

<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;">APRIL 30, 2008</p> <p>Appearances: Bernard Coffey, Q.C. . . . . Commission Co-counsel Sandra Chaytor, Q.C. . . . . Commission Co-counsel</p> <p>Rolf Pritchard/Megan Collins . . . . Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury . . . . Doctors Kara Laing et al</p> <p>Daniel Simmons/Sarah Learmonth . . . Eastern Regional Integrated . . . . . Health Authority</p> <p>Darlene Russell. . . . . Members of the Breast Cancer . . . . . Testing Class Action</p> <p>Mark Pike . . . . . NL Medical Association</p> <p>Jennifer Newbury . . . . Canadian Cancer Society (NL Division) Stacey O’Dea . . . . Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-0785 TO P-0789 INCLUSIVE . . . . . Pg. 357</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>MS. LOUISE JONES - RESUMES THE STAND</p> <p>Examination by Sandra Chaytor, Q.C. (Cont’d) . . . Pgs. 4 - 320</p> <p>Examination by Rolf Pritchard . . . . . Pgs. 320 - 323</p> <p>Examination by Peter Browne . . . . . Pgs. 323 - 357</p> <p>Examination by Jennifer Newbury . . . . . Pgs. 357 - 425</p> <p>Examination by Darlene Russell . . . . . Pgs. 425 - 441</p> <p>Examination by Daniel Simmons . . . . . Pgs. 441 - 458</p> <p>Re-examination by Sandra Chaytor, Q.C. . . . . Pgs. 458 - 468</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Good morning. Please be seated. 3 CHAYTOR, Q.C.: 4 Q. Good morning, Commissioner. 5 THE COMMISSIONER: 6 Q. Ms. Chaytor? 7 MS. LOUISE JONES, EXAMINATION-IN-CHIEF BY SANDRA CHAYTOR, 8 Q.C. 9 CHAYTOR, Q.C.: 10 Q. Thank you, Commissioner. Good morning, Ms. 11 Jones. 12 MS. JONES: 13 A. Good morning, Ms. Chaytor. 14 CHAYTOR, Q.C.: 15 Q. The last thing I want to do, having said that 16 I’d be under an hour, is to start the morning 17 by going backwards. So backwards we shall go. 18 Ms. Jones, if we could have, please, 19 Registrar, Exhibit 0730? This is the letter 20 that we talked about yesterday, Ms. Marion 21 Crowley, addressed to Ms. Marion Crowley, 22 September 19th, 2007 from the physicians. And 23 then 0731, Ms. Crowley’s response? 24 MS. JONES: 25 A. Yes.</p>

Page 5

1 CHAYTOR, Q.C.:

2 Q. So you remember our discussion yesterday on

3 this?

4 MS. JONES:

5 A. Yes, yeah.

6 CHAYTOR, Q.C.:

7 Q. Okay. There was a news story yesterday, and

8 maybe it's not correct, but I thought I should

9 put it to you. I don't know if you heard it,

10 but Carolyn Stokes reported that late

11 yesterday, or late this afternoon, so the same

12 day that you would have given your evidence on

13 this.

14 MS. JONES:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. The question of who drafted the letter was

18 answered, the question of who drafted the

19 letter that went to the patients, "Eastern

20 Health informed the media that the letter was

21 written by their lawyers." Are you aware of

22 that, are you aware of the news story?

23 MS. JONES:

24 A. No, just I heard the news story this morning

25 at the 8:00 news.

Page 6

1 CHAYTOR, Q.C.:

2 Q. Okay. Are you aware that Eastern Health

3 informed the media that the letter was written

4 by their lawyers, is that correct?

5 MS. JONES:

6 A. There was no--I'm not aware of that, unless

7 they picked it up from the testimony

8 yesterday.

9 CHAYTOR, Q.C.:

10 Q. So but you didn't say that in your testimony

11 yesterday.

12 MS. JONES:

13 A. No, I didn't.

14 CHAYTOR, Q.C.:

15 Q. Okay. So did anyone from your organization

16 tell the media that the letter to the patients

17 was drafted by your lawyers?

18 MS. JONES:

19 A. I have no idea. I was here yesterday. I gave

20 testimony yesterday based upon what I knew

21 about the letter and the October the 11th

22 which says that we understood from our lawyers

23 that we could not change the words in the

24 cover letter, and I think we talked to that

25 yesterday. And I've had no contact with

Page 7

1 people inside the organization since I left

2 here 5:00 yesterday afternoon.

3 CHAYTOR, Q.C.:

4 Q. So you heard the story for the first time this

5 morning?

6 MS. JONES:

7 A. At the 8:00 news.

8 CHAYTOR, Q.C.:

9 Q. And did you question that, have you asked

10 anyone in your organization who would have

11 said that?

12 MS. JONES:

13 A. I -

14 CHAYTOR, Q.C.:

15 Q. Was that said and who said it?

16 MS. JONES:

17 A. I have not because I was preparing to come

18 here this morning, so I have not followed up

19 on that.

20 CHAYTOR, Q.C.:

21 Q. Okay. You clearly told us yesterday that you

22 didn't know who drafted the letter but that it

23 was not drafted by Eastern Health or on its

24 behalf?

25 MS. JONES:

Page 8

1 A. It's not drafted by Eastern Health staff.

2 CHAYTOR, Q.C.:

3 Q. Or on its behalf?

4 MS. JONES:

5 A. On its behalf. It was a court--my

6 understanding is is that because we had the

7 database names, that we had to comply with

8 that in sending information to clients around

9 the class action suit, that's what I

10 understand about that.

11 CHAYTOR, Q.C.:

12 Q. Let's go back.

13 MR. SIMMONS:

14 Q. Madam Commissioner, if I might, I might be

15 able to shed a little more light on that

16 issue. The question certainly came up

17 yesterday in the course of the evidence about

18 the source of the letter. And I can convey to

19 you my understanding of what I've been

20 informed happened, if that would be helpful.

21 THE COMMISSIONER:

22 Q. What you have been informed in respect of the

23 drafting of the letter?

24 MR. SIMMONS:

25 Q. Yes, yes.

Page 9

1 THE COMMISSIONER:  
 2 Q. Or what you have been informed happened  
 3 yesterday?  
 4 MR. SIMMONS:  
 5 Q. Well, what I've been informed happened  
 6 concerning the drafting of the letter, Madam  
 7 Commissioner, if that would be helpful at this  
 8 point, I can certainly do that.  
 9 THE COMMISSIONER:  
 10 Q. Well, I think that -  
 11 MR. SIMMONS:  
 12 Q. And I'm happy for Ms. Chaytor continue.  
 13 THE COMMISSIONER:  
 14 Q. Well, I'd prefer to hear it from the witness  
 15 who told us a story yesterday to resolve it.  
 16 Certainly we will have to resolve it in due  
 17 course and perhaps you could communicate with  
 18 counsel at the convenient time as to the  
 19 appropriate witness who may be able to shed  
 20 the light.  
 21 MR. SIMMONS:  
 22 Q. Yes.  
 23 THE COMMISSIONER:  
 24 Q. Assuming this witness can't.  
 25 MR. SIMMONS:

Page 10

1 Q. Yeah. My concern, Madam Commissioner, is that  
 2 Ms. Jones may not--is obviously not aware of  
 3 events yesterday to try and answer these  
 4 questions, so I don't know how useful that  
 5 questioning -  
 6 THE COMMISSIONER:  
 7 Q. She's told us she cannot tell us who did  
 8 yesterday's announcement, assuming an  
 9 announcement was made yesterday for the  
 10 moment, in any event. Carry on Ms. Chaytor.  
 11 CHAYTOR, Q.C.:  
 12 Q. Yes. But the issue being that you are the CEO  
 13 of the organization.  
 14 MS. JONES:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. We spent a fair amount of time yesterday  
 18 talking about accountability and  
 19 accountability including that anything that  
 20 gets said externally in--from Eastern Health,  
 21 external to Eastern Health to have that  
 22 information checked by someone at the  
 23 executive level. And we spent time yesterday  
 24 discussing that.  
 25 MS. JONES:

Page 11

1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. So did anyone, to your knowledge, at the  
 4 executive level, authorize the release of  
 5 information to the media which, in fact, is  
 6 contradictory to the information that you have  
 7 given to the Commissioner?  
 8 MS. JONES:  
 9 A. I have not, okay. And because I was here  
 10 yesterday until nearly 20 after 5 and have not  
 11 talked to anybody inside the organization, I  
 12 do not know what happened, transcribed (sic.)  
 13 between yesterday afternoon and this morning  
 14 while I'm here.  
 15 CHAYTOR, Q.C.:  
 16 Q. And it's important in terms of the accuracy  
 17 and completeness, obviously, for the  
 18 Commissioner to able to do her job that the  
 19 evidence that is being put forward be complete  
 20 and accurate. And if we could just go back  
 21 then, and we will need some clarification on  
 22 this issue.  
 23 MS. JONES:  
 24 A. And Mr. Simmons will provide that  
 25 clarification when I get -

Page 12

1 CHAYTOR, Q.C.:  
 2 Q. Mr. Simmons -  
 3 MS. JONES:  
 4 A. When I get back and can find out what actually  
 5 happened, if there was any contact with the  
 6 media. All I will know yesterday is that at  
 7 the end of the day my communication person was  
 8 here at 20 after 5 indicated that the media  
 9 wanted response with respect to the budget,  
 10 and she had indicated that they hadn't has  
 11 any calls throughout the days. But whether,  
 12 in fact, there was other individuals and it  
 13 didn't come through communications, I don't  
 14 know.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay.  
 17 MS. JONES:  
 18 A. But that was the extent of my discussion with  
 19 anybody inside of Eastern Health yesterday.  
 20 CHAYTOR, Q.C.:  
 21 Q. And, Ms. Jones, though, you told us yesterday  
 22 that you did have discussions with Dan Boone  
 23 around this issue of this letter?  
 24 MS. JONES:  
 25 A. After the letter was -

Page 13

1 CHAYTOR, Q.C.:

2 Q. Yes, at the time.

3 MS. JONES:

4 A. Yes, when the issue was brought forward, why

5 would we have to have sent out a letter that

6 had incorrect information in it.

7 CHAYTOR, Q.C.:

8 Q. Right. And you had that conversation

9 personally with yourself, so this is something

10 that you did have personal knowledge about?

11 MS. JONES:

12 A. After the fact.

13 CHAYTOR, Q.C.:

14 Q. Yes, after the letter went out?

15 MS. JONES:

16 A. That's right.

17 CHAYTOR, Q.C.:

18 Q. And my line of questioning to you yesterday in

19 terms of your knowledge of who drafted the

20 letter and whether it was drafted on behalf of

21 Eastern Health, that was based on your

22 knowledge of having had discussions with

23 whoever you needed to have discussions with

24 around the time, which included Dan Boone?

25 MS. JONES:

Page 14

1 A. And that was in relation to we had sent out a

2 letter that was from a court ordered process

3 and that the letter was inaccurate.

4 CHAYTOR, Q.C.:

5 Q. Yes, okay. I have a copy of the transcript

6 from yesterday. And at page 162 of the

7 transcript, this is Ms. Jones speaking to the

8 issue, I read the portion of the letter, "What

9 was all that about?" Question. Answer, "That

10 was all about a court ordered letter to be

11 sent out as part of the class action suit and

12 the letter was, we had the names in the

13 database and the court did not have the names

14 in the database, so we were responsible to put

15 a letter that was provided through the

16 solicitors and mail it out to clients, and

17 that would have been somewhere before the 19th

18 of September."

19 MS. JONES:

20 A. Yes.

21 CHAYTOR, Q.C.:

22 Q. Continuing on at 163. "The other thing is

23 that we were very, very clear and they were

24 very clear in lots of our messages and our

25 communication that this had nothing to do with

Page 15

1 the breast screening. And on a couple of

2 occasions when we were doing media releases

3 and discussions around this particular issue

4 of ER/PR breast screening, we would always say

5 this is not for breast screening. So this, we

6 really were just creating the mailing the

7 lists and addressing the envelopes and putting

8 the information that we had from the courts to

9 move forward."

10 MS. JONES:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. Coming down to page 164. "What action did you

14 take? Well, I would have spoken to Pat

15 Pilgrim at the time to say what is this issue

16 about. But we had heard that they were going

17 to send a letter and at the end of the day we

18 would respond inside of that." And this point

19 you're talking about the physicians.

20 MS. JONES:

21 A. The physicians, yes.

22 CHAYTOR, Q.C.:

23 Q. "I understood at that point in time that the

24 information that was in the letter wasn't

25 anything that Eastern Health had generated."

Page 16

1 MS. JONES:

2 A. Yes. Being our staff, was.

3 CHAYTOR, Q.C.:

4 Q. And my question was--sorry?

5 MS. JONES:

6 A. Being our staff, Eastern Health didn't

7 generate the letter.

8 CHAYTOR, Q.C.:

9 Q. Yes. My next question -

10 THE COMMISSIONER:

11 Q. Wait now. But Eastern Health not generating

12 does not include people who might represent

13 you?

14 MS. JONES:

15 A. At that time, when I responded to that, it

16 wasn't our--I understand where you're going

17 with that one. But it wasn't like our quality

18 people or whatever who had said, "This is a

19 letter generated by the courts and we have to

20 send it out, so" -

21 CHAYTOR, Q.C.:

22 Q. And that's what you understood -

23 THE COMMISSIONER:

24 Q. No, no, I'm afraid you don't understand where

25 I'm going with the question, if that's your

Page 17

1 response. When you said yesterday that it,  
 2 fact, was not generated by Eastern Health -  
 3 MS. JONES:  
 4 A. Yes, Eastern Health.  
 5 THE COMMISSIONER:  
 6 Q. - I would have included that people who  
 7 represent Eastern Health.  
 8 MS. JONES:  
 9 A. Yeah.  
 10 THE COMMISSIONER:  
 11 Q. So, for example, if the law firm that was  
 12 representing Eastern Health in this process  
 13 had a part to play -  
 14 MS. JONES:  
 15 A. A part to play, yes.  
 16 THE COMMISSIONER:  
 17 Q. - in the wording in the letter, then it would  
 18 seem to me that Eastern Health had an ability  
 19 to influence what was in the letter.  
 20 MS. JONES:  
 21 A. Yes, and I -  
 22 THE COMMISSIONER:  
 23 Q. So your answer would have lead me to believe  
 24 that that firm had no participation in that.  
 25 Now, is that right or wrong?

