr. Williams, the Vice President, or Dr. Cook,

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1 the clinical chief".
 2 CHAYTOR, Q.C.:
 3 Q. Because you're saying -
 4 MR. GULLIVER:
 5 A. Because once George gets them, he's going to
 6 want explanations on them.
 7 CHAYTOR, Q.C.:
 8 Q. But this wasn't going--just let me be clear
 9 now because it says, "I would not include Dr.
 10 Ejeckam's letter. I think Dr. Williams or Dr.
 11 Cook should send the memo". What memo are you
 12 referring to?
 13 MR. GULLIVER:
 14 A. I guess this overall memo that Heather has
 15 sent us asking for our opinion on it.
 16 CHAYTOR, Q.C.:
 17 Q. Right. So you're saying that that should go
 18 from Dr. Williams or Dr. Cook, the memo that I
 19 showed you before, that she had left blank,
 20 she didn't know who to send it from, and
 21 you're saying that should go from Dr. Williams
 22 or Dr. Cook, is that correct?
 23 MR. GULLIVER:
 24 A. That's what I'm saying, yeah.
 25 CHAYTOR, Q.C.:

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1 Q. Yes, and that's how I had interpreted it, that
 2 you're answering her question down here where
 3 she says, "I'm not sure who this should go
 4 from, so I left it blank", and if we could
 5 just go back to -
 6 MR. GULLIVER:
 7 A. I know--I guess what you're indicating here is
 8 a couple of things. One -
 9 CHAYTOR, Q.C.:
 10 Q. No, I'm just asking the questions, Mr.
 11 Gulliver.
 12 MR. GULLIVER:
 13 A. I'm saying the memo looks fine to me, however,
 14 I don't think we should let George Tilley know
 15 about Dr. Ejeckam's letter, and that's not
 16 what the intent here is at all. I'm saying
 17 that Dr. Williams and Dr. Cook should send the
 18 memo and inform George Tilley of Dr. Ejeckam's
 19 letter. That's what would be in my mind and
 20 my intent.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. So if we just go back to 1930, please.
 23 This is the memo and you'll see she's drafted
 24 it and she left the "from" blank, and if we
 25 could just go back then again, please, "looks

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1 fine to me", and she's asking the question who
 2 it should go from. So you're saying, yes, it
 3 should go from Dr. Cook--Dr. Williams or Dr.
 4 Cook, the memo, meaning the memo that Heather
 5 has attached that's going to go to Mr. Tilley
 6 to update him on the ER/PR? So we're clear on
 7 that, that's what you're saying?
 8 MR. GULLIVER:
 9 A. That part there, yes, that the memo should go
 10 from Dr. Williams or Dr. Cook.
 11 CHAYTOR, Q.C.:
 12 Q. Yes, okay. Now her other question was, "I
 13 didn't include any information re; Dr.
 14 Ejeckam's memos".
 15 MR. GULLIVER:
 16 A. And I'm assuming she means the ones from 2003.
 17 CHAYTOR, Q.C.:
 18 Q. Yes, well, are you aware of any others?
 19 MR. GULLIVER:
 20 A. No, only ones I ever got.
 21 CHAYTOR, Q.C.:
 22 Q. And then, "looks fine to me". So I take it
 23 you're saying the memo that she's drafted
 24 looks fine, the content is fine. "I would not
 25 include Dr. Ejeckam's letter". So what is it

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1 that you're saying you intended to relay to -
 2 MR. GULLIVER:
 3 A. I just--I know I just said to you that my
 4 mind, my intention would mean that this whole
 5 thing should come from Dr. Williams and Dr.
 6 Cook and Dr. Ejeckam's letter, if they want to
 7 include it. I'm saying I wouldn't include Dr.
 8 Ejeckam's letter for me to give it to George
 9 Tilley. Now you can also see here what my
 10 typing skills are like in responding, they're
 11 all higher case, I mean, and who knows how
 12 many things I'm doing this day. I'm just
 13 saying to you that would be my intention, what
 14 would be in my mind at that time, and I can't
 15 explain it any clear.
 16 THE COMMISSIONER:
 17 Q. Okay, let me try. You are saying that your
 18 intention when you're sending this was to say
 19 that Dr. Ejeckam's letter should be conveyed
 20 to Mr. Tilley, but you were not the
 21 appropriate person to do it?
 22 MR. GULLIVER:
 23 A. Pretty well, yes.
 24 THE COMMISSIONER:
 25 Q. And you think that's--and you think that's

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1 what Ms. Predham would have understood that to
 2 mean?
 3 MR. GULLIVER:
 4 A. I don't know. Did she ever reply back and
 5 say, like, anything or clarification or -
 6 CHAYTOR, Q.C.:
 7 Q. On P-0300, she says that she's incorporated
 8 the changes and that it's going to go from Dr.
 9 Williams, and there's no reference to Dr.
 10 Ejeckam in what goes to Mr. Tilley.
 11 MR. GULLIVER:
 12 A. And I don't know what finally went to Mr.
 13 Tilley.
 14 CHAYTOR, Q.C.:
 15 Q. You don't?
 16 MR. GULLIVER:
 17 A. I don't think so. I don't know.
 18 CHAYTOR, Q.C.:
 19 Q. This was sent to you here, P-0300, the update
 20 on ER/PR.
 21 MR. GULLIVER:
 22 A. I know the update went to Mr. Tilley, but I
 23 don't know if they sent Mr. Tilley the copies
 24 of those three memos.
 25 CHAYTOR, Q.C.:

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1 Q. So you know that the memo that's being
 2 discussed here did go to Mr. Tilley and it
 3 didn't have any reference to Dr. Ejeckam in
 4 the update?
 5 MR. GULLIVER:
 6 A. I don't.
 7 CHAYTOR, Q.C.:
 8 Q. You don't know that?
 9 MR. GULLIVER:
 10 A. No.
 11 CHAYTOR, Q.C.:
 12 Q. So this e-mail then that goes out to you, or
 13 goes from Heather to Dr. Williams indicating
 14 she's heard back from Dr. Cook and Terry
 15 Gulliver re; the letter, and the changes have
 16 been made, "Both agree it should come from
 17 you", to Dr. Williams, and it goes to Dr.
 18 Williams, anyhow, and what's attached here
 19 would not have reference to Dr. Ejeckam in it.
 20 So if at the end of the day it got further
 21 changed and reference to Dr. Ejeckam got put
 22 in the memo or otherwise sent along, you're
 23 not aware of that?
 24 MR. GULLIVER:
 25 A. I don't think at the time I was. I don't

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1 know.
 2 CHAYTOR, Q.C.:
 3 Q. Okay.
 4 MR. GULLIVER:
 5 A. You know, I wasn't involved--I didn't draft
 6 the thing. If I was drafting it, I probably
 7 would have paid much more attention to it.
 8 This is something Heather is saying, okay,
 9 does this look like a summary to go to George
 10 Tilley. I probably skimmed through it and
 11 said, yeah, looks fine to me.
 12 CHAYTOR, Q.C.:
 13 Q. Except she asked a couple of specific
 14 questions and I just want to be clear on what
 15 your response was. If we could go back to
 16 2950.
 17 MR. GULLIVER:
 18 A. I know, and I typed that back, and I'm saying
 19 irregardless how I typed it here, my intention
 20 was as I explained to you earlier.
 21 CHAYTOR, Q.C.:
 22 Q. Right.
 23 MR. GULLIVER:
 24 A. That if Dr. Williams or Dr. Cook should bring
 25 those memos to Mr. Tilley, it should be their

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1 decision.
 2 CHAYTOR, Q.C.:
 3 Q. And that's what you intended to convey to Ms.
 4 Predham?
 5 MR. GULLIVER:
 6 A. Yeah.
 7 CHAYTOR, Q.C.:
 8 Q. And why wouldn't--I mean, one of those
 9 letters, certainly the one you would be most
 10 acutely aware of, is the one addressed to you,
 11 June 19th, 2003. So why wouldn't it be
 12 appropriate -
 13 MR. GULLIVER:
 14 A. It's copied to Dr. Cook also.
 15 CHAYTOR, Q.C.:
 16 Q. But it was addressed -
 17 MR. GULLIVER:
 18 A. And the two prior, I didn't get copies of
 19 them.
 20 CHAYTOR, Q.C.:
 21 Q. So you had the June 19th, 2003, was actually
 22 addressed to you. So why wouldn't that be
 23 appropriate? Why would you be concerned that
 24 that not go from you when it's your letter?
 25 You're the one who, I would take it, would

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

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1 actively involved in. I think this is more
 2 FYI type of thing.
 3 CHAYTOR, Q.C.:
 4 Q. So you weren't involved in any discussions in
 5 terms of notification to the department, and
 6 you're not aware who notified the department
 7 as of July 18th?
 8 MR. GULLIVER:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. This is a good place, please, Commissioner.
 12 THE COMMISSIONER:
 13 Q. Take the afternoon break.
 14 (BREAK)
 15 THE COMMISSIONER:
 16 Q. Ms. Chaytor.
 17 CHAYTOR, Q.C.:
 18 Q. Thank you, Commissioner.
 19 THE COMMISSIONER:
 20 Q. Oh, I guess we should announce for the benefit
 21 of those who maybe want to change their plans
 22 for the evening that while we had anticipated
 23 that we would be sitting in the evening today,
 24 that plan has been changed and we'll be ending
 25 around five.