Page 18

1 MS. JONES:  
 2 A. I'm not sure when you ask it that way. When I  
 3 talk about staff, I generally believe internal  
 4 staff. I do understand that we have people  
 5 who work as agents for ourselves.  
 6 THE COMMISSIONER:  
 7 Q. Um-hm.  
 8 MS. JONES:  
 9 A. When I responded to that, I was responding to  
 10 staff inside of Eastern Health, okay.  
 11 Whether, in fact, the lawyer associated with  
 12 the class action suit, the HIROC lawyer, had  
 13 any play in what was inside that letter or  
 14 whether it was generated by the courts or  
 15 generated by the lawyer for the class action  
 16 suit, that detail, I would not understand how  
 17 the actual letter had got generated.  
 18 CHAYTOR, Q.C.:  
 19 Q. But, let's go on.  
 20 MS. JONES:  
 21 A. Yeah.  
 22 CHAYTOR, Q.C.:  
 23 Q. "So the information in the letter was  
 24 generated by whom?" Question. "Somebody on"  
 25 -

Page 19

1 MS. JONES:  
 2 A. "Somebody on behalf" -  
 3 CHAYTOR, Q.C.:  
 4 Q. - "behalf of Eastern Health?" And your answer  
 5 was, "No, no." "So who drafted the letter? I  
 6 have no idea who drafted the letter" -  
 7 MS. JONES:  
 8 A. That's right.  
 9 CHAYTOR, Q.C.:  
 10 Q. - "but I think if you go to the next exhibit  
 11 you have," and you talk about -  
 12 MS. JONES:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. - Marion's answer.  
 16 MS. JONES:  
 17 A. That's right.  
 18 CHAYTOR, Q.C.:  
 19 Q. And we go on to that. You talked to Dan  
 20 Boone, you told us about your conversation  
 21 with Dan Boone.  
 22 MS. JONES:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And the conversation that you had with Dan

Page 20

1 Boone was about whether you could change  
 2 anything in the letter. And you clearly told  
 3 us about that.  
 4 MS. JONES:  
 5 A. The conversation that I had with Dan Boone was  
 6 after this, the letter had been sent out.  
 7 CHAYTOR, Q.C.:  
 8 Q. Yes.  
 9 MS. JONES:  
 10 A. And was directly in relation to the physicians  
 11 who had a major problem with the wording in  
 12 the letter, and that was the nature of the  
 13 conversation. Because I think I also said  
 14 that I asked how we got brought into that  
 15 particular issue of having to mail out, and it  
 16 was because we had the names in the database  
 17 and why wouldn't the courts be able to do  
 18 that.  
 19 CHAYTOR, Q.C.:  
 20 Q. Yes. And you clearly indicated -  
 21 THE COMMISSIONER:  
 22 Q. I'm sorry, sorry.  
 23 CHAYTOR, Q.C.:  
 24 Q. No, go ahead.  
 25 THE COMMISSIONER:

Page 21

1 Q. But things keep running through my mind. Does  
 2 that mean that Eastern Health would have been  
 3 willing to give our their patients' names to  
 4 the court?  
 5 MS. JONES:  
 6 A. I think that might have been a discussion if  
 7 we had been asked. In my mind I'm thinking if  
 8 the court has some kind of a process that, in  
 9 fact, it has--it can generate or it has to  
 10 notify people, then they must have  
 11 confidentiality and all those kinds of things  
 12 that would be similar to what we would have.  
 13 And I don't--I'm not aware that that was asked  
 14 whether, in fact, we would have the list or  
 15 not, or whether, in fact, it was because we  
 16 had the list of patients that it was us to  
 17 generate the list and send out what came as  
 18 part of the court order. So that was my  
 19 conversation with Dan was how could we as  
 20 Eastern Health now with this particular kind  
 21 of process going on, again, have an issue here  
 22 with confusion in the public.  
 23 CHAYTOR, Q.C.:  
 24 Q. And so in your conversation with Dan, you  
 25 didn't ask him who drafted the letter?

Page 22

1 MS. JONES:  
 2 A. No, because I just assumed that it was a court  
 3 ordered process, we had to put the letters out  
 4 and it was part of what was happening inside  
 5 of the class action suit.  
 6 CHAYTOR, Q.C.:  
 7 Q. And so if the letter was drafted by the  
 8 lawyers for Eastern Health, you don't know?  
 9 MS. JONES:  
 10 A. No.  
 11 CHAYTOR, Q.C.:  
 12 Q. So in saying that it was not drafted on behalf  
 13 of Eastern Health, and clearly saying, "No,  
 14 no," to my question yesterday on that, how can  
 15 you say no to that?  
 16 MS. JONES:  
 17 A. I think that I put on my lens when I talk  
 18 about staff, I respect what Madam Justice  
 19 Cameron has said, that staff includes agents  
 20 of Eastern Health. I did not ask the question  
 21 about how that letter was generated. And the  
 22 wording in the memo that goes back to the  
 23 physicians, and remember I come in after the  
 24 fact, because the physicians have identified  
 25 an issue with the letter in their dealing with

Page 23

1 clients says that the letter which included  
 2 inaccurate reference to screening was part of  
 3 that and we couldn't change it.  
 4 CHAYTOR, Q.C.:  
 5 Q. Ms. Jones, with all due respect, it was two  
 6 distinct separate questions.  
 7 MS. JONES:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. The first was whether or not the information  
 11 that was in the letter was anything that  
 12 Eastern Health had generated. You said that  
 13 it wasn't. The second was, "So the  
 14 information in the letter was generated by  
 15 whom, someone on behalf of Eastern Health?"  
 16 and that you responded, "No, no." So the  
 17 answer wasn't, "I don't know," the answer was  
 18 "No."  
 19 MS. JONES:  
 20 A. Yeah, I answered that yesterday. And you  
 21 asked the question, and when you put lawyers  
 22 in that in terms of, you know, on behalf of  
 23 Eastern Health, reflecting on that there, I  
 24 would have to go back and say how did the--my  
 25 understanding was it was part of a court order

Page 24

1 process. We can go back, as Mr. Simmons has  
 2 indicated, and give you the exact detail  
 3 around how that came forward. We also talked  
 4 about clinically negative to clinically  
 5 positive yesterday, as well -  
 6 CHAYTOR, Q.C.:  
 7 Q. Yes, and we do have a question around that, as  
 8 well.  
 9 MS. JONES:  
 10 A. Yeah.  
 11 CHAYTOR, Q.C.:  
 12 Q. But what I want to get at here and the  
 13 importance, and I'm sure you appreciate the  
 14 importance -  
 15 MS. JONES:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. - of being able to rely--we've been two long  
 19 days at this.  
 20 MS. JONES:  
 21 A. Um-hm.  
 22 CHAYTOR, Q.C.:  
 23 Q. And we have to be able to rely on the  
 24 information that's coming from the witnesses.  
 25 MS. JONES:

Page 25

1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. To be accurate and complete information. And  
 4 if we don't know the answers, we don't know  
 5 the answers, but we have to have complete--so  
 6 is there anything else in reflection over the  
 7 past, the evidence of the past couple of days  
 8 that you've provided to us that you need to go  
 9 back and check?  
 10 MS. JONES:  
 11 A. Not that I'm aware of in reflecting on it in  
 12 the evenings.  
 13 THE COMMISSIONER:  
 14 Q. You indicated that you did not learn about  
 15 this until this morning?  
 16 MS. JONES:  
 17 A. The -  
 18 THE COMMISSIONER:  
 19 Q. The news report?  
 20 MS. JONES:  
 21 A. The news report, I heard the news report on  
 22 the 8:00 news report.  
 23 THE COMMISSIONER:  
 24 Q. So nobody from communications or anybody else  
 25 in your organization--well, perhaps you don't

Page 26

1 have a Blackberry. Do you have a Blackberry?  
 2 MS. JONES:  
 3 A. I have a Blackberry. It's not with me this  
 4 morning because I was at the office last  
 5 night. And I wouldn't -  
 6 THE COMMISSIONER:  
 7 Q. So you were in your office -  
 8 MS. JONES:  
 9 A. I don't answer my Blackberry in the run of a  
 10 day unless I happen to have a look.  
 11 THE COMMISSIONER:  
 12 Q. Okay.  
 13 MS. JONES:  
 14 A. So I was here all day yesterday.  
 15 THE COMMISSIONER:  
 16 Q. I appreciate that.  
 17 MS. JONES:  
 18 A. Yeah.  
 19 THE COMMISSIONER:  
 20 Q. And I'm sure it was a very long day. But  
 21 everybody who's come to give evidence in this  
 22 and a lot of the material, I've been struck by  
 23 sometimes what strange hours people  
 24 communicate with each other.  
 25 MS. JONES:

Page 27

1 A. Yes.  
 2 THE COMMISSIONER:  
 3 Q. In your organization.  
 4 MS. JONES:  
 5 A. Um.  
 6 THE COMMISSIONER:  
 7 Q. And it just strikes me as being out of the  
 8 norm for the kind of activity that we have  
 9 seen that if, indeed--assuming for the moment  
 10 that the report is accurate, we'll check that  
 11 out, but assuming for the moment that the  
 12 report is accurate and that at some point  
 13 Eastern Health advised the media about the  
 14 source of the letter indicating that it was  
 15 something different than you had said, would  
 16 you not expect that they would -  
 17 MS. JONES:  
 18 A. Contact me?  
 19 THE COMMISSIONER:  
 20 Q. - contact you, e-mail you, something?  
 21 MS. JONES:  
 22 A. They would--they know that I'm not a person  
 23 who is tied to my Blackberry, okay. They know  
 24 that after hours they would get me at home. I  
 25 was with the board chair last night preparing

Page 28

1 for the board meeting today just in case I was  
 2 not able to be there. So I was with the board  
 3 chair from 6:30 to 8:00 last night. They  
 4 would have left a voice message at home if  
 5 there was anything, if they felt it was  
 6 important, but there was no communication at  
 7 all.  
 8 CHAYTOR, Q.C.:  
 9 Q. So you've checked your e-mails and nobody e-  
 10 mailed you -  
 11 MS. JONES:  
 12 A. No, I did not -  
 13 CHAYTOR, Q.C.:  
 14 Q. You haven't checked your e-mail?  
 15 MS. JONES:  
 16 A. No.  
 17 CHAYTOR, Q.C.:  
 18 Q. But nobody from Eastern Health -  
 19 MS. JONES:  
 20 A. Nobody from Eastern Health.  
 21 CHAYTOR, Q.C.:  
 22 Q. - has contacted you to say that there's  
 23 something in the media that either is not  
 24 correct or it is corrected and we've given  
 25 information to the media that is not -

Page 29

1 MS. JONES:  
 2 A. Nobody contacted me.  
 3 CHAYTOR, Q.C.:  
 4 Q. - on par with what our CEO has told the  
 5 Commissioner?  
 6 MS. JONES:  
 7 A. Nobody has called me from Eastern Health.  
 8 CHAYTOR, Q.C.:  
 9 Q. And according to your policy that we discussed  
 10 yesterday in terms of external communications,  
 11 somebody from executive level, you would  
 12 expect, signed off on that information going  
 13 to the media, if, in fact, it did?  
 14 MS. JONES:  
 15 A. If, in fact, it did. And all I can say is is  
 16 that yesterday when we finished here, the  
 17 communication person was here who usually  
 18 deals with media, but we do have two who deal  
 19 with external media, and she was here to talk  
 20 about the budget. I asked if there had been  
 21 any calls from the media today and she said,  
 22 no, it was a very quiet day, she hadn't had  
 23 any, so -  
 24 CHAYTOR, Q.C.:  
 25 Q. So you've had conversation with your

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1 communications person -  
 2 MS. JONES:  
 3 A. Yesterday here at 20 after 5.  
 4 CHAYTOR, Q.C.:  
 5 Q. And she didn't advise you of this -  
 6 MS. JONES:  
 7 A. No.  
 8 CHAYTOR, Q.C.:  
 9 Q. What Carolyn Stokes is reporting?  
 10 MS. JONES:  
 11 A. But we have two who report--who deal with  
 12 external media.  
 13 CHAYTOR, Q.C.:  
 14 Q. And on top of page 166, "I'm not sure." And I  
 15 ask, "And would that have been the Eastern  
 16 Health's lawyers?"  
 17 MS. JONES:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. Because there was reference to the lawyers  
 21 being notified.  
 22 MS. JONES:  
 23 A. Um.  
 24 CHAYTOR, Q.C.:  
 25 Q. "And would that have been Eastern Health's

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1 lawyers? I'm not sure" -  
 2 MS. JONES:  
 3 A. "I'm not sure."  
 4 CHAYTOR, Q.C.:  
 5 Q. - "who they were at the time, whether it was  
 6 actually--I'm thinking that it probably came  
 7 through Eastern Health's lawyers" -  
 8 MS. JONES:  
 9 A. That's right.  
 10 CHAYTOR, Q.C.:  
 11 Q. - "in terms of the letter itself, but  
 12 generated by us, no. The content of it would  
 13 have come through the court order."  
 14 MS. JONES:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. And if we continue on page 177. Ms. Jones,  
 18 "Well, this is the letter and the orders were  
 19 court ordered, okay. So there was nothing  
 20 that we were going to do or could do about  
 21 what the wording of that particular court  
 22 order had been. So from my perspective we  
 23 were acting, we were an agent. I do remember  
 24 having discussion with Dan Boone and saying  
 25 here we are, Eastern Health caught in this

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1 again. We have the names of the database and  
 2 we then are perceived, particularly by our  
 3 physicians, to have actioned a court order  
 4 that, in fact, is problematic."  
 5 MS. JONES:  
 6 A. And if I recall, those are the words that were  
 7 used in the, similar words in the reporting  
 8 this morning.  
 9 CHAYTOR, Q.C.:  
 10 Q. Of what you said?  
 11 MS. JONES:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. Yes.  
 15 MS. JONES:  
 16 A. Those words -  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes, they picked up those words about you  
 19 saying that Eastern Health has been caught in  
 20 something that -  
 21 MS. JONES:  
 22 A. Yes, that's right.  
 23 CHAYTOR, Q.C.:  
 24 Q. - Eastern Health did not write?  
 25 MS. JONES:



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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And was not written on behalf of Eastern  
 4 Health?  
 5 MS. JONES:  
 6 A. And that's problematic, yeah.  
 7 CHAYTOR, Q.C.:  
 8 Q. Right. So like that was the discussion. Here  
 9 Eastern Health again is caught because of  
 10 somebody else's action that we had something  
 11 that we had no action on behalf of somebody  
 12 else.  
 13 MS. JONES:  
 14 A. We had to action on behalf.  
 15 CHAYTOR, Q.C.:  
 16 Q. I'm sorry, "we had to action on behalf of  
 17 somebody else."  
 18 MS. JONES:  
 19 A. Yeah, and that seems to be the nature of the  
 20 reporting, those words.  
 21 CHAYTOR, Q.C.:  
 22 Q. Yes.  
 23 MS. JONES:  
 24 A. Would have been the reporting this morning, so  
 25 -

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1 CHAYTOR, Q.C.:  
 2 Q. And you could see how that is not consistent  
 3 with Carolyn Stokes' statement that "late this  
 4 afternoon, the question of who had drafted the  
 5 letter was answered. Eastern Health informed  
 6 the media that the letter was written by their  
 7 lawyers." You didn't tell us that yesterday.  
 8 MS. JONES:  
 9 A. No, I didn't tell you that yesterday.  
 10 CHAYTOR, Q.C.:  
 11 Q. And in fact, what the Commissioner was told  
 12 yesterday would lead us to believe that it  
 13 wasn't done on behalf of Eastern Health, and  
 14 you were taking exception with the fact that  
 15 this had to be done and sent out on Eastern  
 16 letterhead--Eastern Health letterhead -  
 17 MS. JONES:  
 18 A. That's right.  
 19 CHAYTOR, Q.C.:  
 20 Q. - with misinformation?  
 21 MS. JONES:  
 22 A. That's right.  
 23 THE COMMISSIONER:  
 24 Q. When you finish this line of questioning, Ms.  
 25 Chaytor.

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1 CHAYTOR, Q.C.:  
 2 Q. Yes, thank you.  
 3 THE COMMISSIONER:  
 4 Q. While we have this up, there was--it happens  
 5 to be in an area that I had noted a question  
 6 for myself. Can we go back to, I think it's  
 7 page 74, somewhere in there, 74, 75, 76. I  
 8 think this is from--yes, it is, yesterday's  
 9 testimony.  
 10 MS. JONES:  
 11 A. Okay.  
 12 THE COMMISSIONER:  
 13 Q. And when you were talking about the problems  
 14 with the content of the letter -  
 15 MS. JONES:  
 16 A. Yes.  
 17 THE COMMISSIONER:  
 18 Q. - as I understood that, there were two  
 19 problems. One was the incorrect reference to  
 20 screening?  
 21 MS. JONES:  
 22 A. That's right.  
 23 THE COMMISSIONER:  
 24 Q. Which this clearly was not.  
 25 MS. JONES:

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1 A. Yes.  
 2 THE COMMISSIONER:  
 3 Q. And we've noted that before, that screening  
 4 turns up on headings and things like that and  
 5 this was clearly not related to screening.  
 6 And the other problem you identified with the  
 7 letter was a problem that seemed to have come  
 8 from the medical side of the operation.  
 9 MS. JONES:  
 10 A. Yes.  
 11 THE COMMISSIONER:  
 12 Q. And you are saying here on page 174, and I  
 13 think that if you read that, that's exactly--  
 14 because we didn't have "like the discussion  
 15 was, there was nothing in the Court order that  
 16 says, you know, 10 to 30 or 10 to 50 or  
 17 whatever, and what does clinically negative  
 18 and clinically positive mean, and so therefore  
 19 they would have sought direction and then  
 20 ended up having to make a determination inside  
 21 Eastern Health by clinically negative to  
 22 clinically positive has no reference point."  
 23 And then I think, if we go a little further,  
 24 maybe around 76, can we go down to 176? You  
 25 say "well, they would have been probably the

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1 Kara Laings of the world or whatever as around  
 2 that time, it may have been the pathologists  
 3 at the time, but this is clinically negative  
 4 to clinically positive versus an absolute  
 5 number which is the way the pathologists deal  
 6 with it."  
 7 MS. JONES:  
 8 A. Yes.  
 9 THE COMMISSIONER:  
 10 Q. So can you explain a little further what you  
 11 mean by that?  
 12 MS. JONES:  
 13 A. From a pathologist's perspective, it is either  
 14 negative or positive, okay. It is either zero  
 15 or one percent or more is positive. But from  
 16 a clinical perspective, when the oncologists  
 17 are looking at it, they're looking at the  
 18 percentage, in terms of treatment options. So  
 19 there's a technical--you know, it's either  
 20 negative or it is positive versus from a  
 21 clinical perspective, it depends on, in this  
 22 instance, you would see over time the  
 23 percentage of positivity. There were a change  
 24 in the guidelines over time around whether in  
 25 fact Tamoxifen should be given. At one point

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1 in time, it was greater than 30 percent and  
 2 then as we went to 2001, it dropped down to  
 3 ten percent. But -  
 4 THE COMMISSIONER:  
 5 Q. Yes, I understand that there was that  
 6 progression.  
 7 MS. JONES:  
 8 A. Yes, yeah, there was that progression.  
 9 THE COMMISSIONER:  
 10 Q. So is that what you're referring to?  
 11 MS. JONES:  
 12 A. Yes.  
 13 THE COMMISSIONER:  
 14 Q. Or are you saying that--that was the part that  
 15 I didn't understand. Were you saying that  
 16 when you're determining whether someone goes  
 17 from clinically negative to clinically  
 18 positive, you have to know what time the test  
 19 was originally done, so then they can know the  
 20 standard by which they're operating, or were  
 21 you saying that the oncologists of the world  
 22 have indicated to you that in order to do  
 23 their jobs, they need the percentages?  
 24 MS. JONES:  
 25 A. I think inside of this letter, it was the

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1 order had said to identify the clinically  
 2 negative to the clinically positive.  
 3 THE COMMISSIONER:  
 4 Q. Yes.  
 5 MS. JONES:  
 6 A. That is not a way that we would normally  
 7 reference that. So there was discussion about  
 8 what does clinically negative to clinically  
 9 positive mean inside of this order.  
 10 THE COMMISSIONER:  
 11 Q. Okay.  
 12 MS. JONES:  
 13 A. And at the end of the day, it went to the  
 14 panel and the way the decision clinically  
 15 negative to clinically positive was based upon  
 16 the oncology because if you do pathology, it's  
 17 either negative or it's positive. If a  
 18 pathologist was to read it, anything one  
 19 percent or over would have been positive.  
 20 THE COMMISSIONER:  
 21 Q. Okay, so that if I really want to know what  
 22 Kara Laing's problem was, I really should ask  
 23 Kara Laing you're telling me?  
 24 MS. JONES:  
 25 A. Yes, and the wording from the Court was

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1 clinically negative to clinically positive,  
 2 not--that's not the way we normally would talk  
 3 about it. It wouldn't have given us a subset  
 4 to say here is, say, 50 people and these are  
 5 the results, which does this letter apply to.  
 6 THE COMMISSIONER:  
 7 Q. Okay, but was your understanding of the  
 8 problem being conveyed to you by Dr. Laing the  
 9 problem that arises over the fact that the  
 10 numbers would have changed over time in  
 11 respect of what was considered positive or  
 12 negative by an oncologist?  
 13 MS. JONES:  
 14 A. I didn't have any discussion with Kara Laing  
 15 on this. This would have been with Marian  
 16 Crowley, who was -  
 17 THE COMMISSIONER:  
 18 Q. Okay. So your understanding of this comes  
 19 through Marian Crowley?  
 20 MS. JONES:  
 21 A. Through Marian Crowley and the discussion that  
 22 they would have had to have, which clients are  
 23 we talking about that these letters have to go  
 24 out to. Because we have a database, remember,  
 25 of all -

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1 THE COMMISSIONER:  
 2 Q. Yes.  
 3 MS. JONES:  
 4 A. Okay, and this is a subset of the all.  
 5 THE COMMISSIONER:  
 6 Q. I understand that. I just wasn't sure that I  
 7 understood what was being expressed in terms  
 8 of the second problem raised by the  
 9 oncologists about the interpretation in this  
 10 letter, and frankly, I still don't know.  
 11 MS. JONES:  
 12 A. In the oncologists, it was the screening  
 13 piece, but from Eastern Health's perspective,  
 14 we were--we had the Court order that said  
 15 "identify the people in your database who are  
 16 clinically negative to clinically positive.  
 17 Those are the ones that these letters are to  
 18 go to." We have no reference point for  
 19 clinically negative to clinically positive.  
 20 Somebody has to define that for us more.  
 21 THE COMMISSIONER:  
 22 Q. And in the end, you chose to do that by way of  
 23 the panel group?  
 24 MS. JONES:  
 25 A. By the panel group.

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1 THE COMMISSIONER:  
 2 Q. All right, thank you. Ms. Chaytor.  
 3 CHAYTOR, Q.C.:  
 4 Q. Thank you, Commissioner. If we could have P-  
 5 0488, please, page 23? This is an excerpt  
 6 from the executive management minutes, March  
 7 21st 2007, item 2.5, media relations  
 8 specialist recruitment. "Recruitment for a  
 9 media relations specialist for strategist  
 10 communications has been suspended.  
 11 Unfortunately there was only one suitable  
 12 candidate and that individual decided to  
 13 accept another offer. In the interim, Susan  
 14 Bonnell will assume this responsibility. On a  
 15 related note, strategic communications has  
 16 contracted Bristol Communications to develop  
 17 the crisis communication strategy for the  
 18 organization. At a future date, a resource  
 19 person from Bristol will be invited to present  
 20 to executive."  
 21 What is the--why was external  
 22 communicators brought in for this piece, and  
 23 what is the crisis communication strategy?  
 24 MS. JONES:  
 25 A. And just this one here is March?

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1 CHAYTOR, Q.C.:  
 2 Q. March '07, yes.  
 3 MS. JONES:  
 4 A. March '07. At the time we were looking at, we  
 5 didn't have a crisis communication strategy or  
 6 plan inside of Eastern Health and that level  
 7 of experience would not have been inside our  
 8 current internal communication department. So  
 9 at this point in time, we were looking for  
 10 external resources to develop a communication  
 11 strategy for us around--you have regular media  
 12 relations and you have a framework really for  
 13 crisis communication. That was in the winter,  
 14 but there had been discussion before that.  
 15 CHAYTOR, Q.C.:  
 16 Q. So has a crisis management strategy been  
 17 developed?  
 18 MS. JONES:  
 19 A. We've actually contracted with them, but it  
 20 would have been--what are we at now? We're -  
 21 CHAYTOR, Q.C.:  
 22 Q. March 21st, '07.  
 23 MS. JONES:  
 24 A. No, no, I'm thinking we're in April.  
 25 CHAYTOR, Q.C.:

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1 Q. Oh now, we're a year down the road.  
 2 MS. JONES:  
 3 A. Yeah, we're a year down the road. At this  
 4 point in time, they were going to come in and  
 5 do a workshop on crisis communication for us  
 6 and then following that, potentially look to  
 7 do a crisis communication strategy for us, a  
 8 framework. That didn't happen because the  
 9 spring, at the point in time when the workshop  
 10 was set up for executive, we ended up having  
 11 to cancel it. We did put a contract in place  
 12 in around December of '07, which is seven or  
 13 eight months after this, where Bristol came in  
 14 and have done some work for us. They've done  
 15 some polling in the public with respect to  
 16 just Eastern Health and the image of Eastern  
 17 Health and then from that have developed a  
 18 crisis communication framework or plan that we  
 19 had probably in--would have been January.  
 20 February is when we actually had that. So  
 21 it's really at plan around crisis  
 22 communications in the long haul.  
 23 CHAYTOR, Q.C.:  
 24 Q. And what's the definition of crisis? Would  
 25 the ER/PR issue have been considered a crisis?

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1 MS. JONES:  
 2 A. In 2005, yes, and we've been dealing with the  
 3 media issues continuing out of that. So it's  
 4 a very unusual set of circumstances, not your  
 5 normal media that you're getting on a day-to-  
 6 day call. So any events like that, that would  
 7 be considered crisis.  
 8 CHAYTOR, Q.C.:  
 9 Q. So this is to develop a communication  
 10 strategy?  
 11 MS. JONES:  
 12 A. A framework, yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. For the organization around when a crisis  
 15 would -  
 16 MS. JONES:  
 17 A. That's right.  
 18 CHAYTOR, Q.C.:  
 19 Q. - would come up. So this is how Eastern  
 20 Health would then communicate on the issue, I  
 21 take it not to patients?  
 22 MS. JONES:  
 23 A. No.  
 24 CHAYTOR, Q.C.:  
 25 Q. You have your policies in place for that.