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1 CHAYTOR, Q.C.:
 2 Q. Thank you. If we could have, please, P-516.
 3 This is a meeting, July 21st, 2005, and again
 4 it involves yourself and Drs. Cook and
 5 Williams. It says, number one, "Agreed to get
 6 Dr. Carter's information she needs. Number
 7 two, Dr. Carter to do only this service. Mary
 8 Butler to report and take direction from Dr.
 9 Carter. Will arrange someone from QA to be
 10 assigned. We have proficiency testing and
 11 microhematology and biochemistry need to have
 12 proficiency testing and QA program for immuno
 13 pathology. Immunohistochemistry in separate
 14 space while awaiting final space. Dedicated
 15 techs to immunohistochemistry, don't have
 16 enough work for three techs, but need three
 17 people for holidays, sick leave, etc, and then
 18 when Barry Dyer and Dr. Ejeckam return, they
 19 will work with Dr. Cook and Mr. Gulliver to
 20 deliver QA and proficiency testing program".
 21 Mr. Gulliver, in terms of the reference here
 22 to the immunohistochemistry in separate space
 23 while awaiting final space and the dedicated
 24 techs to do the work, this is now July 21st,
 25 2005. At that point in time, wasn't the

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1 immunohistochemistry already in its own space,
 2 hadn't that happened the end of December '03?
 3 MR. GULLIVER:
 4 A. Mr. Dyer--we physically moved them, but what
 5 I'm alluding to here was the file space was to
 6 actually have the space upgraded to today's
 7 standards, like new benches and work benches
 8 for the whole pathology lab that had been
 9 promised back as far as 1998.
 10 CHAYTOR, Q.C.:
 11 Q. I'm sorry. So you were moved into your
 12 separate space?
 13 MR. GULLIVER:
 14 A. In the lab you've seen -
 15 CHAYTOR, Q.C.:
 16 Q. Yes.
 17 MR. GULLIVER:
 18 A. - I mean, they'd been there.
 19 CHAYTOR, Q.C.:
 20 Q. Since December, 2003, or thereabouts?
 21 MR. GULLIVER:
 22 A. Right, but within that lab, even though they
 23 were in their own space, we had still expected
 24 facilities management to put in new bench work
 25 and upgrade the space like 2005, and not still

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1 operating in a facility that was built in
 2 1978.
 3 CHAYTOR, Q.C.:
 4 Q. What does it mean, "while awaiting final
 5 space"? Was it anticipated that the lab would
 6 be moved again?
 7 MR. GULLIVER:
 8 A. No, no, no, I just think that's Dr. Williams
 9 notes of the way or wrote it.
 10 CHAYTOR, Q.C.:
 11 Q. And the dedicated techs to
 12 immunohistochemistry, don't have enough work
 13 for three techs, weren't they already, as you
 14 said earlier, dedicated?
 15 MR. GULLIVER:
 16 A. Yes. Again, I think, this is probably Dr.
 17 Williams early on trying to get a grasp on the
 18 issue and just getting background information.
 19 I was probably saying at the time we have
 20 three techs who are trained for
 21 immunohistochemistry, they used to rotate to
 22 the gross bench, but they are now dedicated
 23 techs for IHC.
 24 CHAYTOR, Q.C.:
 25 Q. And perhaps was it because they were also

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1 rotating, was this perhaps trying not to have
 2 them rotate through, is that -
 3 MR. GULLIVER:
 4 A. I don't think at this time they were rotating
 5 anywhere else. They were just doing the
 6 immunohistochemistry work for the lab.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, and if we could have then, please, P-
 9 0520. Actually, I think it's P-3091 first.
 10 Sorry, 3092, and this e-mail originates with
 11 Ms. Predham, I believe, or perhaps with Ms.
 12 Bonnell. Yes, Ms. Predham, here we go, July
 13 19th, 2005, and she sends this to yourself
 14 along with others, including Drs. Williams and
 15 Dr. Cook, "I had a long conversation with
 16 representatives from HIROC yesterday evening.
 17 As a bit of background, they are currently
 18 defending a class action lawsuit against
 19 Health Labrador", and it goes on from there,
 20 "and the organization felt the need to
 21 disclose publicly, ran it by their legal
 22 counsel, and then wrote letters to every
 23 person affected and send out a news release.
 24 Sound familiar. Their vulnerability comes
 25 from of lack of weighing out the risk from the

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1 exposure versus the anxiety of being told
 2 about it", and she goes on, "This leads us to
 3 our situation. It's not that they don't want
 4 us to disclose, they just don't want us to
 5 disclose until we are sure of our facts. I've
 6 had a quick voice mail from Dan after my chat
 7 with HIROC. They contacted him after they
 8 hung up from me reiterating this, and they
 9 will be in touch again in the morning. So I
 10 guess we will have to reevaluate where we are
 11 before we plan to send those letters, etc.
 12 Should we chat about this face to face", and
 13 then Ms. Bonnell gets back to her, and you
 14 respond as well saying that, "Your calendar is
 15 free all day". This is July 19th, 2005, and
 16 do you recall did you then attend a meeting in
 17 which this subject was discussed?
 18 MR. GULLIVER:
 19 A. I do remember attending a meeting where it was
 20 discussed about disclosure and contacting
 21 patients, and I know I was at a meeting where
 22 Dan Boone was in attendance because that was
 23 the first time I had ever met Dan Boone. I
 24 don't know if it was this day, or which exact
 25 day it was, Ms. Chaytor.

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1 CHAYTOR, Q.C.:
 2 Q. Okay, and what -
 3 MR. GULLIVER:
 4 A. I was at meetings where we talked about
 5 patient disclosure. I'm not saying that I
 6 actively, you know, was involved in that
 7 discussion or the decision making piece of it.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, and if we could look then, please, at
 10 521. and this is a meeting of the same date
 11 which does include Dan Boone and yourself,
 12 along with Ms. Predham, and it's July 19th,
 13 2005. So what do you--this is the first time,
 14 you say, you would have met Mr. Boone?
 15 MR. GULLIVER:
 16 A. I think it was the first time I ever met Dan
 17 Boone, yes.
 18 CHAYTOR, Q.C.:
 19 Q. And this meeting then, do you recall the issue
 20 of notification of patients or possible public
 21 disclosure, those things being discussed?
 22 MR. GULLIVER:
 23 A. I think so because it was, I guess, the
 24 background--I think by this time I certainly
 25 would assume that Dr. Williams, Dr. Cook,

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1 myself, and Heather, and communications
 2 people, would have a fair idea of what the
 3 background was, like, numbers of patients
 4 we're talking about, average tests per year,
 5 question mark, the 2002 results. So I think
 6 we're probably giving this to Dan Boone
 7 because this is probably his first time
 8 meeting with us and asking about this.
 9 CHAYTOR, Q.C.:
 10 Q. And what do you recall--what else do you
 11 recall being discussed at that meeting?
 12 MR. GULLIVER:
 13 A. I'm assuming this is the meeting where if
 14 Susan is there, Bonnell, who was our
 15 Communications Director, and Deborah Thomas
 16 from Communications, I'm assuming we're
 17 talking about communicating to the public and
 18 to the patients.
 19 CHAYTOR, Q.C.:
 20 Q. And what do you recall being discussed about
 21 that?
 22 MR. GULLIVER:
 23 A. I--you know, I don't know if it's this exact
 24 meeting, Ms. Chaytor.
 25 CHAYTOR, Q.C.:

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1 Q. Perhaps you can just tell us what you recall
 2 being discussed?
 3 MR. GULLIVER:
 4 A. Well, I recall--probably various meetings, not
 5 just this one.
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 MR. GULLIVER:
 9 A. There was other meetings with more people than
 10 this there.
 11 CHAYTOR, Q.C.:
 12 Q. Yes.
 13 MR. GULLIVER:
 14 A. We had a meeting later on with the--it's a
 15 broader group where it includes--the
 16 oncologists are there, and other pathologists
 17 are there.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, and I think that comes a little bit
 20 later.
 21 MR. GULLIVER:
 22 A. Yeah.
 23 CHAYTOR, Q.C.:
 24 Q. And I'll ask you about that.
 25 MR. GULLIVER:

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

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

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1 advocates who wanted immediately to go public
 2 and make some kind of statement.
 3 CHAYTOR, Q.C.:
 4 Q. And who was saying anything other than that?
 5 MR. GULLIVER:
 6 A. Well, I think it kind of evolved over the next
 7 week or two. As more and more information was
 8 being gathered, you know, about the hormone
 9 receptor testing, and the treatment of, and, I
 10 think you've heard it here already that by the
 11 time the organization is ready to make a
 12 decision on public communications, by that
 13 time I know I was at meetings where the
 14 oncologists--the oncologists were never
 15 concerned about disclosing to the public. The
 16 oncologists were concerned about not having
 17 enough information to go to their patients,
 18 and they were concerned about people who had
 19 this test performed who would not be affected
 20 by a retesting or outcomes, that it was going
 21 to actually put undue stress on those, the
 22 patients who would not be affected by this.
 23 CHAYTOR, Q.C.:
 24 Q. And -
 25 MR. GULLIVER:

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1 A. So, I mean, I just know, I mean, and I'm not a
 2 communications person, but I do know in
 3 hearing the discussions that, boy, it would be
 4 very hard to decide to do one without another.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, and so in terms of, though, making any
 7 kind of statement to the public and if that
 8 were to happen, then a lot of different
 9 patients out there would hear about that.
 10 Weren't the oncologists concerned about that?
 11 MR. GULLIVER:
 12 A. Yes, that was their -
 13 CHAYTOR, Q.C.:
 14 Q. Yes, they were concerned.
 15 MR. GULLIVER:
 16 A. That was a part of their concern.
 17 CHAYTOR, Q.C.:
 18 Q. And what else did you hear, was there anything
 19 else, any other factors or any other reasons
 20 of concern articulated by the oncologists?
 21 MR. GULLIVER:
 22 A. Again, it's, you know, they wanted to have
 23 more information that they felt like, you
 24 know, if I'm going to call up one of my
 25 patients and say, "Listen, you know, we're not

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1 sure about your original hormone receptor
 2 testing. We're going to have it retested. I
 3 can't tell you how long it's going to take to
 4 get retested. You have to wait for me to call
 5 back; it could be a week, four weeks, six
 6 weeks." At this time early on Mount Sinai had
 7 said they may have our retesting done in six
 8 weeks, and we know that just didn't happen.
 9 Again, I just think it was the uncertainty
 10 around the whole thing.
 11 CHAYTOR, Q.C.:
 12 Q. And did you hear any concern articulated as to
 13 the number of phone calls that the oncologists
 14 would receive if there were to be any kind of
 15 public announcement?
 16 MR. GULLIVER:
 17 A. Well, certainly. I mean, once the discussion
 18 was ongoing, I mean, that was a part of the
 19 discussion is that, you know, how many
 20 patients are going to call and, you know, want
 21 to speak to them directly and knowing--not
 22 knowing what they would tell the patients.
 23 CHAYTOR, Q.C.:
 24 Q. And did you hear any issue discussed as to any
 25 concerns regarding whether they would--whether

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1 the timing of notification to patients or the
 2 manner of notification to patients could
 3 impact insurance coverage?
 4 MR. GULLIVER:
 5 A. Not at all, no.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. If we could have, please, P-0521? Oh,
 8 this is 0521, sorry. Yes, so that was the
 9 meeting on the 19th. And there's nothing else
 10 sticks out in your mind as to what happened at
 11 that meeting, is that right?
 12 MR. GULLIVER:
 13 A. No, no.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. Looks like then on July 20th you also
 16 attend a meeting with Mr. Tilley this time,
 17 Doctors Williams and Cook and Ms. Predham and
 18 Ms. Thomas. And take you down through these
 19 bullets and then down at the bottom "Technical
 20 consultant from Mount Sinai coming in on
 21 September 12th, 2005." So I take it that's
 22 Trish Wegrynowski?
 23 MR. GULLIVER:
 24 A. Yeah.
 25 CHAYTOR, Q.C.:

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1 Q. So by July 20th that had been set up. And "No
 2 issues brought up at tumour board rounds." Do
 3 you know what that was in relation to?
 4 MR. GULLIVER:
 5 A. No. I'm thinking, I'm thinking George Tilley
 6 asked, you know, "Is there tumour board rounds
 7 and was this issue ever raised before amongst
 8 the pathologists, oncologists and those kinds
 9 of clinical groups?"
 10 CHAYTOR, Q.C.:
 11 Q. Okay. And P-0514, please? And, Mr. Gulliver,
 12 this is dated July 20th, 2005. It's for you,
 13 from you. And its subject is "Review of ER/PR
 14 Stats from 2000 to 2004, 2005." Perhaps you
 15 could tell us what this document is?
 16 MR. GULLIVER:
 17 A. Well, this is again at this point in time,
 18 remember we had seen a meeting maybe a the
 19 week before, it was trying to look at overall
 20 in our laboratory the numbers of tests we did
 21 a year and trying to ascertain, you know, how
 22 many do we have, how many positives and how
 23 many negatives do we have in our laboratory.
 24 And this was the very beginnings of starting
 25 that process. And, I mean, along the way you

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1 may see another 20 updates.
 2 CHAYTOR, Q.C.:
 3 Q. Of this document?
 4 MR. GULLIVER:
 5 A. Or similar documents where I'm adding years.
 6 I think after this one I went back then to do
 7 '97, '98, '99 as they were much more difficult
 8 to do in trying to access three different
 9 computer systems which you've heard, the
 10 Grace, you know, St. Clare's and the General.
 11 CHAYTOR, Q.C.:
 12 Q. Okay so this is the exercise of -
 13 MR. GULLIVER:
 14 A. But this beginnings of that.
 15 CHAYTOR, Q.C.:
 16 Q. - trying to show the positivity rates -
 17 MR. GULLIVER:
 18 A. Right.
 19 CHAYTOR, Q.C.:
 20 Q. - through the various years?
 21 MR. GULLIVER:
 22 A. Yeah.
 23 CHAYTOR, Q.C.:
 24 Q. And did this just include the primary breast
 25 cancer patients?

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1 MR. GULLIVER:
 2 A. I can't--I have to say no.
 3 CHAYTOR, Q.C.:
 4 Q. Okay.
 5 MR. GULLIVER:
 6 A. My intention, when this was being done--and
 7 this wasn't just me, I had other staff help
 8 me.
 9 CHAYTOR, Q.C.:
 10 Q. Yes.
 11 MR. GULLIVER:
 12 A. This meant going in--to get to this one simple
 13 page took hours and hours and days and days
 14 and days because if you look at, take the year
 15 2000, when I searched the Meditech system
 16 looking for the ER/PR procedures that were
 17 performed in our lab, it meant printing up
 18 hard copies of the patient's report; it meant
 19 then physically reading the reports to see
 20 what the pathologist's interpretation was, if
 21 they simply called it positive/negative, if
 22 they simply--or if they said a percentage; and
 23 then tabulating from those hard copies what
 24 the positive and negative rates were. At the
 25 time I tried to remove the non-breast

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1 primaries because you do ER/PR testing
 2 sometimes for metastatic disease to the liver
 3 or lung or other parts of the body. Those
 4 were taken out. But I do know upon further
 5 review, when we did the NLCHI stuff and
 6 reviewed all this again and reread every
 7 report again to verify, these numbers changed,
 8 they do change a little bit, not
 9 significantly, there were some years where
 10 there might have been some specimens that were
 11 left in that should have been taken out.
 12 CHAYTOR, Q.C.:
 13 Q. Yes. Now, Mr. Gulliver, you said originally
 14 Dr. Williams had asked you to undertake this?
 15 MR. GULLIVER:
 16 A. Yeah.
 17 CHAYTOR, Q.C.:
 18 Q. And did you tell him it's taking hours and
 19 hours and days and days to get this
 20 information together?
 21 MR. GULLIVER:
 22 A. Oh, I think, I think he knew that. And at
 23 this time my pathology manager, Barry Dyer,
 24 was on vacation, so I'm pretty well, I think,
 25 doing most of this reading myself. And then

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1 myself and Barry, Mary Butler, actually, Mary
 2 actually helped me with some of these, too, at
 3 some point in time. I think might have been
 4 2000 that Mary did. But Dr. Williams was
 5 aware that it's time consuming.
 6 CHAYTOR, Q.C.:
 7 Q. Yes. And in doing this, I take it, this had
 8 nothing to do with the actual getting the
 9 patients retested? This is -
 10 MR. GULLIVER:
 11 A. At this point in time, no.
 12 CHAYTOR, Q.C.:
 13 Q. That's not what this was about. This is -
 14 MR. GULLIVER:
 15 A. The first -
 16 CHAYTOR, Q.C.:
 17 Q. - to check your positivity rate?
 18 MR. GULLIVER:
 19 A. Right. This is the first exercise to start
 20 identifying patients who had ER/PR testing
 21 done and this was the first go through looking
 22 at the positive and negatives. And then the
 23 next exercise was Dr. Carter was going to
 24 review all the patient reports and her role
 25 was going to be to identify patients who