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1 MS. JONES:  
 2 A. We have our policies in that. This would be -  
 3 CHAYTOR, Q.C.:  
 4 Q. This is intended for external communications  
 5 to the broader public?  
 6 MS. JONES:  
 7 A. And stakeholder development and those kinds of  
 8 things. So it's that kind of thing.  
 9 CHAYTOR, Q.C.:  
 10 Q. And so has that--so I'm sorry, where are we in  
 11 that process?  
 12 MS. JONES:  
 13 A. They came on in December. They did the  
 14 polling through January or so and then in  
 15 February, developed a draft and presented that  
 16 to the Board in February.  
 17 CHAYTOR, Q.C.:  
 18 Q. So there is a draft?  
 19 MS. JONES:  
 20 A. Well, it would have been approved at that  
 21 point in time, after it came out of the Board  
 22 in February.  
 23 CHAYTOR, Q.C.:  
 24 Q. Oh, so it's now approved as of February?  
 25 MS. JONES:

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1 A. Yeah, it's a strategy.  
 2 CHAYTOR, Q.C.:  
 3 Q. February of 2008?  
 4 MS. JONES:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And that deals with how on a go-forward basis  
 8 to communicate--in the event of a crisis, how  
 9 to communicate with stakeholders and how to  
 10 communicate with the broader public?  
 11 MS. JONES:  
 12 A. It's a framework and it is components of. So  
 13 it doesn't actually talk about how do you  
 14 communicate. It talks about stakeholders and  
 15 stakeholder alignment and working with  
 16 individuals, those kinds of things.  
 17 CHAYTOR, Q.C.:  
 18 Q. And what does it recommend? What does it  
 19 recommend, for example, in terms of talking or  
 20 communicating with your stakeholders?  
 21 MS. JONES:  
 22 A. There's a bunch of principles in there, but it  
 23 also bounces out of the work that they had  
 24 done around the polling that they had done in  
 25 January which talks about Eastern Health and

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1 you know, from a clinical perspective and that  
 2 people have trust in Eastern Health, but when  
 3 you get down to the administrative kinds of  
 4 things and being open and transparent, they  
 5 would not be rated as high and that we would  
 6 have to find vehicles that would allow us to  
 7 be able to talk and get our messages out into  
 8 the public. So there's a bunch of principles  
 9 in there.  
 10 There's a bunch of issues with respect to  
 11 stakeholders and identifying stakeholders who  
 12 have an interest in a particular issue, and  
 13 then involving them as we move forward, seeing  
 14 where they stand on an issue, using  
 15 individuals who are able to converse with the  
 16 public in that, like using our physicians as  
 17 part of communication with the public, those  
 18 kinds of things.  
 19 CHAYTOR, Q.C.:  
 20 Q. And does it address communications with other  
 21 health authorities?  
 22 MS. JONES:  
 23 A. Not in the sense of other health authorities,  
 24 only in the sense as they being a stakeholder  
 25 and if they're important on a particular

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1 issue. But it's not on an issue by issue  
 2 basis. So it is really the bigger picture.  
 3 So depending on what the issue is, the  
 4 regional health authorities would be a  
 5 stakeholder. Government would be a  
 6 stakeholder. Some of the advocacy groups  
 7 would be a stakeholder. So it depends on the  
 8 issue and identifying what the issue is and  
 9 then putting a plan in place to move forward  
 10 on all aspects, including internal  
 11 communication around what the issue is and  
 12 what our internal population need to know as  
 13 well.  
 14 CHAYTOR, Q.C.:  
 15 Q. And what about not only what the issue is, but  
 16 how the issue has been addressed and any key  
 17 findings from having investigated the issue  
 18 and getting that information out to the people  
 19 who need to have the information?  
 20 MS. JONES:  
 21 A. It wouldn't be specific in those things, other  
 22 than being transparent and providing as much  
 23 information as we can inside of whatever the  
 24 issue was at the time.  
 25 CHAYTOR, Q.C.:

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1 Q. And the people who developed this are Bristol,  
 2 who are a communications group?  
 3 MS. JONES:  
 4 A. That's right.  
 5 CHAYTOR, Q.C.:  
 6 Q. And was there consultation with any people who  
 7 would have expertise in patient safety issues?  
 8 MS. JONES:  
 9 A. No. In developing their strategy, they did  
 10 bring in some people from outside of the  
 11 province to develop their framework, and there  
 12 was discussion with them. So I'm not -  
 13 CHAYTOR, Q.C.:  
 14 Q. So what kind of people were they, what area of  
 15 expertise?  
 16 MS. JONES:  
 17 A. They were communications people who had dealt  
 18 with -  
 19 CHAYTOR, Q.C.:  
 20 Q. So PR people?  
 21 MS. JONES:  
 22 A. PR people. I'm not sure where their expertise  
 23 lay and how much consultation they had done  
 24 outside, but they had used the polling as part  
 25 of what they understood and it is a crisis

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1 communication framework issue.  
 2 CHAYTOR, Q.C.:  
 3 Q. So I just want to understand. The purpose for  
 4 this particular exercise or document would be  
 5 in terms of Eastern Health's PR, Eastern  
 6 Health's image in going forward and  
 7 communicating in the event of a crisis?  
 8 MS. JONES:  
 9 A. In the event of a crisis.  
 10 CHAYTOR, Q.C.:  
 11 Q. As opposed to any documentation aimed at  
 12 relaying relevant information to various  
 13 external bodies?  
 14 MS. JONES:  
 15 A. That's right.  
 16 CHAYTOR, Q.C.:  
 17 Q. That's not the purpose of that?  
 18 MS. JONES:  
 19 A. That's not the purpose of this.  
 20 CHAYTOR, Q.C.:  
 21 Q. Has that exercise happened? Has Eastern  
 22 Health gone through any similar exercises to  
 23 how on a go-forward basis, in the event of a  
 24 crisis, how to communicate findings to other  
 25 people who may need to know?

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1 MS. JONES:  
 2 A. No. No, only in terms of the framework of who  
 3 needs to be involved or what kind of--on an  
 4 individual issue, then it would be working  
 5 with the individual issue and how you would  
 6 end up communicating. This is not meant to be  
 7 this. This is meant to have the bigger  
 8 components of inside of a crisis communication  
 9 framework, what things you need to keep in  
 10 your mind as you move forward.  
 11 CHAYTOR, Q.C.:  
 12 Q. So why hasn't a similar effort been undertaken  
 13 by Eastern Health in terms of the  
 14 communication of information which could be  
 15 germane to patient safety? Why hasn't that  
 16 piece taken place?  
 17 MS. JONES:  
 18 A. I think that if you look at that, you would  
 19 have heard me say in the fall, we have really  
 20 believed that we are under resourced in  
 21 communications. We did put some additional  
 22 resources in communications, to the tune of  
 23 \$200,000 in the fall. This is where, even  
 24 though there was discussion earlier on about  
 25 bringing a consultant in to talk about a

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1 crisis communication framework, we had had  
 2 media relations. We had very little internal  
 3 communications. We had publications going on,  
 4 but there is a need to sophisticate the  
 5 communications inside of Eastern Health. So  
 6 the start in the fall was putting a contract  
 7 in place. We put--we split internal  
 8 communications away from external  
 9 communications. We're doing some work on what  
 10 it is we need to do there. So there is work  
 11 that has to be done, and we will do that work  
 12 as we move forward.

13 CHAYTOR, Q.C.:

14 Q. And the priority was given to the PR piece, in  
 15 terms of Eastern Health's image on a go-  
 16 forward basis?

17 MS. JONES:

18 A. The priority was given to, because of the  
 19 crisis nature and we were continuing to have  
 20 issues with the media around ER/PR, that let's  
 21 ignore ER/PR. Let's talk about, okay, what is  
 22 it, if there are crisis that come up, what is  
 23 it that we would need to be doing and keeping  
 24 in mind as we move forward. So that's the  
 25 tenure of why that was developed and why that

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1 was put there.

2 CHAYTOR, Q.C.:

3 Q. Okay. So whatever resources were available to  
 4 be spent on communications have been spent in  
 5 the area of the PR?

6 MS. JONES:

7 A. The communications, the new money that we have  
 8 put in, is on internal communications because  
 9 we have split the department. We have put a  
 10 contract in place on this one, and we've hired  
 11 an additional individual inside for  
 12 communications. Communications is very, very  
 13 broad and we've also had discussion around  
 14 partnerships and stakeholder relations because  
 15 whether you think about it or not,  
 16 stakeholders and how you deal with  
 17 stakeholders requires a lot of interaction  
 18 with and the building of trust and those kinds  
 19 of things and you can't do it off the corner  
 20 of your desk. So there is a lot of work that  
 21 has to be done in communications, strategic  
 22 communications, internal communications,  
 23 crisis communications and you really--there  
 24 are many aspects of that that were not in  
 25 place inside of Eastern Health.

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1 CHAYTOR, Q.C.:

2 Q. So is it Eastern Health's intention to now  
 3 develop those aspects of the communications?

4 MS. JONES:

5 A. All those elements, as we move forward, will  
 6 be developed.

7 CHAYTOR, Q.C.:

8 Q. So that hasn't been done, but that's to come?

9 MS. JONES:

10 A. That's to come.

11 CHAYTOR, Q.C.:

12 Q. And is that also being managed by Bristol  
 13 Communications?

14 MS. JONES:

15 A. No, Bristol Communications is a contract only  
 16 for crisis communication and on a retainer  
 17 with respect to if in fact we had questions or  
 18 there was issues that we would want an  
 19 external lens to give us some sense of, rather  
 20 than an internal, just an external lens to be  
 21 brought in.

22 CHAYTOR, Q.C.:

23 Q. Because my question is really more geared  
 24 towards--it's not work for PR people, the  
 25 question is more policy, isn't it? It's

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1 policy within your own organization?

2 MS. JONES:

3 A. That's right, around disclosure. I told you  
 4 that we had just re-did our values with  
 5 respect to in the fall, November, December, as  
 6 part of our strategic planning process and  
 7 those values include things such as openness,  
 8 honesty, transparency, being available, those  
 9 kinds of things. So they all become part of  
 10 how we do our work and how we do our work into  
 11 the future.

12 CHAYTOR, Q.C.:

13 Q. Yes. And really in terms of that piece,  
 14 that's internal, that's people within your  
 15 organization, so whatever resources you need  
 16 to do that piece of work, are within your  
 17 organization, although you may need to have  
 18 some external--you may need to look at what  
 19 your colleagues or your peers are doing across  
 20 the country in terms of those types of  
 21 disclosure.

22 MS. JONES:

23 A. That's right.

24 CHAYTOR, Q.C.:

25 Q. If we could have 0773, please?

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1 THE COMMISSIONER:  
 2 Q. Before we move on on this point, it seems to  
 3 me that that document would be quite valuable.  
 4 CHAYTOR, Q.C.:  
 5 Q. Yes.  
 6 THE COMMISSIONER:  
 7 Q. Mr. Simmons, can I add that to your list if we  
 8 do not have it. Perhaps we do, I frankly  
 9 don't know what's in all of those 5,000  
 10 documents.  
 11 MR. SIMMONS:  
 12 Q. We'll certainly produce it.  
 13 CHAYTOR, Q.C.:  
 14 Q. I requested that document last week.  
 15 THE COMMISSIONER:  
 16 Q. Oh, okay.  
 17 CHAYTOR, Q.C.:  
 18 Q. That's the document that you came back on an  
 19 e-mail, that was the communication strategy -  
 20 MR. SIMMONS:  
 21 Q. Yes, but -  
 22 CHAYTOR, Q.C.:  
 23 Q. And I understood it didn't exist.  
 24 MR. SIMMONS:  
 25 Q. I understood this to be a different one, but

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1 now what -  
 2 THE COMMISSIONER:  
 3 Q. All right, we can get that and while we're  
 4 adding to your list, Mr. Simmons, sorry to do  
 5 this to you this morning, but earlier in the  
 6 week the witness talked about the--you've said  
 7 in the fall you did a revision in terms of the  
 8 statement of values?  
 9 MS. JONES:  
 10 A. Yes.  
 11 THE COMMISSIONER:  
 12 Q. And I said if it's on the website, I'll go  
 13 look at it, not a problem. I went to the  
 14 website and I don't think the website is  
 15 current. So could we have the document which  
 16 changed the statement of values as well,  
 17 please?  
 18 MS. JONES:  
 19 A. Can I just respond to that? Those values are  
 20 inside the strategic planning document which  
 21 have to be approved by government first.  
 22 THE COMMISSIONER:  
 23 Q. Okay, all right.  
 24 MS. JONES:  
 25 A. So they would not be on the website until such

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1 time as -  
 2 THE COMMISSIONER:  
 3 Q. So as of yet, the government has not approved?  
 4 MS. JONES:  
 5 A. Approved inside of the strategic plan, so that  
 6 would be where those would be, but that's not  
 7 a problem. They are internal, the board has  
 8 approved them and the strategic plan has gone  
 9 forward to government.  
 10 THE COMMISSIONER:  
 11 Q. Thank you. I appreciate that.  
 12 CHAYTOR, Q.C.:  
 13 Q. Openness, transparency--I'm sorry, what else  
 14 did you say were included in the core values?  
 15 MS. JONES:  
 16 A. Under the connectedness piece.  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes, the connectedness, we talked about that  
 19 yesterday.  
 20 MS. JONES:  
 21 A. Remember I had indicated that we have core  
 22 values and then we have expected behaviours,  
 23 what we would expect staff to--how to behave,  
 24 okay, and that is a piece of work where the  
 25 value, like respect is expanded to say this is

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1 what we expect in a respect -  
 2 THE COMMISSIONER:  
 3 Q. I understood you to say yesterday that in a  
 4 value such as transparency and accountability  
 5 would be within what you've described as  
 6 connectedness.  
 7 MS. JONES:  
 8 A. There's five or six values and the words  
 9 "transparency and accountability", you  
 10 actually would go over to the behaviours that  
 11 we would expect and you would find them there.  
 12 THE COMMISSIONER:  
 13 Q. All right, thank you.  
 14 CHAYTOR, Q.C.:  
 15 Q. Is there a difference, you say openness and  
 16 transparency, is there a difference?  
 17 MS. JONES:  
 18 A. Some people would--we've tried to put as many  
 19 words around it so people understand what we  
 20 expect them to act like. So openness in terms  
 21 of open to discuss issues, those kinds of  
 22 things. Transparency, sometimes people  
 23 understand it to be more transparency and  
 24 honesty is another word that you would be  
 25 used, so they're kind of not interchangeable

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1 because they all have different elements, but  
 2 we try to use as many concepts in that so that  
 3 people will understand how we wish them to act  
 4 with the public.  
 5 CHAYTOR, Q.C.:  
 6 Q. I think I was about to go to 0773. Ms. Jones,  
 7 this is a Confidentiality Acknowledgement  
 8 Agreement which we understand is a fairly new  
 9 document at Eastern Health.  
 10 MS. JONES:  
 11 A. It's new, yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. Could you tell us about the background to this  
 14 document?  
 15 MS. JONES:  
 16 A. The background to this document is is that in  
 17 the redevelopment of policies inside of  
 18 Eastern Health, all the legacy boards would  
 19 have had a confidentiality agreement signed  
 20 generally by their staff and so over the last  
 21 couple of years, two years or so, this has  
 22 come to being to be what we want to move  
 23 forward inside of Eastern Health with respect  
 24 to confidentiality agreement and including the  
 25 signing by physicians, which hasn't always