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1 should be retested and she was going to have
 2 them retested and then correlate that results
 3 with the oncologists.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. So up to this point in time you weren't
 6 involved in that, that's something you take on
 7 in terms of the patient identification -
 8 MR. GULLIVER:
 9 A. That happens maybe a week or two after this.
 10 CHAYTOR, Q.C.:
 11 Q. After this, after you've got this piece done?
 12 MR. GULLIVER:
 13 A. Yeah. And again, I have to emphasize, you
 14 know, this is not--this was not scientific
 15 methodology that was used; this was simply at
 16 home in the nighttime, lots of times, just
 17 reading and writing numbers up and adding up
 18 and doing that kind of thing.
 19 CHAYTOR, Q.C.:
 20 Q. And did you tell that to--so I take it you had
 21 some concerns that, you know, these are
 22 basically just some rough numbers and -
 23 MR. GULLIVER:
 24 A. Exactly. And this, we're looking at--and
 25 really, that's what we're looking at, sort of

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1 a rough idea.
 2 CHAYTOR, Q.C.:
 3 Q. Yes. And not anything, you know, not anything
 4 to put any great reliance on in terms of your
 5 positivity rate?
 6 MR. GULLIVER:
 7 A. I wouldn't say not great reliance on, but at
 8 least it gave us a snapshot or an indicator.
 9 That no one had ever looked on a year-by-year
 10 from our laboratory what the positives and
 11 negatives were that were coming from the lab.
 12 CHAYTOR, Q.C.:
 13 Q. And that wasn't being tracked at the time?
 14 MR. GULLIVER:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. Is that tracked now, Mr. Gulliver, your
 18 positivity rates?
 19 MR. GULLIVER:
 20 A. I really can't tell you for sure. I thought
 21 Dr. Carter before she left was tracking that
 22 and I think Dr. Elms may be. I mean, that's
 23 now a subspecialty breast group who are
 24 reviewing that and that really would be
 25 something that they would be doing as the

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1 pathologists.
 2 CHAYTOR, Q.C.:
 3 Q. And here we see, for example, in 2004, '05 it
 4 indicates a 90 percent positivity rate. Has
 5 that subsequently been checked and -
 6 MR. GULLIVER:
 7 A. That's been changed, yes.
 8 CHAYTOR, Q.C.:
 9 Q. Yes.
 10 MR. GULLIVER:
 11 A. But see the '04, '05, those '04, '05s, sorry,
 12 Ms. Chaytor, it's a long day, they were--
 13 that's the Ventana ones.
 14 CHAYTOR, Q.C.:
 15 Q. Yes. And they were subsequently changed then.
 16 Do you know how it came about that that number
 17 was changed?
 18 MR. GULLIVER:
 19 A. I know I reviewed--and you see, the, I guess
 20 most--at this point in time most of the focus
 21 was on the ER/PRs that were done in 2002 and
 22 then broadened to really look at the DAKO
 23 system. Because we had gotten good positive
 24 feedback from, you know, from April, '04 to,
 25 at this point, July, '05, we had gotten good

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1 feedback from the pathologists in the Ventana
 2 system and the quality of slides from there.
 3 We had also, by this time, from Ventana, had
 4 retested some of the 2002s on our internal
 5 system and had gotten positive results. So it
 6 really wasn't at this point questioning the
 7 validity of Ventana. So -
 8 THE COMMISSIONER:
 9 Q. I think the question, Mr. Gulliver, was
 10 directed towards what--as I understood it, the
 11 90 percent change subsequently.
 12 MR. GULLIVER:
 13 A. Yeah, I guess my--I guess my point is -
 14 THE COMMISSIONER:
 15 Q. The question was how did it change.
 16 MR. GULLIVER:
 17 A. At this point in time we just did the raw
 18 numbers for Ventana and never focused as much--
 19 -paid much attention to it. Later on I reread
 20 every single report from Ventana and I had not
 21 removed the non-breast primary specimens like
 22 the livers and the brains that were done
 23 looking for metastatic disease. And then once
 24 I pulled those out, we had a--it changed, I
 25 think, down to 82 percent, maybe 82, 18 -

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1 CHAYTOR, Q.C.:

2 Q. And do you know whether Dr. Gown was involved

3 in pointing that out in terms of -

4 MR. GULLIVER:

5 A. Oh, well, I don't think Dr. Gown was pointed

6 it out. When he was in, there was some issue

7 about are we getting too many positives off

8 the Ventana. He just seemed -

9 THE COMMISSIONER:

10 Q. Mr. Simmons, do you want to stand on your feet

11 at this point?

12 MR. SIMMONS:

13 Q. I was just going to say, anything to do with

14 information passed on from Mr. Gown -

15 THE COMMISSIONER:

16 Q. From Mr. Gown.

17 MR. SIMMONS:

18 Q. - is -

19 THE COMMISSIONER:

20 Q. Considered privileged.

21 MR. SIMMONS:

22 Q. Perhaps, I mean, you know, perhaps I guess the

23 question might be did it arise out of some

24 interaction with Dr. Gown that (inaudible) go

25 back and look at those (inaudible).

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1 THE COMMISSIONER:

2 Q. You do not tell us what Dr. Gown may have said

3 because his -

4 MR. GULLIVER:

5 A. Okay, I didn't realize that.

6 CHAYTOR, Q.C.:

7 Q. Yes.

8 THE COMMISSIONER:

9 Q. - particular consult is regarded as -

10 CHAYTOR, Q.C.:

11 Q. We could look at -

12 THE COMMISSIONER:

13 Q. - being under privilege.

14 CHAYTOR, Q.C.:

15 Q. P-1135, please? And this is some time later

16 then, June of 2006, Dr. Williams to yourself.

17 "As per your request, in light of the remarks

18 from Dr. Gown regarding our 2004, '05 Ventana

19 ER/PR rates, I've reread each report and have

20 identified the total number of positives

21 previously reported and also included

22 specimens that were ER/PR positive that were

23 not breast specimens." So it appears that

24 something that Dr. Gown said then caused the

25 changes or to look at the 2004 Ventana ER/PR

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1 rates?

2 MR. GULLIVER:

3 A. That's correct.

4 CHAYTOR, Q.C.:

5 Q. That's correct.

6 THE COMMISSIONER:

7 Q. So, in looking at the earlier exhibit then for

8 2004, 2005 I should substitute these new

9 results?

10 MR. GULLIVER:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. Yes.

14 THE COMMISSIONER:

15 Q. Thank you.

16 CHAYTOR, Q.C.:

17 Q. What about the results for the first three

18 months of 2004?

19 MR. GULLIVER:

20 A. They should be--do you have them on another -

21 CHAYTOR, Q.C.:

22 Q. We can go back to the other exhibit.

23 MR. GULLIVER:

24 A. For January, February, March, the last three

25 months of DAKO?

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1 CHAYTOR, Q.C.:

2 Q. So they are all lumped in here, is that right,

3 in this--is this where they are?

4 MR. GULLIVER:

5 A. No, no.

6 CHAYTOR, Q.C.:

7 Q. No?

8 MR. GULLIVER:

9 A. No, I don't--no, at this point in time they

10 weren't.

11 CHAYTOR, Q.C.:

12 Q. No?

13 MR. GULLIVER:

14 A. Again, this is the beginnings of it.

15 CHAYTOR, Q.C.:

16 Q. Yes.

17 MR. GULLIVER:

18 A. This certainly grows and adds to it. I

19 probably at this point in time, July 20th, had

20 these years fully reviewed and then I did the

21 January, February, March of '04 as a separate

22 group for DAKO. And then I did '97, '98, '99.

23 CHAYTOR, Q.C.:

24 Q. Okay. The adjustment that was made at some

25 comment from Dr. Gown and this number 90 comes

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1 down, insofar as that included other than
 2 primary breast cases, do you know whether or
 3 not further adjustments were made in your
 4 other years to allow for whether or not -
 5 MR. GULLIVER:
 6 A. Yes, there was.
 7 CHAYTOR, Q.C.:
 8 Q. There were adjustments?
 9 MR. GULLIVER:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. So all of these numbers came down eventually?
 13 MR. GULLIVER:
 14 A. I don't think all of them did, no.
 15 CHAYTOR, Q.C.:
 16 Q. But -
 17 MR. GULLIVER:
 18 A. I think, I think what you see here, 2000 may
 19 have come down a little bit afterwards. And
 20 maybe '98. But you'll probably see it some
 21 other point, exhibits we've given you, so that
 22 the final, the final statistics for this kind
 23 of review, and was after refining and
 24 updating, refining and updating.
 25 CHAYTOR, Q.C.:

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1 Q. And what purpose did you think that Dr.
 2 Williams was going to use this information?
 3 MR. GULLIVER:
 4 A. I thought just so we can get an idea in the
 5 lab what our--and Dr. Cook, what our positive-
 6 -total positives and negatives were.
 7 CHAYTOR, Q.C.:
 8 Q. And did you realize the information would be
 9 included in the briefing note to the Minister?
 10 MR. GULLIVER:
 11 A. No, no, I didn't.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, and if we could look, please, at P-0075?
 14 And on page two of this document, you'll see
 15 July 20th, "upon review of the statistical
 16 data, it" I think that should be, "has been
 17 concluded that the positivity rates are, while
 18 on the low end of the scale, within acceptable
 19 range" and then total positivity numbers and
 20 it goes on from there and you'll see those
 21 numbers, including the 90 percent. So you
 22 didn't realize that this was going to be
 23 forward?
 24 MR. GULLIVER:
 25 A. I was just asked by Dr. Williams. What he was

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1 going to do with it would be his, you know,
 2 his decision.
 3 CHAYTOR, Q.C.:
 4 Q. And then as time went on -
 5 MR. GULLIVER:
 6 A. But I have to say, even for myself and for our
 7 lab, you know, it was also a good exercise to
 8 be able to see, you know, really--Dr. Cook had
 9 said that he had made some phone calls and
 10 some people said that you should get around a
 11 75 percent, 25 percent ratio. Other people
 12 said it could be like 65 percent. So at least
 13 we could see where do we fall in as a trend
 14 type of thing.
 15 CHAYTOR, Q.C.:
 16 Q. Yes, and when the testing resumed in February
 17 2007, you're not sure if anybody tracked the
 18 positivity rates then over the next year or so
 19 that the tests were done here in St. John's?
 20 MR. GULLIVER:
 21 A. I'm not 100 percent sure if Dr. Carter or Dr.
 22 Cook was doing that, or Dr. Elms.
 23 CHAYTOR, Q.C.:
 24 Q. And this exercise of tracking the positivity
 25 rates or going back over the tests, you

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1 continued to do that for a period of time, I
 2 take it?
 3 MR. GULLIVER:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. And we see updated versions from time to time.
 7 For example, if we look at P-0522, it's just a
 8 few days later. There's another document
 9 here.
 10 MR. GULLIVER:
 11 A. That's Sunday, so another three or four nights
 12 doing it and now added 99 to it, and -
 13 CHAYTOR, Q.C.:
 14 Q. '99 was added, yes.
 15 MR. GULLIVER:
 16 A. - I still don't see the -
 17 CHAYTOR, Q.C.:
 18 Q. No, the '04, beginning of '04.
 19 MR. GULLIVER:
 20 A. No, three months, January, February, March.
 21 CHAYTOR, Q.C.:
 22 Q. Do you see that here?
 23 MR. GULLIVER:
 24 A. I thought I had them in there, Ms. Chaytor, as
 25 a separate three months.

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1 CHAYTOR, Q.C.:

2 Q. Okay, well, we'll -

3 MR. GULLIVER:

4 A. I don't think I added them to the 2003's.

5 THE COMMISSIONER:

6 Q. On the side (inaudible) there's 2004 with

7 numbers. Is that it?

8 CHAYTOR, Q.C.:

9 Q. Right over here.

10 MR. GULLIVER:

11 A. That's not my writing.

12 THE COMMISSIONER:

13 Q. Oh, okay.

14 CHAYTOR, Q.C.:

15 Q. That looks like Dr. Cook's, I believe, okay,

16 and perhaps it is somewhere. We can certainly

17 check, but you basically went through this

18 exercise throughout then 2005 and 2006 and you

19 were updating this from time to time?

20 MR. GULLIVER:

21 A. Most of the work was done in the first, you

22 know, in the first few weeks of this here.

23 The refinement came, you know, at a later

24 date, and I guess, the final review, when I

25 worked with NLCHI in--who were, as you know,

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1 doing the database or what we call the

2 database, we went back and reviewed all those

3 reports to verify, because they wanted to see

4 exactly, here are all the reports, to make

5 sure this number is the final number type of

6 thing.

7 CHAYTOR, Q.C.:

8 Q. Okay. If we could have, please, P-0515? And

9 this is a meeting of July 21st, 2005. You're

10 not in attendance at this meeting. It's

11 Doctors Carter, Cook and Williams and I just

12 wanted to bring your attention though to--it

13 says here, "some runs, on retrospect, were not

14 normal." Was that discussed with you around

15 this time, that some of the runs -

16 MR. GULLIVER:

17 A. Dr. Carter never discussed any of this, any

18 findings that she may have had, with me.

19 CHAYTOR, Q.C.:

20 Q. Okay, "inconsistency from one batch to

21 another," was that discussed with you?

22 MR. GULLIVER:

23 A. No.

24 CHAYTOR, Q.C.:

25 Q. "Techs may need to be retrained in

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1 immunoperoxidase and need controlled access to

2 the room." Was that discussed with you?

3 MR. GULLIVER:

4 A. No.

5 CHAYTOR, Q.C.:

6 Q. "Training of techs," then it says again "in

7 immunohistochemistry."

8 MR. GULLIVER:

9 A. No.

10 CHAYTOR, Q.C.:

11 Q. "Need separate service. Need QA and

12 proficiency testing." Those points were

13 discussed. We've seen those in -

14 MR. GULLIVER:

15 A. At a later point. I think when Dr. Ejeckam

16 comes back from holidays and Barry comes back,

17 they start looking at some of that.

18 CHAYTOR, Q.C.:

19 Q. Okay, and the second bullet here, "the

20 sentinel case, reviewed old slides. Program

21 would not always run a control."

22 MR. GULLIVER:

23 A. Well, I think that's--this is probably Dr.

24 Williams' notes. I think what really it

25 should say there--well, that's not think,

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1 that's completely wrong, the program would not

2 always run a control. I think what he's

3 probably trying to understand is that the

4 program wouldn't always run a control for

5 every single pathologist. At some point in

6 time, they ran a control for the batch. There

7 were times where controls were run for--it

8 could be five controls in the same batch,

9 depending on if there was five different

10 pathologists were going to interpret the

11 slides. So I think what you have written

12 there really is completely wrong.

13 CHAYTOR, Q.C.:

14 Q. What Dr. Williams has recorded you mean from

15 the meeting?

16 MR. GULLIVER:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. Yes, and so, and I take it, he didn't come

20 back to you and ask you anything else about

21 this -

22 MR. GULLIVER:

23 A. No.

24 CHAYTOR, Q.C.:

25 Q. - in terms of, you know -

1 MR. GULLIVER:
2 A. No.
3 CHAYTOR, Q.C.:
4 Q. - "well, Mr. Gulliver, would the program run
5 controls? Because you've indicated to me that
6 they did."
7 MR. GULLIVER:
8 A. Yeah.
9 CHAYTOR, Q.C.:
10 Q. That wasn't an issue brought up with you by
11 Dr. Williams after this?
12 MR. GULLIVER:
13 A. Not that I remember, after this, no.
14 CHAYTOR, Q.C.:
15 Q. Okay. If we could have then, P-2001? And
16 then this is a July 24th meeting and it is a
17 fairly large group and these are Dr. Cook's
18 notes. So we don't have a typed version, but
19 it appears to include Mr. Tilley, Dr.
20 Gardiner, Dr. Williams, Heather Predham, Dan
21 Boone, yourself, Susan Bonnell, Dr. Laing,
22 Alan Kwan, Dr. Kwan, Deborah Thomas.
23 MR. GULLIVER:
24 A. I think this is the one now we're talking
25 about, the disclosure and stuff.

1 MR. GULLIVER:
2 A. Yeah, but we've already got, I think, some
3 things retested at this point in time. I know
4 there was a lot of -
5 CHAYTOR, Q.C.:
6 Q. At Mount Sinai?
7 MR. GULLIVER:
8 A. I'm thinking by July 24th.
9 CHAYTOR, Q.C.:
10 Q. Okay.
11 MR. GULLIVER:
12 A. Yeah, I think so. But there was some debate
13 too about the whole science behind this test,
14 and the people in the room who, you know,
15 really are decision makers who are not lab
16 medicine people, they're not pathologists or
17 technologists, is trying to make them aware
18 and understand some of the science behind this
19 test and this discussion was really about--
20 even over the years, if you look at how this
21 test was performed in '97 and the actual step-
22 by-step process, it didn't really change much
23 in 2004. What changed over the years, as you
24 know, the new and improvements that you see
25 from the vendors, you know, at some point we

1 CHAYTOR, Q.C.:
2 Q. So this is the one you think -
3 MR. GULLIVER:
4 A. I think so, yeah.
5 CHAYTOR, Q.C.:
6 Q. - concerning the--and the oncologists stating
7 their views on disclosure?
8 MR. GULLIVER:
9 A. I think so.
10 CHAYTOR, Q.C.:
11 Q. And there's a comment in here and this says,
12 Dr. Cook said it in his evidence, "large
13 percentage of conversions probably due to
14 technical changes, technical change" and do
15 you recall that being discussed at this
16 meeting?
17 MR. GULLIVER:
18 A. Well, whether it was this meeting or not, I
19 can't tell you, but certainly there was
20 discussion talking about, at this point in
21 time, Dr. Cook had sent cases to Mount Sinai,
22 you know, older cases, and there was a lot of
23 debate--well, first of all, it was a lot of -
24 CHAYTOR, Q.C.:
25 Q. This is July 24th, 2005.