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1 been in the legacy organizations.  
 2 CHAYTOR, Q.C.:  
 3 Q. So physicians hadn't always been asked to sign  
 4 a confidentiality agreement?  
 5 MS. JONES:  
 6 A. To physically sign, but as part of their  
 7 employment or their credentialing, it would  
 8 have been acknowledged in it, but to  
 9 physically sign the agreement just like all  
 10 other staff hadn't been in all of the legacy  
 11 boards.  
 12 CHAYTOR, Q.C.:  
 13 Q. And why is that now being of physicians?  
 14 MS. JONES:  
 15 A. Well this is one way and even though you would  
 16 understand that signing on the piece of paper  
 17 was really for them to acknowledge that they  
 18 had read the policy, were aware of the content  
 19 of the policy and understand and would abide  
 20 by the policy. You and I can have a  
 21 conversation to say have you, do you  
 22 understand, this is really a documentation of  
 23 that, that in fact they have seen it, that  
 24 they have read it, that they are aware of it  
 25 and that they in fact have documented that

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1 that is--that has happened.  
 2 CHAYTOR, Q.C.:  
 3 Q. I'm not sure I got the answer, so in the past,  
 4 they weren't asked to sign?  
 5 MS. JONES:  
 6 A. It was part of their credentialing that they  
 7 would keep information confidential, patient  
 8 confidentiality was -  
 9 CHAYTOR, Q.C.:  
 10 Q. I guess part of their code of ethics too in  
 11 terms of -  
 12 MS. JONES:  
 13 A. Code of ethics as well.  
 14 CHAYTOR, Q.C.:  
 15 Q. Is this about patient, personal patient  
 16 information?  
 17 MS. JONES:  
 18 A. Yes, personal patient information, anything in  
 19 terms of their employment, their affiliation,  
 20 anything that they learn inside of the  
 21 workplace that is privileged to the workplace,  
 22 needs to stay in the workplace, and those  
 23 would be the same things that we would be  
 24 saying of all of our staff.  
 25 CHAYTOR, Q.C.:

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1 Q. Is this agreement of "Confidentiality  
 2 Acknowledgment", it's entitled, is this  
 3 broader than what was in place previously  
 4 under the Health Care Corporation?  
 5 MS. JONES:  
 6 A. In terms of the Health Care Corporation, I'd  
 7 almost have to go back to the original, I  
 8 don't think the previous Health Care  
 9 Corporation was all encompassing in the actual  
 10 paper that we signed. And the reference  
 11 around business thing is the point that the  
 12 physicians have picked up in the media this  
 13 week and it specifically references it in  
 14 here. I don't believe -  
 15 CHAYTOR, Q.C.:  
 16 Q. It's right here, we have "this includes  
 17 confidential and/or private information  
 18 concerning patient client resident" which of  
 19 course would be covered in any event, I would  
 20 think.  
 21 MS. JONES:  
 22 A. That's right.  
 23 CHAYTOR, Q.C.:  
 24 Q. In particular with respect to professionals.  
 25 "Staff or the business of Eastern Health which



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1 may come to my knowledge or attention in the  
 2 course of my employment/affiliation."  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. So that's the portion that we've heard  
 7 publicly that physicians -  
 8 MS. JONES:  
 9 A. That's the piece that we've heard publicly.  
 10 CHAYTOR, Q.C.:  
 11 Q. - have an issue with.  
 12 MS. JONES:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And I take it that has been expressed  
 16 internally to Eastern Health by its  
 17 physicians?  
 18 MS. JONES:  
 19 A. By Dr. Howell or John Guy because they have  
 20 been the ones who had been dealing with the  
 21 physicians on this. But I do know that they  
 22 would have, it's a new concept for them and  
 23 that they would have expressed concern and  
 24 even with the media on Monday, Dr. Guy has  
 25 indicated that once it's been talked to with--

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1 and I wouldn't have that level of detail, but  
 2 just from hearing him on Monday, it was once  
 3 it's explained to the clinical chiefs, which  
 4 are physician leaders, they understand what  
 5 the concept is all about.  
 6 CHAYTOR, Q.C.:  
 7 Q. Yes, and if we go to the second page of the  
 8 document, so this is a policy, I take it, that  
 9 has been signed off on?  
 10 MS. JONES:  
 11 A. It's come up through, it's a level one policy  
 12 which means that it's a regional policy and it  
 13 has come up through all of the levels and  
 14 screens inside the organization and it's in  
 15 the process of being implemented.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, so it's signed off on in terms of you're  
 18 the issuing authority, Louise Jones -  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. - is indicated to be the issuing authority.  
 23 MS. JONES:  
 24 A. All level one policies, which are regional  
 25 policies in this nature would be signed off by

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1 the CEO.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay, so it is a policy currently in effect at  
 4 Eastern Health. The issue that's now ongoing  
 5 is the implementation of having the staff and  
 6 physicians execute the document.  
 7 MS. JONES:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Is that the issue?  
 11 MS. JONES:  
 12 A. Yes. Now this one has been in the works for a  
 13 long time because we had a lot of issues  
 14 around access to computer information and  
 15 personal information, the individual's  
 16 personal information, so there has been a lot  
 17 of discussion around this.  
 18 CHAYTOR, Q.C.:  
 19 Q. And so when you say a long time, when did this  
 20 become an issue?  
 21 MS. JONES:  
 22 A. We did some discipline of staff around  
 23 accessing their individual records through a  
 24 computer system two summer's ago, well it will  
 25 be two summers this summer, so eighteen months

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1 or so. And at that point in time, we had--we  
 2 were using old legacy board policies and so  
 3 this group has been on the go for at least  
 4 eighteen months dealing with this issue.  
 5 CHAYTOR, Q.C.:  
 6 Q. So about eighteen months ago it started?  
 7 MS. JONES:  
 8 A. This one, yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. And if we look at the type of confidential  
 11 information on page two of the document, page  
 12 three of the exhibit, it includes financial  
 13 human resources, legal, other administrative  
 14 information, business initiatives, operational  
 15 service delivery.  
 16 MS. JONES:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. So I take it, is it the other administrative  
 20 information business initiatives that are  
 21 causing concern amongst the physicians? This  
 22 refers to any information used for  
 23 administrative purposes, clinic schedules,  
 24 patient census, employee list, patient list or  
 25 donor lists, is that contentious?

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1 MS. JONES:  
 2 A. These have patient names and that on it, so I  
 3 would hope that they are not contentious.  
 4 What we've heard is the business.  
 5 CHAYTOR, Q.C.:  
 6 Q. So any information related to the  
 7 organization's initiatives, example,  
 8 organizational restructuring, mergers,  
 9 outsourcing of business units, recruitment--is  
 10 that recruitment?  
 11 MS. JONES:  
 12 A. I'm not sure.  
 13 CHAYTOR, Q.C.:  
 14 Q. Looks to me like it's recruitment. So that's  
 15 considered a business initiative?  
 16 MS. JONES:  
 17 A. Yes, restructuring, mergers, outsourcing,  
 18 business initiatives, they way John Guy  
 19 explained it was we have physicians who are  
 20 involved in the assessment of contracts, okay,  
 21 for the purchase of new equipment and those  
 22 kinds of things, so there's information that  
 23 is known through that contract and that  
 24 selection of preferred vendors and those kinds  
 25 of things, then that is part of doing the

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1 business and physicians are involved in that,  
 2 particularly if we look at bigger pieces of  
 3 equipment, like diagnostics and those things.  
 4 CHAYTOR, Q.C.:  
 5 Q. And what about physicians coming forward and  
 6 talking about issues of difficulty, recruiting  
 7 and retaining certain specialties? Is that  
 8 covered by this agreement?  
 9 MS. JONES:  
 10 A. I'm not sure. We would have to look at  
 11 business initiatives, they're out there, we  
 12 talk all the time about our issues with  
 13 recruitment and retention, so unless it is  
 14 particularly proprietary in terms of -  
 15 CHAYTOR, Q.C.:  
 16 Q. But they haven't signed the agreement yet.  
 17 MS. JONES:  
 18 A. A lot of our physicians have, they're coming--  
 19 some of them are coming into my office and  
 20 we're just sending them on to the medical  
 21 files, so here if there is business  
 22 initiatives around recruitment, retention  
 23 bonuses or specialty kinds of agreements that  
 24 we've had with individual physicians, I would  
 25 believe that that should stay internal as

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1 well.  
 2 THE COMMISSIONER:  
 3 Q. For example if a physician were to speak about  
 4 things like overworked because we don't have  
 5 enough persons of a particular specialty or  
 6 because they don't have enough people in  
 7 another department, that kind of thing, would  
 8 that be contrary to this?  
 9 MS. JONES:  
 10 A. We have physicians out there who talk to us  
 11 about that all the time and we, in fact,  
 12 provide those individuals to the media if in  
 13 fact those issues come forward.  
 14 THE COMMISSIONER:  
 15 Q. Yes, but I'm asking whether you anticipate  
 16 that that would be contrary to that, if what  
 17 they wanted to say was contrary to what  
 18 Eastern Health's view of the world?  
 19 MS. JONES:  
 20 A. We would just want to be able to put our view  
 21 out there as well.  
 22 CHAYTOR, Q.C.:  
 23 Q. So would they be prevented from speaking on  
 24 that if they signed this agreement?  
 25 MS. JONES:

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1 A. We would want to know that they were speaking  
 2 on that.  
 3 CHAYTOR, Q.C.:  
 4 Q. So they'd have to have your authorization to  
 5 be able -  
 6 MS. JONES:  
 7 A. No, not the authorization because physicians  
 8 are independent--they are credentialed by us,  
 9 this here really goes around the initiatives  
 10 that are inside of Eastern Health that are  
 11 proprietary to Eastern Health. We have  
 12 physicians all the time who talk about  
 13 workload.  
 14 CHAYTOR, Q.C.:  
 15 Q. Pathologists are employees, aren't they?  
 16 MS. JONES:  
 17 A. Pathologists are employees, they're still  
 18 credentialed, but I've been with Nash Denic in  
 19 the last couple of weeks -  
 20 THE COMMISSIONER:  
 21 Q. I understand that, Ms. Jones, but what I'm  
 22 trying to get at is whether, in your view of  
 23 this document, which I understand you're  
 24 asking physicians to sign, which they did not  
 25 have to sign prior to this, that in any way

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1 prohibits a physician from, who doesn't tell  
 2 you about it, from deciding to make his or her  
 3 concerns about the level of staffing in his or  
 4 her specialty or the level of staffing in  
 5 another specialty as far as that goes, public?  
 6 MS. JONES:  
 7 A. No, it doesn't prevent that and they have many  
 8 vehicles that they use to do that, whether  
 9 it's a personal vehicle, Newfoundland and  
 10 Labrador Medical Association and they also  
 11 have the vehicle to government because they -  
 12 THE COMMISSIONER:  
 13 Q. Oh I understand you're not preventing the  
 14 Medical Association from doing it, but my  
 15 concern for the moment is -  
 16 MS. JONES:  
 17 A. No, no, for documenting individuals.  
 18 THE COMMISSIONER:  
 19 Q. - whether--well I guess the real question is  
 20 whether or not when it says recruitment in  
 21 business initiatives, how you interpret it.  
 22 MS. JONES:  
 23 A. That's right.  
 24 THE COMMISSIONER:  
 25 Q. And as I understand what you're saying to me

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1 is that interpretation from Eastern Health's  
 2 perspective is not going to prohibit doctors  
 3 from--and we're just talking about doctors  
 4 because I guess they haven't, prior to this,  
 5 had to deal with it.  
 6 MS. JONES:  
 7 A. But many of our staff have not had and Ms.  
 8 Chaytor has already alluded to that, in the  
 9 old Health Care Corporation business was not  
 10 part of what they signed as well.  
 11 THE COMMISSIONER:  
 12 Q. Okay.  
 13 MS. JONES:  
 14 A. So this is not just a physician issue. This  
 15 would be an understanding of what would be  
 16 included in that kind of initiative, things  
 17 such as information that they've learned as  
 18 part of their business or inside a contract,  
 19 negotiations inside of choosing, you know,  
 20 vendors, those kinds of things. This one here  
 21 talks about /recruitment and that I would  
 22 suggest that some of those may very well be  
 23 individual arrangements that we have made that  
 24 are part of a personal file at the end of the  
 25 day.

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1 THE COMMISSIONER:  
 2 Q. Okay, so we should interpret recruitment in  
 3 this document as being really information  
 4 regarding contractual arrangements.  
 5 MS. JONES:  
 6 A. That's personal, right.  
 7 THE COMMISSIONER:  
 8 Q. It may be, but I'm just trying to figure out  
 9 what the document means.  
 10 CHAYTOR, Q.C.:  
 11 Q. This says "any information" it's quite broad,  
 12 related to the organization's initiatives and  
 13 then, for example, recruitment is one of  
 14 those.  
 15 MS. JONES:  
 16 A. It's one of the points underneath that  
 17 particular bullet on business -  
 18 CHAYTOR, Q.C.:  
 19 Q. So any information, so if a physician or a  
 20 nurse or whoever were to go out and speak as  
 21 to shortage of staff in their particular  
 22 profession, you're saying that's not covered  
 23 by this.  
 24 MS. JONES:  
 25 A. No.