1 got a new detection kit. You might have
2 changed your antibody clone. You have a new--
3 we got a new pH for boiling the slides on the
4 hot plate. So all those technological changes
5 that took place over the years that the new--
6 the old specimens being retested the new way,
7 there was some discussion around, and wonder
8 what impact--has that had an impact on the
9 changed results, you know, because we retested
10 it in 1999 using this kit and this reagent and
11 this one and now it's retested six years later
12 using the newer reagent and new upgrade, you
13 know, would that have an impact on the change
14 in results. That was this discussion.
15 CHAYTOR, Q.C.:
16 Q. So if Dr. Cook attributed this comment to you
17 that a large percentage of the conversions
18 could probably be due to technical changes,
19 would you take issue with that?
20 MR. GULLIVER:
21 A. I don't think that can be attributed to me
22 saying that. I'm just saying I think that was
23 some of the discussion that was going on
24 amongst the group, was talking about just the
25 change in technology, not equipment

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1 technology, but just changing and upgrading
 2 the different reagents and antibody clones in
 3 any test that you do over the years.
 4 CHAYTOR, Q.C.:
 5 Q. And who in this group, out of people that
 6 we've identified here, would be discussing
 7 those issues?
 8 MR. GULLIVER:
 9 A. Well, I think most of them there are
 10 physicians and it's something that physicians
 11 would certainly be well aware of. There's
 12 changes in practice all the time. Whether
 13 it's a lab practice or lab procedure, whether
 14 it's an oncology practice or oncology
 15 procedure or you have a new MRI system come in
 16 that's better than the old one. I mean,
 17 that's the kind of discussion that was going
 18 on.
 19 CHAYTOR, Q.C.:
 20 Q. But there's no pathologist in attendance,
 21 except for Dr. Cook.
 22 MR. GULLIVER:
 23 A. Dr. Cook is there.
 24 CHAYTOR, Q.C.:
 25 Q. Yes, except for Dr. Cook, and the rest

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1 certainly wouldn't be very familiar with the
 2 laboratory medicine program, I take it.
 3 MR. GULLIVER:
 4 A. No, no, we're talking in general, in any
 5 program.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, so that's your recollection -
 8 MR. GULLIVER:
 9 A. Where there is a change in -
 10 CHAYTOR, Q.C.:
 11 Q. - as to what this was about?
 12 MR. GULLIVER:
 13 A. That's my best recollection, yeah.
 14 CHAYTOR, Q.C.:
 15 Q. And you're not taking credit or blame for this
 16 statement that "a large percentage of the
 17 conversion is probably due to technical
 18 change," that wasn't something you were
 19 putting forward?
 20 MR. GULLIVER:
 21 A. No, but the fact is there was technical
 22 change. You know, the issue was did a
 23 percentage of these conversions, was that a
 24 cause of the conversion.
 25 CHAYTOR, Q.C.:

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1 Q. P-0078, please? This is an e-mail from Ms.
 2 Predham, July 28th, 2005, to yourself and Mr.
 3 Cook and it's copied to Dr. Williams re:
 4 ER/PR, and she writes "the more I thought of
 5 it last night, the more I realized that it is
 6 critical that we get the results for the time
 7 we ran both the DAKO and the Ventana system in
 8 April 2004. This would give us exactly what
 9 we need, our positivity rate with both systems
 10 and our conversion rate as well. We would
 11 have been in close contact with the company at
 12 that time and our rates during that period
 13 obviously were satisfactory to all involved
 14 because we went live on the Ventana system.
 15 Can we get the results for that period of time
 16 quickly? Also, I hate to nag. Could you give
 17 me the numbers of samples we sent to Mount
 18 Sinai during that six-week period in 2003? If
 19 we had more than about 15 or so, we should
 20 probably look at the positivity rate, as they
 21 were done elsewhere. Thanks, Heather."
 22 Now Mr. Gulliver, what do you recall
 23 about this and any response that you would
 24 have provided to Ms. Predham on those issues?
 25 MR. GULLIVER:

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1 A. I think where Heather was--again, it's the
 2 early days. People are trying to understand
 3 even the lingo, what goes on in a medical
 4 laboratory. I think what Heather was asking,
 5 "well, if you had the Ventana system and you
 6 are validating it and you're still operating
 7 DAKO for a period of a few months that you
 8 were reporting off DAKO, was there side-by-
 9 side testing done on both and is there
 10 interpretation from both?" So did a
 11 pathologist take a test off Ventana, the same
 12 patient off DAKO and compare results? And I
 13 don't think that happened. I think what
 14 happened was Dr. Ejeckam just took cases and
 15 had them run through the Ventana system to
 16 assure and to get the results he expected to
 17 get from that particular patient. I don't
 18 ever remember seeing a side-by-side direct
 19 comparison from this breast cancer patient and
 20 the same patient over on this side. Now I
 21 could not be 100 percent sure. Mr. Dyer may
 22 know more, and Dr. Ejeckam certainly would
 23 know more.
 24 CHAYTOR, Q.C.:
 25 Q. And this was sent to you and -

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1 MR. GULLIVER:
 2 A. But this is what she was actually asking for.
 3 CHAYTOR, Q.C.:
 4 Q. Yes, so I take it, it was sent to you and Dr.
 5 Cook, so you made inquiries as to what
 6 happened, I would take it, back in 2005 when
 7 you received this, and what were you able to
 8 find out?
 9 MR. GULLIVER:
 10 A. I think that's what I just told--what I said
 11 to Heather, what I just told you.
 12 CHAYTOR, Q.C.:
 13 Q. So you made inquiries of Mr. Dyer?
 14 MR. GULLIVER:
 15 A. Yeah.
 16 CHAYTOR, Q.C.:
 17 Q. And did you have any discussions with Dr.
 18 Ejeckam about it?
 19 MR. GULLIVER:
 20 A. I don't even know if Dr. Ejeckam was even back
 21 then.
 22 CHAYTOR, Q.C.:
 23 Q. Well, you know, around this time period.
 24 MR. GULLIVER:
 25 A. I don't remember asking Dr. Ejeckam.

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1 CHAYTOR, Q.C.:
 2 Q. Back from vacation, you mean?
 3 MR. GULLIVER:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. Is that what you mean?
 7 MR. GULLIVER:
 8 A. And I don't know if Dr. Cook responded to
 9 Heather either.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and the fact that samples weren't sent
 12 out is what you're able to ascertain in that
 13 six-week period?
 14 MR. GULLIVER:
 15 A. I know, and really I don't think that any
 16 samples were sent out during that time, that
 17 few weeks where Dr. Ejeckam was optimizing
 18 those antibodies.
 19 CHAYTOR, Q.C.:
 20 Q. When you went through -
 21 MR. GULLIVER:
 22 A. I think they were just held in house.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and when you went through in--and we'll
 25 get to what you did in trying to identify the

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1 patients. When you went through all the
 2 pathology reports, did you see any evidence of
 3 that period of time that tests had been sent
 4 to Mount Sinai in the spring of 2003?
 5 MR. GULLIVER:
 6 A. I didn't, see. I mean, that's the thing.
 7 When I read those reports, obviously there's
 8 the occasional report that was probably a
 9 consult. It was like a pathologist asking for
 10 a second opinion on a particular case, but it
 11 wasn't asking for a second retest anywhere
 12 else. But you know, I didn't come across a
 13 period where like there was 20 or 30 that were
 14 resulted from Mount Sinai.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. All right, Mr. Gulliver, we understand
 17 there was another--shortly after this, there
 18 was another large group meeting on August 1st
 19 and it involved Mr. Tilley, the CEO. Did you
 20 attend that meeting?
 21 MR. GULLIVER:
 22 A. Yeah. Well, there was--there was lots of
 23 them, but there was another one where George
 24 called it and there was a large group there.
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and what happened at that meeting? What
 2 do you recall from that meeting?
 3 MR. GULLIVER:
 4 A. I think, you know, is that a few days after
 5 this one, on a Sunday or Monday or something?
 6 I think George called that meeting. Again, I
 7 still think, you know, from the organization's
 8 perspective, to get their heads around, you
 9 know, like where do we go from here? You
 10 know, if we have this much information so far,
 11 what are we doing as an organization now to
 12 deal with this particular issue? I think that
 13 was the context of the meeting as a group, and
 14 to, I guess to lay our plan so he would know,
 15 as the CEO, like what are we planning to do to
 16 deal with this.
 17 CHAYTOR, Q.C.:
 18 Q. And leading up to that meeting, Mr. Gulliver,
 19 did you hear anything--Mr. Dyer, back on May
 20 17th, had come to you and was upset about
 21 whatever had transpired in that meeting and
 22 felt that the lab was being blamed. Did you
 23 hear, yourself, any accusations along those
 24 lines after that, following into June, July of
 25 2005?

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1 MR. GULLIVER:
 2 A. No, I never heard nothing directly, but you
 3 know, in some of the e-mails or letters, I
 4 mean, if I'm reading them, I kind of can infer
 5 something from them. I don't really hear that
 6 again, as you know, until the meeting with Mr.
 7 Tilley, the August 1st of 2nd meeting,
 8 whenever it may be.
 9 CHAYTOR, Q.C.:
 10 Q. And so then you attend the large group meeting
 11 and what do you recall happening at that
 12 meeting?
 13 MR. GULLIVER:
 14 A. Well again, I mean, it was a cross group of
 15 oncologists, you know, Mr. Tilley, my Vice
 16 President, Dr. Williams, Dr. Cook was there.
 17 Dr. Carter was there. I actually think I
 18 brought Barry Dyer, my pathology manager, to
 19 this meeting. He's back from vacation. I
 20 think he's just back actually from vacation,
 21 and I think Susan Bonnell and Heather Predham,
 22 there was a large group there, and again, it
 23 was George wanted to get an update from all
 24 the groups of how are we dealing with this
 25 issue, what's the next action plan that's

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1 going to happen.
 2 CHAYTOR, Q.C.:
 3 Q. And so what happens? What's discussed?
 4 MR. GULLIVER:
 5 A. Well, again, we're talking about--well,
 6 obviously the lab is a big piece of the
 7 discussion. You know, up to this point, no
 8 one still has any idea really, you know.
 9 There's some debate about, well, we have a new
 10 Ventana system, so is that why we have result
 11 changes? Or do we have result changes because
 12 the old system really wasn't working? We've
 13 got other people who were saying, you know,
 14 there's also a false negative rate built into
 15 this test. There's also a science behind this
 16 whole testing, and then there's also an
 17 interpretation to this test by the
 18 pathologists and then an application of that
 19 interpretation by the oncologists to the
 20 patients. I mean, that really was the big
 21 picture discussion that was going on at this
 22 meeting.
 23 CHAYTOR, Q.C.:
 24 Q. So was there any discussion that pathologists
 25 somehow weren't interpreting the slides

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1 properly?
 2 MR. GULLIVER:
 3 A. Not really. Most of the lab discussion was
 4 being carried on, I guess, early on by Dr.
 5 Carter and you know, you just opened up that
 6 avenue what you just said earlier about the
 7 May 17th, the meeting with Mr. Barry Dyer. At
 8 this meeting, this is the one where after some
 9 discussion and, you know, all these different
 10 kinds of theories were being put around the
 11 testing. This is the one where Dr. Carter,
 12 who was sitting across the table from me, and
 13 Mr. Dyer. You know, Dr. Carter, it was her
 14 opinion that our laboratory was making
 15 mistakes and errors and she made several
 16 statements or comments that really, I think
 17 really ramped up the whole, everyone in the
 18 room, really ramped up the whole issue.
 19 CHAYTOR, Q.C.:
 20 Q. And how so?
 21 MR. GULLIVER:
 22 A. Well, I think you're sitting in a room with
 23 people who doesn't have--don't have a good
 24 understanding of lab medicine and you've got
 25 the CEO there and the Vice President, I think

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1 Dan Boone may be there from HIROC. You've got
 2 our communications people, our risk management
 3 people, and here you have a doctor sitting
 4 there, a pathologist, you know, pointing
 5 across the table at myself, whether it was me
 6 or Mr. Dyer or both of us, and saying that,
 7 you know, "your lab is making mistakes and
 8 errors" and she said that, you know, "your
 9 lab." She said that I have--at one point in
 10 time, she said that she never seen a positive
 11 result from your lab in over six months, when
 12 she went to St. Clare's, and she said things
 13 like "your lab should have been running
 14 negative controls along with the positive
 15 control." I mean, those are the kinds of
 16 things that Dr. Carter was saying to me, and
 17 when she finished saying them, it was--well, I
 18 guess the room was a bit silent, and I mean, I
 19 felt, as director of the program, that I
 20 really had to respond to her and respond to
 21 her, you know, right there and not at a later
 22 date, and I certainly did respond to her.
 23 CHAYTOR, Q.C.:
 24 Q. And what did you say?
 25 MR. GULLIVER:

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1 A. Well, I think my first thing, I mean, well
 2 first of all it was just absorbing of what she
 3 was pretty well saying. I think my first
 4 response to her was that, well, Dr. Carter,
 5 you're a part of the lab, you know, when she
 6 was saying "your lab was making mistakes and
 7 errors" that, you know, she's a part of the
 8 lab program also. And I said to her that, you
 9 know, if you're informing me now in 2005 that
 10 you seen a six month period where you didn't
 11 see one positive result for six months and I
 12 think it was in 2003 she was talking about,
 13 that it's two years later that you're even
 14 telling someone that. And I also said to her
 15 that you've been here as our breast specialist
 16 for over two and a half years and why is it
 17 now just at this meeting that you are
 18 recommending to run negative controls with
 19 IHC, you know, why has it taken you two and a
 20 half years to recommend that? At that point,
 21 things were getting really heated. She was
 22 starting to get pretty well, you know ansy,
 23 and Mr. Tilley pretty well called the meeting
 24 to order and finished the meeting.
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and how did Dr. Carter respond to the
 2 things that you pointed out in terms of why
 3 you were only now being informed of those
 4 issues?
 5 MR. GULLIVER:
 6 A. She didn't make no other comment. She left
 7 the meeting.
 8 CHAYTOR, Q.C.:
 9 Q. Did anyone else speak up and defend the
 10 Laboratory Medicine Program or the lab?
 11 MR. GULLIVER:
 12 A. I don't think they had time because I think
 13 Mr. Tilley at this point realized that this
 14 meeting, you know, I don't think it was
 15 getting what he figured it was going to
 16 accomplish -
 17 CHAYTOR, Q.C.:
 18 Q. It had deteriorated, I take it.
 19 MR. GULLIVER:
 20 A. And I think he was--he decided that, you know,
 21 we'll just adjourn the meeting and we'll
 22 discuss this again later.
 23 CHAYTOR, Q.C.:
 24 Q. Was there then any decision at the end of that
 25 meeting as to how everybody was going to go

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1 forward to investigate the problem at hand?
 2 MR. GULLIVER:
 3 A. At that meeting there was no decision, no.
 4 But now immediately following that meeting and
 5 -
 6 CHAYTOR, Q.C.:
 7 Q. And I'll ask you about that, but before we
 8 leave the meeting, other than this somewhat of
 9 a confrontation, I would take it between
 10 yourself and Dr. Carter -
 11 MR. GULLIVER:
 12 A. I don't know if it was a con--I mean, she said
 13 her say and I had my say.
 14 CHAYTOR, Q.C.:
 15 Q. Yes, okay, well the heated discussion, I think
 16 "heated" was your word, was anyone else--was
 17 anyone else engaging in that kind of a
 18 discussion? For example, did anyone else say
 19 that they thought it was the lab's fault or
 20 the technologists' fault?
 21 MR. GULLIVER:
 22 A. Not--no, I mean, there was no one else there
 23 who was pointing a finger and saying it was
 24 the lab's fault. I just think people wanted
 25 to try and get a grasp and understand the

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1 testing and the implications from the testing.
 2 CHAYTOR, Q.C.:
 3 Q. And was there any kind of accusations amongst
 4 any other professional groups where -
 5 MR. GULLIVER:
 6 A. I did not, like the oncologist weren't blaming
 7 the pathologists; the pathologists weren't
 8 blaming the oncologist, no, that wasn't going
 9 on.
 10 CHAYTOR, Q.C.:
 11 Q. And did you ever hear of that, did you ever
 12 hear anybody suggest well the oncologist
 13 should have picked up on this or the
 14 pathologists weren't doing their job properly?
 15 MR. GULLIVER:
 16 A. I didn't hear directly.
 17 CHAYTOR, Q.C.:
 18 Q. And where did you hear it indirectly?
 19 MR. GULLIVER:
 20 A. Well this is after this meeting and I guess
 21 it's the fall out from this meeting.
 22 CHAYTOR, Q.C.:
 23 Q. Okay, well then continue on and tell us this
 24 story.
 25 MR. GULLIVER:

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1 A. Because the fall out from this meeting was
 2 that when I left this meeting, by this time,
 3 you know, I'm almost a month and I mean, a
 4 month, day and night, you know, dealing with
 5 and responding and reading reports and doing
 6 positive rates and negative rates and at
 7 meetings. At this point in time and I think
 8 it was late in the evening by the time the
 9 meeting was over, myself and Mr. Dyer were
 10 walking back to my office and I was going to
 11 resign the next day.