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1 CHAYTOR, Q.C.:  
 2 Q. But if they know that they have brought  
 3 forward issues within to say there's been a  
 4 shortage and they're not happy with the  
 5 organization's response to that, are they then  
 6 prevented -  
 7 MS. JONES:  
 8 A. No.  
 9 CHAYTOR, Q.C.:  
 10 Q. - from saying that I've brought this forward -  
 11 MS. JONES:  
 12 A. I brought this forward--we see that all the  
 13 time--we brought it forward. We brought it  
 14 through all the channels inside the  
 15 organization which is generally your manager,  
 16 your program director.  
 17 CHAYTOR, Q.C.:  
 18 Q. I know you see it all the time, but this is  
 19 new.  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And in answering my question about is this  
 24 broader -  
 25 MS. JONES:

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1 A. And the answer is yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. - you weren't sure, you'd have to go back.  
 4 But this is broader, business initiatives is  
 5 new.  
 6 MS. JONES:  
 7 A. Is broader, it's not in the--usually what we  
 8 would have seen in the past was more around  
 9 patient confidentiality and this includes  
 10 human resources, legal, other administrative -  
 11 CHAYTOR, Q.C.:  
 12 Q. So, all of that is new?  
 13 MS. JONES:  
 14 A. All that's new.  
 15 CHAYTOR, Q.C.:  
 16 Q. So, all that's broader than what they have  
 17 been traditionally been asked to sign, if  
 18 they'd been asked to sign anything.  
 19 MS. JONES:  
 20 A. If they've been asked to sign anything. It's  
 21 been part of their understanding, like you  
 22 indicated, their code of ethics as they apply  
 23 for credentials and in terms of the medical  
 24 bylaws that they have to abide by. All those  
 25 issues of confidentiality would be included in

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1 those kinds of vehicles or medical -  
 2 CHAYTOR, Q.C.:  
 3 Q. So why, at this point in time, did eastern  
 4 health, in particular dealing with business  
 5 initiatives, why is it that that's seen  
 6 necessary to include under the umbrella of  
 7 confidentiality?  
 8 MS. JONES:  
 9 A. Because it's confidential information inside  
 10 of eastern health. Part of the business, you  
 11 would not normally be exposed to that or have  
 12 knowledge of that if you were not part of an  
 13 employee or some kind of relationship inside  
 14 of eastern health. This also applies to  
 15 contractors and that as well. So, it's much  
 16 broader than just staff. Anybody who comes  
 17 inside of eastern health, this applies to them  
 18 as well.  
 19 THE COMMISSIONER:  
 20 Q. Don't you have a confidentiality arrangement--  
 21 I mean, wouldn't your normal contracts include  
 22 confidentiality for everybody who walks  
 23 through your door -  
 24 MS. JONES:  
 25 A. Through who -

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1 THE COMMISSIONER:  
 2 Q. - to do contractual employment.  
 3 MS. JONES:  
 4 A. That's right. And this is -  
 5 THE COMMISSIONER:  
 6 Q. So, that wouldn't have to cover off on that,  
 7 would it?  
 8 MS. JONES:  
 9 A. But we still--and my understanding is, is with  
 10 that, apart from even having the contract,  
 11 like contractors on site to do maintenance  
 12 work or roofing or all those kinds of things  
 13 that would be part of the contract and they  
 14 would also end up having to sign off on  
 15 something like this. So, it's the  
 16 documentation piece of it, not just in terms  
 17 of in the contract itself, it the  
 18 documentation to understand that this is what  
 19 it means inside of our organization.  
 20 CHAYTOR, Q.C.:  
 21 Q. You've indicated that a fair amount of time  
 22 has gone into developing this over the past 18  
 23 months?  
 24 MS. JONES:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. Is there also a policy which would allow an  
 3 individual, within your employ or one of your  
 4 independent contractors, to report concerns he  
 5 or she may have within the organization? For  
 6 example, concerns regarding quality control or  
 7 patient safety.  
 8 MS. JONES:  
 9 A. Policy, I'm not sure, but there is a process  
 10 where they can bring forward issues. If it's  
 11 on a form, I can't say throughout the entire  
 12 organization, but they deal with the immediate  
 13 supervisor in any issue that they would have.  
 14 OH&S is a good example of that. If they have  
 15 issues, we have vehicles--particularly, if  
 16 it's Occupational Health and Safety, where we  
 17 have committee structures and form structures.  
 18 We also have issues inside our nurses. If, in  
 19 fact, they do identify an issue, then there is  
 20 a reporting process for that that goes through  
 21 a formal channel to look at the issue, address  
 22 the issue. An issue such as staffing and they  
 23 believe that care was comprised, there's a  
 24 whole process in the organization around  
 25 investigating, getting back to nurses what

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1 we've done, those kinds of things.  
 2 CHAYTOR, Q.C.:  
 3 Q. But why wouldn't that also be a policy? If we  
 4 have a policy here, this is confidentiality.  
 5 This is how we keep things within ourselves,  
 6 but here's our parallel policy on if you have  
 7 concerns, here's how we deal with it.  
 8 MS. JONES:  
 9 A. The complaints policy would be there and it's  
 10 -  
 11 CHAYTOR, Q.C.:  
 12 Q. And what's the complaints policy?  
 13 MS. JONES:  
 14 A. Well, you've seen it in terms of quality,  
 15 okay, that would be external complaints.  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes, that's people coming to complain from  
 18 outside.  
 19 MS. JONES:  
 20 A. Coming in--and then we also have, as I just  
 21 indicated, with our nursing areas, there is an  
 22 internal process that if they have issues that  
 23 they've identified from a safety perspective,  
 24 there's a process, a whole -  
 25 CHAYTOR, Q.C.:

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1 Q. Is that a policy?  
 2 MS. JONES:  
 3 A. Yes, it would be.  
 4 CHAYTOR, Q.C.:  
 5 Q. For nurses.  
 6 MS. JONES:  
 7 A. A whole validated process around how we  
 8 investigate, how we get back nurses on that.  
 9 We have professional practice forms inside of  
 10 the organization where--and that's similar to  
 11 what I'm talking about for nurses,  
 12 professional practice forms where issues are  
 13 identified and there is a process of  
 14 investigation and getting back to staff. So,  
 15 those kinds of vehicles do exist, whether they  
 16 exist in a new regional eastern health format,  
 17 they all are not transitioned into eastern  
 18 health, but they're in the process of  
 19 transitioning.  
 20 CHAYTOR, Q.C.:  
 21 Q. And this policy pertains to all people -  
 22 MS. JONES:  
 23 A. All eastern health.  
 24 CHAYTOR, Q.C.:  
 25 Q. - whether they're employees, independent

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1 contractors, anyone who comes within your  
 2 doors, this policy applies, the  
 3 confidentiality policy.  
 4 MS. JONES:  
 5 A. That's right, yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. But there's no similar policy that pertains to  
 8 everyone who comes within your doors in terms  
 9 of if you have an issue, if you have a  
 10 concern, here's the reporting process, here's  
 11 what's going to happen.  
 12 MS. JONES:  
 13 A. In legacy boards you would have seen it. I  
 14 can't, in my mind, recall whether I signed off  
 15 on a policy, but there is a process that you  
 16 work through the organization bringing--and  
 17 most of the union agreements have all of that  
 18 in place, as well, where there is structure  
 19 and process around if you have an issue, how  
 20 you can bring an issue forward. And because  
 21 we're talking about staff, the sign off on  
 22 that would be generally Mr. Dodge from a human  
 23 resource perspective. So, there may very well  
 24 be already, eastern health regionalized  
 25 policies, but I know in the legacy boards,

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1 particularly around professional practice and  
 2 that, that there is vehicles. There is  
 3 vehicles inside the unionized environments  
 4 that allow for complaints to come forward and  
 5 are dealt in the fashion inside of the  
 6 unionized agreements as well.  
 7 CHAYTOR, Q.C.:  
 8 Q. So why does this policy have to go all the way  
 9 to the top, you're signing off on it?  
 10 MS. JONES:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. Why is that?  
 14 MS. JONES:  
 15 A. Because it is deemed--we have a structure  
 16 inside of our new eastern health regional  
 17 policies where we have level 1, 2, 3 and 4.  
 18 Regional policies that are applicable to all  
 19 staff consent policies. This one would be a  
 20 confidentiality policy, some of the things  
 21 around, maybe values or those kinds of things,  
 22 ethics policies, would come to this level.  
 23 Then we have a second level which was COO.  
 24 So, if they're more on a particular portfolio,  
 25 but apply to more that one area, like human

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1 resource policies, Mr. Dodge would be the lead  
 2 on human resource policies. Then we have  
 3 level the policies where they might be  
 4 programs or might be more than one program.  
 5 And then we have a level four policy which is  
 6 a very specific and a very work area that  
 7 doesn't affect anybody else, maybe how you  
 8 technically do your task and you're the only  
 9 one doing your task. So, there's four levels  
 10 of policies.  
 11 CHAYTOR, Q.C.:  
 12 Q. And my question to you was, in terms of a  
 13 policy, similar policy to what you have in  
 14 your confidentiality privacy policy, something  
 15 that would be all encompassing, umbrella,  
 16 standardized for everyone, whether you're a  
 17 lab technologist or you're a nurse or you're a  
 18 physician, whatever you are, you have the same  
 19 policy for reporting -  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. - any issues that you have or concerns that  
 24 you might have, in particular with respect to  
 25 quality control, patient safety.

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1 MS. JONES:  
 2 A. And I would say to you, it wouldn't be  
 3 specifically quality control patient safety.  
 4 It would be any complaint that you would have  
 5 and it could be quality control or patient  
 6 safety. It could also be working conditions.  
 7 It could be anything that you have a concern  
 8 with in your work environment.  
 9 CHAYTOR, Q.C.:  
 10 Q. A vehicle by which they may speak as -  
 11 MS. JONES:  
 12 A. A vehicle.  
 13 CHAYTOR, Q.C.:  
 14 Q. - opposed to a vehicle by which they may not  
 15 speak. That's what I'm talking about.  
 16 MS. JONES:  
 17 A. Vehicle which by they speak, lots of vehicles  
 18 by which they speak.  
 19 CHAYTOR, Q.C.:  
 20 Q. But no policy.  
 21 MS. JONES:  
 22 A. I will go back and check, but I'm sure that we  
 23 will find parts of that, that are in legacy  
 24 organizations, maybe not redrafted like this  
 25 one which is a new policy for eastern health

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1 and we'll bring forward what we've got.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay. So, what the answer is right, you don't  
 4 know.  
 5 THE COMMISSIONER:  
 6 Q. Did I understand you to say that you believe  
 7 contracts with CUPE--is CUPE your major -  
 8 MS. JONES:  
 9 A. NAPE.  
 10 THE COMMISSIONER:  
 11 Q. NAPE--contracts with NAPE would include  
 12 provisions that would address patient safety?  
 13 MS. JONES:  
 14 A. No, they would include provisions that would  
 15 address, if there were issues in the work  
 16 place, that the employee could bring forward  
 17 issues in a certain framework.  
 18 THE COMMISSIONER:  
 19 Q. Okay. And those issues would not just be  
 20 employment related issues, but issues related  
 21 to patient safety?  
 22 MS. JONES:  
 23 A. Could be any issue.  
 24 THE COMMISSIONER:  
 25 Q. Okay.

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1 MS. JONES:  
 2 A. Just like we have Occupational Health and  
 3 Safety, if, in fact, they identify issues of  
 4 safety in the workplace which sometimes also  
 5 cross over to issues of patient safety, not  
 6 just worker safety, there is a whole structure  
 7 and process around Occupational Health and  
 8 Safety and reporting in the workplace as well  
 9 and that would be regional as well.  
 10 THE COMMISSIONER:  
 11 Q. I understand that there can be occasions when  
 12 issues relating to occupational safety also  
 13 relates to patient safety.  
 14 MS. JONES:  
 15 A. Yes, that's right.  
 16 THE COMMISSIONER:  
 17 Q. But I'm now, I think, hearing you say that in  
 18 respect of patient safety issues, you're  
 19 citing numerous avenues.  
 20 MS. JONES:  
 21 A. Yes.  
 22 THE COMMISSIONER:  
 23 Q. And those avenues are as broad, you think, as  
 24 to include the standard NAPE contract.  
 25 MS. JONES:

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1 A. Yes. And I'll use the example that I'm most  
 2 familiar with and that's professional practice  
 3 issues inside of nursing. And there is a  
 4 whole process for issues that are related to  
 5 safety and that with respect to nursing.  
 6 There is a whole process inside of the  
 7 unionized contract in identifying professional  
 8 practice issues.  
 9 CHAYTOR, Q.C.:  
 10 Q. And if there is a concern by people within  
 11 your organization, that they somehow feel that  
 12 they are going to be constrained from speaking  
 13 out on certain issues, my question is, an  
 14 overall umbrella policy signed off at the top  
 15 by yourself or the person in the position as  
 16 CEO, reassuring people that there are certain  
 17 issues which are so fundamental to this  
 18 organization, such as quality control, such as  
 19 patient safety, that you can speak out and we  
 20 want you to speak out and we encourage you to  
 21 speak out and here's the overall umbrella  
 22 policy by which you do that. Has eastern  
 23 health given any consideration to such a  
 24 policy?  
 25 MS. JONES:

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1 A. I'm sure that they have. Whether it's  
 2 completed at this point in time, I'm not sure  
 3 and I will get back to you on that one.  
 4 CHAYTOR, Q.C.:  
 5 Q. So, it's in the works?  
 6 MS. JONES:  
 7 A. There is obviously--in the works would be  
 8 policy in that particular realm. Whether, in  
 9 fact, it is exactly the way you have or there  
 10 are multiple parts of that policy like  
 11 confidentiality is only one part of a policy,  
 12 I can't speak to what it would be called  
 13 specifically, but we'll get that for you.  
 14 CHAYTOR, Q.C.:  
 15 Q. And let's assume the employee or independent  
 16 contractor signs the confidentiality agreement  
 17 today.  
 18 MS. JONES:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. And you're saying that there is a process in  
 22 place an there's an issue--there's something  
 23 of concern to your employee or independent  
 24 contractor and I take it, they go up the  
 25 normal chain of reporting to their supervisor.

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And it goes on up as far as it has to go up in  
 5 the chain -  
 6 MS. JONES:  
 7 A. That's right.  
 8 CHAYTOR, Q.C.:  
 9 Q. - to be addressed. The next day the employee  
 10 has the concern. What avenue is available to  
 11 the employee or independent contractor in that  
 12 situation?  
 13 MS. JONES:  
 14 A. If it's not resolved, then it generally goes  
 15 to a level higher, okay. So, if the manager -  
 16 CHAYTOR, Q.C.:  
 17 Q. But it's gone all the way that it has to go  
 18 and then from the employee's perspective, the  
 19 issue continues. What avenue is available to  
 20 the employee in that situation?  
 21 MS. JONES:  
 22 A. Then they have exhausted all avenues inside -  
 23 CHAYTOR, Q.C.:  
 24 Q. Internally, within and they can't say  
 25 anything.

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1 MS. JONES:  
 2 A. - of it's -  
 3 CHAYTOR, Q.C.:  
 4 Q. This confidentiality agreement, they can't say  
 5 anything. What do they do?  
 6 MS. JONES:  
 7 A. If they've exhausted all avenues inside, then  
 8 they do have a right to go outside to seek  
 9 resolution to whatever issue that they have.  
 10 CHAYTOR, Q.C.:  
 11 Q. And where do they get that right? Where's  
 12 that?  
 13 MS. JONES:  
 14 A. It is once it has been addressed internally or  
 15 identified internally, then that is just the  
 16 understood that they have used all the  
 17 vehicles that they have to be able to address  
 18 an issue and they still have a concern -  
 19 CHAYTOR, Q.C.:  
 20 Q. And is that in writing, it's understood, but  
 21 is that reduced to a policy or where -  
 22 MS. JONES:  
 23 A. That wouldn't be--that's been the general  
 24 practice, it's always been the practice, if,  
 25 in fact, something cannot be resolved

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1 internally, that people have dealt with all of  
 2 the levels of the organization, then you will  
 3 generally see it in the external going through  
 4 to either government or through their  
 5 different associations or, in fact, them  
 6 contacting the media or whatever vehicles that  
 7 they would deem appropriate.  
 8 CHAYTOR, Q.C.:  
 9 Q. They'd be able to go to the media or to  
 10 government if they've signed this  
 11 confidentiality agreement?  
 12 MS. JONES:  
 13 A. If, in fact, they've exhausted all of the  
 14 vehicles inside and their issue hasn't been  
 15 appropriately resolved.  
 16 CHAYTOR, Q.C.:  
 17 Q. And they risk being in breach of the  
 18 agreement?  
 19 MS. JONES:  
 20 A. In this instance once that documentation is  
 21 there that we have met with them, we've  
 22 addressed it or not addressed it to their  
 23 satisfaction, yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. So this agreement would not prevent them from

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1 taking the issue wherever they need to go with  
 2 it?  
 3 MS. JONES:  
 4 A. Once they have exhausted their internal issue.  
 5 CHAYTOR, Q.C.:  
 6 Q. And is that in this agreement? Is that  
 7 written in there anywhere? You can just  
 8 scroll down.  
 9 MS. JONES:  
 10 A. If you go through the types of things that are  
 11 there, at the end of the day when we talk  
 12 about patient information, really from the new  
 13 legislation and that, that can't go anywhere,  
 14 they would be in breach of the law.  
 15 CHAYTOR, Q.C.:  
 16 Q. Right.  
 17 MS. JONES:  
 18 A. On that, right.  
 19 CHAYTOR, Q.C.:  
 20 Q. And we're not talking about that. We're  
 21 talking about an issue that they may have  
 22 concern with, for example, what if a lab  
 23 technologist had concern about what was  
 24 happening in the lab, what if some concern  
 25 came to a lab technologist?

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And they reported it, did what they thought  
 5 they should do with it, but then from their  
 6 point of view that it wasn't resolved and that  
 7 there was some practice continuing that they  
 8 had concern with, what avenue is available to  
 9 that lab technologist as opposed to showing up  
 10 the next day, doing his or her job, doing it  
 11 in the same manner, what avenue is available  
 12 to that lab technologist?  
 13 MS. JONES:  
 14 A. That lab technologist would have dealt with  
 15 their manager. If that wasn't acceptable,  
 16 then they would go to the program director.  
 17 If that wasn't acceptable, they would have  
 18 went to the VP. And you would hope along the  
 19 line that if it was not able to be resolved,  
 20 that the manager would have gone to the  
 21 program director to say that "I have an issue  
 22 here that I can't resolve," because that does  
 23 happen. Sometimes the individual manager  
 24 can't resolve it and it may need more  
 25 resources to be able to address the issue,

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1 then they have to bring in higher levels of  
 2 the organization to address a particular  
 3 issue. And then at the end of the day if  
 4 we're not able as an organization to address a  
 5 particular issue for whatever reason, whether  
 6 it's resourcing or it's education or whatever  
 7 it is, then we would generally bring that  
 8 forward to government to say "In this  
 9 particular area, this is an issue. We're not  
 10 able to resolve it internally. What is it  
 11 that we're able to do?" And then we would be  
 12 moving it through the system.  
 13 CHAYTOR, Q.C.:  
 14 Q. So the next step above you -  
 15 MS. JONES:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. - is government?  
 19 MS. JONES:  
 20 A. Next step above me, depending on the nature of  
 21 the issue, it may very well end up having to  
 22 go to board, if it's something like that, if  
 23 not, it would end up going to straight  
 24 through. We have issues, resource issues or  
 25 whatever that we bring to board and then the



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1 minister and the board chair will meet on  
 2 particular issues that we're not able to  
 3 resolve. But if it's a very operational  
 4 nature issue, then I would directly go to  
 5 government and say, "This is an issue inside  
 6 the organization. We have not been able to  
 7 resolve it. Where are you on this issue?  
 8 What can we do with it?"  
 9 CHAYTOR, Q.C.:  
 10 Q. Yes. And I guess my question is more that you  
 11 have resolved it, you've made a decision,  
 12 you've resolved it?  
 13 MS. JONES:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. But the lab technologist is not satisfied, the  
 17 lab technologist doesn't feel that the issue  
 18 has been satisfactorily addressed.  
 19 MS. JONES:  
 20 A. Well, then we haven't resolved it, have we?  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay. So that person can still then have  
 23 avenues to go beyond Eastern Health?  
 24 MS. JONES:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. And are not constrained from doing so?  
 3 MS. JONES:  
 4 A. No. And we've got many, many examples of that  
 5 and we will have people who will say, "I've  
 6 been through all parts of the organization,"  
 7 but they may have not completed their journey  
 8 in the organization. They may have talked to  
 9 their manager, but clearly--and their manager  
 10 has not been able to resolve it, but then we  
 11 would have to say, okay, "Where was the  
 12 program director in that? Are they aware of  
 13 it?" And usually it'll come up the line and  
 14 we will work to resolve whatever issues. We  
 15 all have many constraints on us about having--  
 16 but if it's a safety issue, you know, if it's  
 17 an equipment issue or whatever, those issues  
 18 come forward and we will go to board and we  
 19 will go to government and say "This needs to  
 20 be resolved. We have to take down this  
 21 service at the end of the day because it's not  
 22 safe."  
 23 CHAYTOR, Q.C.:  
 24 Q. And from a practical point of view how  
 25 comfortable is that, and I'm just using lab

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1 technologists, but how comfortable is that lab  
 2 technologist at the end of the day still  
 3 speaking if it's gone all the way up the chain  
 4 and the answer has been, "no," how comfortable  
 5 are they still to speak?  
 6 MS. JONES:  
 7 A. I think if they, if they really believe in  
 8 what their issue is and they're an advocate  
 9 for patient care, irrespective of where they  
 10 work in the organization, and they really  
 11 believe that the issue that they want, that  
 12 they need addressed is affecting safety, then  
 13 they will carry that forward. They have other  
 14 vehicles, it's not just them. If, in fact,  
 15 they haven't been able to address the issue,  
 16 they have unionized vehicles that usually come  
 17 in and support them and work their way through  
 18 the organization in that fashion. So they're  
 19 generally not alone. And many times they  
 20 would end up coming collectively versus  
 21 individually.  
 22 CHAYTOR, Q.C.:  
 23 Q. There's no, I take it, and I don't  
 24 necessarily, you know, particularly like the  
 25 term, but I take it there's no whistle blower

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1 type policy in place?  
 2 MS. JONES:  
 3 A. No, not--that term, I've not -  
 4 CHAYTOR, Q.C.:  
 5 Q. You're familiar with the term?  
 6 MS. JONES:  
 7 A. I'm familiar with the term. I'm familiar with  
 8 they're also looking for whistle blower  
 9 legislation inside of the province or that,  
 10 but we don't have that. We basically -  
 11 CHAYTOR, Q.C.:  
 12 Q. All right, so we don't have it legislatively  
 13 which some provinces do?  
 14 MS. JONES:  
 15 A. Do, that's right.  
 16 CHAYTOR, Q.C.:  
 17 Q. And sometimes when it's not mandated through  
 18 legislation, there are policies within  
 19 organizations to deal with that issue, but  
 20 Eastern Health doesn't have that?  
 21 MS. JONES:  
 22 A. no.  
 23 CHAYTOR, Q.C.:  
 24 Q. No. And no contemplation to putting such a  
 25 policy in place?

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1 MS. JONES:  
 2 A. Well, we've--I'm not sure where the thinking  
 3 is in human resources, but if we already know  
 4 that there is some potential legislation  
 5 coming and that would be something that we  
 6 would, we would work in the spirit of whatever  
 7 that legislation is.  
 8 CHAYTOR, Q.C.:  
 9 Q. And in the spirit of openness, transparency  
 10 and honestly and the core values that we  
 11 discussed earlier, we have a confidentiality  
 12 agreement?  
 13 MS. JONES:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. We have no written policy in terms of overall  
 17 coming from the CEO as the confidentiality  
 18 agreement come forward as to how the employees  
 19 could speak, and nothing in writing as to how  
 20 they can come back at the end of the day and  
 21 continue to pursue their issue?  
 22 MS. JONES:  
 23 A. And I will check on that just so that you're  
 24 absolutely sure that there is no Eastern  
 25 Health and there may very well be legacy board

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1 policies that I wouldn't have seen in this  
 2 last ten months.  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay. Thank you. Okay, I'll go back to where  
 5 I left off yesterday, which is where I  
 6 intended to start. 0738, please? Okay,  
 7 you'll remember, Ms. Jones, yesterday we were  
 8 looking at, this is the document you sent to  
 9 the board of trustees around the government  
 10 announcement on November 1st, 2007.  
 11 MS. JONES:  
 12 A. Um.  
 13 CHAYTOR, Q.C.:  
 14 Q. And the third page of this document I didn't  
 15 get to yesterday.  
 16 MS. JONES:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. And this is an Eastern Health statement in  
 20 response.  
 21 MS. JONES:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. November 2nd, 2007. Did this document go out?  
 25 MS. JONES:

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1 A. Yes, it did.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay. And so this would have--this is a press  
 4 release, I take it?  
 5 MS. JONES:  
 6 A. This is a press release.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay. And this says that "Eastern Health has  
 9 been working with NLCHI and the department on  
 10 developing the ER/PR database to prepare for  
 11 the work of the Commission of Inquiry. Out of  
 12 respect for that we will address any issues  
 13 arising from the database through the public  
 14 process of the Commission."  
 15 MS. JONES:  
 16 A. Um.  
 17 CHAYTOR, Q.C.:  
 18 Q. "Right now our primary focus is on insuring  
 19 that any individuals who need to be notified  
 20 as a result of the database will be notified.  
 21 We recognize that effective database  
 22 management is a key issue for this  
 23 organization. This is why we have identified  
 24 information technology investment and decision  
 25 support systems as two of our top three budget

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1 requests."  
 2 MS. JONES:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. "For the upcoming year."  
 6 MS. JONES:  
 7 A. Um.  
 8 CHAYTOR, Q.C.:  
 9 Q. Ms. Jones--and this is signed off by you,  
 10 yourself?  
 11 MS. JONES:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. Why did you feel it necessary to go out with  
 15 your own press release on November 2nd?  
 16 MS. JONES:  
 17 A. We would have been getting many calls from the  
 18 media in response to the minister's press  
 19 release that day which talked about the 939  
 20 going to nearly 1000, so the media would have  
 21 been wanting us to explain that, plus the  
 22 other contents of the press release. And you  
 23 heard me clearly say yesterday that this was a  
 24 work in process, that we were not convinced  
 25 that it was fully done. We were working with

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1 each individual question that was coming from  
 2 NLCHI at the time and providing answers. So  
 3 things were changing. Even though the number  
 4 had gone up considerably, there was the issue  
 5 of, you know, late samples coming in from  
 6 boards and those kinds of things. And so we  
 7 really didn't believe that if we were to talk  
 8 to the about 1000, that that would have been  
 9 correct, because we didn't know all of the  
 10 answers to that. And then on the--I clearly  
 11 said and in the e-mail that had gone out to  
 12 the board of trustees that our concern was  
 13 that we absolutely wanted to insure that--I  
 14 talked to the chair, we wanted to make sure  
 15 that patients were contacted personally,  
 16 because that is the--that was the stance that  
 17 we had taken, whenever we became aware of  
 18 something, we would immediately try to contact  
 19 patients, and we knew that all those patients  
 20 were not contacted. And that would have been  
 21 in that release. And the other one was we  
 22 were well past sending in and doing the work  
 23 on the budget where database management and  
 24 issues of data collection and database  
 25 management would have been. And we had

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1 identified that two of the three top priority  
 2 items were in that area, the first one being  
 3 human resources, but the second and the third  
 4 being technology and decision support. So  
 5 rather than trying to be out there trying to  
 6 explain why the 939 versus 1000 when we  
 7 weren't sure that that 1000 was going to hold  
 8 and it may have gone up or it may have gone  
 9 down, at that point in time we didn't know,  
 10 that this was what the Commission of Inquiry  
 11 was all about, and so that was the reason for  
 12 that. And this was a Friday afternoon. And  
 13 so it was really they wanted a response, the  
 14 media wants a response from us, so this was a  
 15 written response to them and nobody spoke to  
 16 it.  
 17 CHAYTOR, Q.C.:  
 18 Q. This is what the Commission of Inquiry is all  
 19 about. And not in terms of figuring out if  
 20 it's 939 or 1013?  
 21 MS. JONES:  
 22 A. No.  
 23 CHAYTOR, Q.C.:  
 24 Q. No, okay.  
 25 MS. JONES:

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1 A. It was this one was relating to the database  
 2 issue and the number of patients and were they  
 3 actually all identified and were they  
 4 contacted and all of that. So there's more  
 5 than just this issue in the Commission of  
 6 Inquiry.  
 7 CHAYTOR, Q.C.:  
 8 Q. And so was there something lacking or missing,  
 9 you felt, or not sufficiently clear in the  
 10 government's announcement that you felt this  
 11 would help clarify?  
 12 MS. JONES:  
 13 A. It was just that we knew absolutely that soon  
 14 as the minister made that, that they would  
 15 have been coming to Eastern Health to  
 16 absolutely clarify. And there was the issue  
 17 in the press release that talked about the  
 18 poor data management practices, and we had  
 19 seen that, and so we wanted to assure the  
 20 public that we were already, had identified  
 21 that as one of our key priorities as we move  
 22 forward.  
 23 CHAYTOR, Q.C.:  
 24 Q. And there's only really a couple of key points  
 25 in what you're trying to get out here, one is