12 CHAYTOR, Q.C.:
 13 Q. And why is that?

14 MR. GULLIVER:
 15 A. Because I didn't think that our lab warranted
 16 -

17 CHAYTOR, Q.C.:
 18 Q. Because of what had just transpired with Dr.
 19 Carter?

20 MR. GULLIVER:
 21 A. (No audible response).

22 CHAYTOR, Q.C.:
 23 Q. That's okay, take your time.

24 MR. GULLIVER:
 25 A. As it happened, when I got back to my office,

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1 Dr. Williams called me and he said to me that
 2 George was with him in the office, George
 3 Tilley and he said that George wanted to rely
 4 that he was impressed how I handled myself at
 5 that meeting and he apologized for how he let
 6 the meeting get out of hand. And that really
 7 made my decision to stay at my job, to hear
 8 that from Dr. Williams. And that evening, I
 9 stayed however long it took, I don't know how
 10 many hours, but I did do a Meditech search. I
 11 looked for and I think it was 2003, Ms.
 12 Chaytor, I could be wrong, but I'm thinking it
 13 was 2003, but the year, the six-month period
 14 that Dr. Carter had said that there hadn't
 15 been a positive result come from the
 16 laboratory, I printed every patient report, I
 17 sorted them by positive, by negative. I
 18 tabulated the results and then the first thing
 19 the next morning, I called Dr. Williams, I
 20 went to meet with him in his office and I
 21 showed him the actual facts and statistics.
 22 Obviously Dr. Williams was very upset. He
 23 called Dr. Cook on the phone who was at St.
 24 Clare's and asked Dr. Cook to come over to the
 25 office immediately. We waited for Don to show

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1 up and we showed Don the actual patient
 2 reports and the facts, that there was more
 3 positives every single month reported than
 4 negatives for the time period Dr. Carter had
 5 said that she hadn't seen a result from the
 6 lab that came out positive. And Dr. Cook, you
 7 know, he did not defend Dr. Carter; however,
 8 he did say, "well you know, Bob, you know what
 9 Bev is like, you know, she really ramps things
 10 up and she says things before she thinks about
 11 them and, you know, I don't know if that's
 12 exactly what Bev really meant at the meeting
 13 yesterday". Anyway, so Dr. Williams asked Dr.
 14 Cook to call Dr. Carter at St. Clare's and ask
 15 her to come over and meet with them and I was
 16 last then to leave the meeting. And to my
 17 knowledge, Dr. Carter came over and she met
 18 with Dr. Williams and Dr. Cook.

19 CHAYTOR, Q.C.:
 20 Q. And in looking and reviewing those reports for
 21 that six-month period, was that something you
 22 did on your own initiative or did Dr. Williams
 23 -

24 MR. GULLIVER:
 25 A. I did it myself, yes. I was not asked to do

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1 that.

2 CHAYTOR, Q.C.:
 3 Q. And did you ever have occasion afterwards to
 4 discuss this with Dr. Carter?

5 MR. GULLIVER:
 6 A. No, because either the next day or the day
 7 after, it was very shortly after this here,
 8 the next thing I knew Dr. Carter had then sent
 9 over her letter of resignation to Dr. Williams
 10 resigning from any review that she was
 11 supposed to be the one who was going to review
 12 and identify patients for retesting and do all
 13 that piece of the work, because I had brought
 14 all those reports, the two boxes of reports
 15 that I had gone through for positivity rates,
 16 were the same reports we had to review and
 17 identify patients who should be retested.

18 CHAYTOR, Q.C.:
 19 Q. So you had gone into Meditech, is that right
 20 and found -

21 MR. GULLIVER:
 22 A. That was all done.

23 CHAYTOR, Q.C.:
 24 Q. And printed off all the pathology reports,
 25 reviewed them for purpose of positivity rates

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1 and then delivered them to -

2 MR. GULLIVER:

3 A. Dr. Carter.

4 CHAYTOR, Q.C.:

5 Q. Dr. Carter.

6 MR. GULLIVER:

7 A. At St. Clare's. So to this day when she

8 resigned from doing the review, then I was

9 asked by Dr. Williams, well, you know, who is

10 going to do, review all these reports and I

11 said, well, I will do it. And I drove back to

12 St. Clare's that same day, I think, and went

13 to Dr. Carter's office and I removed the

14 reports I had given her a couple of weeks

15 prior. And that's when I started the review

16 then of taking on that responsibility, I

17 guess.

18 CHAYTOR, Q.C.:

19 Q. And you didn't, in getting the reports back

20 from her, discuss the issue with her?

21 MR. GULLIVER:

22 A. I did not, no.

23 CHAYTOR, Q.C.:

24 Q. And do you know whether or not she attempted

25 to discuss it with you or Barry Dyer?

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1 MR. GULLIVER:

2 A. No, the only thing that happened was and it's

3 all within the same day or two of each other,

4 Dr. Carter had called Mr. Dyer. She got his

5 voice mail and she left him a message on his

6 voice mail system and it seems like she

7 immediately hung up and called back again,

8 like ten seconds later because she forgot to

9 say something and, you know, when that

10 happened, Barry--I knew the voice mails were

11 there in Barry's system and I don't know why,

12 I said to Barry, don't ever erase those, keep

13 them. And then we had them taped and

14 transcribed and gave them as evidence for the

15 Commission of Inquiry.

16 THE COMMISSIONER:

17 Q. Wherever you can find a spot, Ms. Chaytor.

18 CHAYTOR, Q.C.:

19 Q. So perhaps then we'll just have a quick look

20 at P-0079 and then we'll pick it up next time

21 with how you then go about identifying the

22 patients. And this is the letter where it's

23 August 7th, 2005 to Dr. Cook, where Dr. Carter

24 in fact resigns from her involvement and at

25 the time were you--had you seen a copy of this

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1 letter and the reasons set out by Dr. Carter?

2 MR. GULLIVER:

3 A. No, she never sent me a copy, no.

4 CHAYTOR, Q.C.:

5 Q. And the fact that she writes, "Meeting with

6 Mr. George Tilley on August 1, 2005, showed in

7 my opinion that Mr. Terry Gulliver and Mr.

8 Barry Dyer do not have a good understanding of

9 the limitations of automated

10 immunohistochemistry, rigorous clinical and

11 technical validation of antibodies against ER

12 and PR and establishment of reliable and

13 reproducible means of providing ER/PR results

14 to our patients. Using the substantial

15 published peer reviewed and accepted

16 scientific literature on the development of a

17 continuous monitoring of immunohistochemical

18 testing protocol." And Mr. Gulliver, what in

19 the meeting of August 1st, 2005 was discussed

20 that could lead Dr. Carter to think this?

21 MR. GULLIVER:

22 A. There was nothing discussed of this nature at

23 that meeting, nothing.

24 CHAYTOR, Q.C.:

25 Q. And did she ever at any other point in time

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1 bring this up with you that her, what she felt

2 were the limitations of your knowledge and

3 that of Mr. Dyer?

4 MR. GULLIVER:

5 A. Never directly.

6 CHAYTOR, Q.C.:

7 Q. And she also writes, "It also became clear to

8 me during that meeting that the current

9 administrative structure within Eastern Health

10 and within the laboratory allows decisions

11 regarding the development of a reliable and

12 reproducible system for assessing hormone

13 receptor status to remain in the hands of

14 professional staff within the laboratory."

15 And the issue or a concern regarding the

16 decision making under the current

17 administrative structure, was that ever

18 discussed with you directly by Dr. Carter or

19 the letter is being written to Dr. Cook?

20 MR. GULLIVER:

21 A. No, she never spoke to me about it, no.

22 CHAYTOR, Q.C.:

23 Q. It's also being copied to Dr. Williams. Did

24 Dr. Williams bring either of those issues up?

25 MR. GULLIVER:

1 A. I think Dr. Williams--after this happened when
 2 Dr. Williams asked would I then, you know,
 3 take on this role, I think this is when I seen
 4 this letter.
 5 CHAYTOR, Q.C.:
 6 Q. So Dr. Williams showed you the letter. Did he
 7 also speak to you about the concerns that were
 8 expressed by Dr. Carter?
 9 MR. GULLIVER:
 10 A. No, I don't think he had the same opinion.
 11 CHAYTOR, Q.C.:
 12 Q. And just one other question about the August
 13 1st meeting, do you recall Dr. Carter taking
 14 issue with any public or any assertion to be
 15 made to the public that the reason for the
 16 conversions could be due to changes in
 17 technology?
 18 MR. GULLIVER:
 19 A. I don't think Dr. Carter ever believed that it
 20 was a change in technology.
 21 CHAYTOR, Q.C.:
 22 Q. Yes, and she was taking issue with any
 23 assertion that would be made along those
 24 lines, do you recall that being discussed? I
 25 don't remember her taking issue with it, but I

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

1 would certainly think, you know, that Dr.
 2 Carter's opinion would have been that this is
 3 not a technology issue type of thing.
 4 CHAYTOR, Q.C.:
 5 Q. Yes. Thank you, Commissioner.
 6 THE COMMISSIONER:
 7 Q. We'll adjourn now until 9:30 in the morning.
 8 There's another witness scheduled for the
 9 morning who is coming in from outside of the
 10 province. Mr. Gulliver, your counsel and
 11 Commission counsel will work out the date when
 12 we can continue with you.
 13 MR. GULLIVER:
 14 A. Thank you.
 15 THE COMMISSIONER:
 16 Q. Thank you.

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