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1 -  
 2 MS. JONES:  
 3 A. Absolutely.  
 4 CHAYTOR, Q.C.:  
 5 Q. - telling people, look, we're going to be  
 6 contacting the people that this is about -  
 7 MS. JONES:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. - we're in the process of notifying. And the  
 11 second one is, we're dealing with the database  
 12 management issues?  
 13 MS. JONES:  
 14 A. That's right.  
 15 CHAYTOR, Q.C.:  
 16 Q. Right. That's what you're really telling the  
 17 public?  
 18 MS. JONES:  
 19 A. That's right.  
 20 CHAYTOR, Q.C.:  
 21 Q. Did you ask the department to include that in  
 22 its release?  
 23 MS. JONES:  
 24 A. We didn't see its release, if you remember, we  
 25 saw a release on the midnight was the redraft

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1 based upon what we had said. And -  
 2 CHAYTOR, Q.C.:  
 3 Q. You were seeing drafts back and forth?  
 4 MS. JONES:  
 5 A. Yeah. We had a first draft, we had offered  
 6 some comments to it. We got a second draft  
 7 come close to midnight. We were waiting for  
 8 the final draft because usually you do get it  
 9 before the minister goes out. And it was, you  
 10 know, close to probably 11:00 or so, probably  
 11 even after that that we had actually got the  
 12 press release, and inside the press release  
 13 there were those comments about the database  
 14 management inside of Eastern Health. We  
 15 hadn't seen those in earlier drafts. And so  
 16 we just wanted to assure the public that, in  
 17 fact, we were looking at that and were aware  
 18 of it and that we had identified it for  
 19 information investment.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay. 0740, please, Registrar? And this is  
 22 an e-mail exchange dealing with a, if you want  
 23 to just scroll down through and see, it's  
 24 Robert Thompson on November 9th, 2007  
 25 contacting you about getting together for a

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1 meeting?  
 2 MS. JONES:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. And "Now that I have almost a week at this  
 6 work," he writes, "preparing for the  
 7 Commission (on a sustained basis) I have  
 8 revamped our work plan and would like to sit  
 9 down with you to review it. I can also see  
 10 more clearly that confusion exists around the  
 11 mandate of this office and how it relates--and  
 12 how we relate," sorry, "to the department and  
 13 to the RHAs," the regional health authorities.  
 14 "Therefore, I would like to meet with you  
 15 early next week, if possible, to connect these  
 16 dots and lay the basis for a smooth process as  
 17 we head towards the Commission." And you're  
 18 looking at your calendar and you're hoping to  
 19 come up with a date to meet. Did you actually  
 20 meet?  
 21 MS. JONES:  
 22 A. Yes, we did meet.  
 23 CHAYTOR, Q.C.:  
 24 Q. What did this mean, what's he talking about,  
 25 what was the purpose of the meeting, to see

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1 more clearly, what was the confusion around  
 2 the mandate of his office and how it relates  
 3 to the department and to Eastern Health is the  
 4 only one, I guess, you could speak to?  
 5 MS. JONES:  
 6 A. I think that at that time Robert was working  
 7 with--he was the acting deputy minister for  
 8 the--for health at the time until he moved  
 9 over into doing the task force. So he was  
 10 carrying two functions, so he was doing the  
 11 deputy minister function. And when we were  
 12 interacting with him, we didn't know whether  
 13 we were interacting with him on behalf of in  
 14 his deputy minister role or was it his  
 15 Commission role or was it the task force that  
 16 we hadn't seen the actual terms of reference  
 17 for, which we didn't see until much later. So  
 18 when he's asking for information and those  
 19 kinds of things, in what role is he asking it  
 20 for, and so that was the kind of discussion  
 21 that we had had in terms of -  
 22 CHAYTOR, Q.C.:  
 23 Q. So is he still deputy minister now in November  
 24 of '07?  
 25 MS. JONES:

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1 A. He's just, if you said he's almost a week into  
 2 his new role, so Don Keats has now moved into  
 3 the deputy minister role. And so all of the  
 4 issues around the task force and the  
 5 Commission of Inquiry, Robert is informing me  
 6 that, in fact, everything around the  
 7 Commission of Inquiry and the ER/PR is in this  
 8 particular realm of government and that Don  
 9 Keats and the department really, any requests  
 10 around ER/PR are coming from him and not from  
 11 Don. So that -  
 12 CHAYTOR, Q.C.:  
 13 Q. But Don Keats would have no involvement with  
 14 the ER/PR issue?  
 15 MS. JONES:  
 16 A. That's right, that's right. And that is why  
 17 as we move forward with the budget submission,  
 18 remember the decision support thing that I had  
 19 sent in on the 16th or so of November, it was  
 20 sent to the department because it was part of  
 21 a budget. But Robert said any issues arising  
 22 out of ER/PR, he will be dealing with it, so  
 23 therefore you would have had, because it was a  
 24 budget submission, gone to Don Keats and the  
 25 minister, and then on the other hand because I

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1 knew he was dealing with the ER/PR issue and  
 2 budget requests around that, then I also sent  
 3 a copy to him. So that helped to clarify the  
 4 issues of ER/PR, the discussion, the preparing  
 5 for the Commission of Inquiry was going to be  
 6 out of Robert's new office in the role that he  
 7 had.  
 8 CHAYTOR, Q.C.:  
 9 Q. But the preparing of government, I take it?  
 10 MS. JONES:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. Not the preparing of Eastern Health?  
 14 MS. JONES:  
 15 A. Not the preparing of Eastern Health.  
 16 CHAYTOR, Q.C.:  
 17 Q. Although, Eastern Health had to send all of  
 18 its documents to Mr. Thompson?  
 19 MS. JONES:  
 20 A. Which was the discussion that we had had,  
 21 yesterday about asking that question, why  
 22 would they need all of that level of detail.  
 23 CHAYTOR, Q.C.:  
 24 Q. Yes. And you didn't get the answer to that?  
 25 MS. JONES:

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1 A. Did never got the answer to that. And we had  
 2 worked out a process between the lawyers.  
 3 CHAYTOR, Q.C.:  
 4 Q. Yes.  
 5 MS. JONES:  
 6 A. Part of the discussion at the meeting that  
 7 happened, which was in the early part of the  
 8 next week, was again around the information  
 9 that Robert had requested through the summer  
 10 and where were we and at what point in time  
 11 could we expect, the department expect to  
 12 receive all of that information. And on the  
 13 task force piece here it was we were  
 14 wondering, because it wasn't--there was very  
 15 little information out there, we just knew  
 16 that there was a task force on adverse events.  
 17 And Robert had indicated that he hadn't gotten  
 18 his head around exactly what that--where that  
 19 was going to go, but he had a time line for  
 20 reporting on it, but it wasn't to get into the  
 21 specific aspects of adverse events. Because  
 22 we did talk about was the province, maybe, as  
 23 he moved forward, going to look at mandatory  
 24 reporting for adverse events like they have in  
 25 some of the western provinces and he hadn't

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1 done the research or got his head around that.  
 2 But we did talk about events that we could  
 3 have some learnings from like Burin, like  
 4 Gander with the radiology, like ER/PR, not the  
 5 specifics of them, but the learnings from them  
 6 would be something that as they move forward,  
 7 so it wasn't a specific event itself. And he  
 8 wasn't clear at that point in time just where  
 9 it would go. Sterilization in Labrador had  
 10 also been one of these events. So whether  
 11 they would use them kind of as a case study or  
 12 how they would become involved in the work of  
 13 the task force. That was just a generic  
 14 discussion.  
 15 CHAYTOR, Q.C.:  
 16 Q. And so that was basically what happened at  
 17 your meeting which took place, I take it,  
 18 sometime mid November?  
 19 MS. JONES:  
 20 A. Yeah. And the other discussion that happened  
 21 would have been me having a discussion around  
 22 all of the information. And it was the  
 23 information, it was really how the staff were  
 24 holding up in terms of there's very little  
 25 redundancy inside of the organization when you

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1 have a very specialized area like the lab, you  
 2 have one manager who knows that particular  
 3 area or a director who knows the area, so with  
 4 all of the information requests that were  
 5 coming from the Commission, we still had the  
 6 database on the go and we had the class action  
 7 lawsuit, that we were relying on a small cadre  
 8 of individuals who there was no natural backup  
 9 for and you couldn't hire individuals back  
 10 into the organization to support them, that it  
 11 was becoming difficult to be able to meet all  
 12 of the requests that were coming forward and  
 13 the time lines. Because really what I was  
 14 trying to say was that we are running an  
 15 organization, the lab still has to keep going,  
 16 we still have issues that are coming into our  
 17 quality, we have all of those regular work  
 18 that somebody has to fill in an eight-hour day  
 19 and because these are specialty skilled  
 20 individuals and workers, there's no backup for  
 21 them, that's the way the system works. So  
 22 these people were working 12, 15 hours a day,  
 23 depending on the requests that were coming in.  
 24 And I had already expressed, I think maybe in  
 25 the 1st of November when we met with

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1 Commission lawyers, around we had a small  
 2 cadre of individuals who knew this, there was  
 3 nobody else who had this information, that you  
 4 would have in some ways to be patient with us  
 5 because we could only run so fast as well as  
 6 keep an organization going.  
 7 CHAYTOR, Q.C.:  
 8 Q. Did you--so your meeting with Robert Thompson  
 9 that day was to address him also requesting  
 10 the information, I take it, from you, the  
 11 information that you were compelled to have to  
 12 produce to the Commission?  
 13 MS. JONES:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And the necessity to have to produce it for  
 17 him, as well?  
 18 MS. JONES:  
 19 A. That's right. And we had already had a little  
 20 bit of that discussion when we met on the 1st  
 21 of November when Robert met with yourself and  
 22 Mr. Coffey with the database that he was  
 23 almost ready to pass over.  
 24 CHAYTOR, Q.C.:  
 25 Q. And if we could move on then. There is a--

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1 actually 11:00. Did you want to break now?  
 2 THE COMMISSIONER:  
 3 Q. If this is a convenient place for you.  
 4 CHAYTOR, Q.C.:  
 5 Q. I'm about to move into--actually, there's a  
 6 set of minutes from the executive management  
 7 committee that I need to go back to.  
 8 THE COMMISSIONER:  
 9 Q. All right. We'll take 15 minutes.  
 10 CHAYTOR, Q.C.:  
 11 Q. Thank you.  
 12 (RECESS)  
 13 THE COMMISSIONER:  
 14 Q. Please be seated. Ms. Chaytor.  
 15 CHAYTOR, Q.C.:  
 16 Q. Exhibit P-0488, page 32, please, Registrar?  
 17 Ms. Jones, this is executive management. And  
 18 I apologize in going back here to May 30th.  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And then we'll skip back to November. But we  
 23 missed this one, I believe, in going through  
 24 yesterday. And this is executive management  
 25 meeting of that date. You are present and Mr.

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1 Tilley is chairing the meeting?  
 2 MS. JONES:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. And Ms. Pilgrim, Ms. Bonnell are in  
 6 attendance?  
 7 MS. JONES:  
 8 A. Um.  
 9 CHAYTOR, Q.C.:  
 10 Q. 2.1.1, "Update on ER/PR Receptor Issue." "The  
 11 executive reflected on the events of the past  
 12 week and discussed briefly public confidence  
 13 in the health system. The board held a  
 14 special meeting on May 23rd, 2007 and they are  
 15 sensitive to the tremendous media pressure the  
 16 organization is currently experiencing and is  
 17 also concerned that the confidence in the  
 18 system is being eroded as a result of the  
 19 misrepresentation of the facts. Strategic  
 20 communications and external communication  
 21 specialists will begin to explore other  
 22 communication strategies to insure the correct  
 23 messages are communicated to the public."  
 24 What were the misrepresentation of the facts  
 25 that was of concern to Eastern Health?

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1 MS. JONES:  
 2 A. I can't speak specifically to what the board  
 3 and that, but it was potentially more around  
 4 the issue of why we made--why the CEO made the  
 5 decision about just releasing part of the  
 6 information or talking about the deaths  
 7 because it was around the treatment changes.  
 8 And in this instance I think at some point  
 9 there was an apology there. Plus the issue of  
 10 error rates and the fact that there's been no  
 11 discussion really about the issue of false  
 12 negatives and those kinds of things. So other  
 13 than that, I can't really recall, but it was  
 14 in, potentially in those particular areas.  
 15 CHAYTOR, Q.C.:  
 16 Q. So how were the facts misrepresented and who  
 17 were the facts misrepresented by?  
 18 MS. JONES:  
 19 A. The media was not reporting the entire story.  
 20 They had had technical briefings in the past  
 21 around ER/PR, what the test was, the nature of  
 22 the test, that there was false positives--  
 23 false negatives, and that would be part of  
 24 looking at this entire issue. And those kinds  
 25 of things were generally never reported in the

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1 media.  
 2 CHAYTOR, Q.C.:  
 3 Q. So the fact that the media didn't give  
 4 information that had been provided to it by  
 5 Eastern Health as to what -  
 6 MS. JONES:  
 7 A. The full scope, yeah.  
 8 CHAYTOR, Q.C.:  
 9 Q. - a, what a range, acceptable range of error  
 10 would be?  
 11 MS. JONES:  
 12 A. Yes, part of it.  
 13 CHAYTOR, Q.C.:  
 14 Q. As opposed to what the range of error was in  
 15 this particular case -  
 16 MS. JONES:  
 17 A. And the sensitivity of the test and tests on  
 18 any one day or so may, you know, may have--the  
 19 numbers were not an absolute, and  
 20 understanding what the numbers actually meant.  
 21 CHAYTOR, Q.C.:  
 22 Q. And that was deemed to be a misrepresentation  
 23 of the facts as opposed to incomplete -  
 24 MS. JONES:  
 25 A. Not a full complete picture.

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1 CHAYTOR, Q.C.:  
 2 Q. So that's misrepresentation?  
 3 MS. JONES:  
 4 A. Yeah.  
 5 CHAYTOR, Q.C.:  
 6 Q. So when there's not a full complete picture  
 7 given, that's misrepresentation?  
 8 MS. JONES:  
 9 A. In this instance that was the way the  
 10 secretary captured that in that way.  
 11 CHAYTOR, Q.C.:  
 12 Q. Well, I guess a word such as  
 13 "misrepresentation", the secretary wouldn't  
 14 use that unless the word was being used?  
 15 MS. JONES:  
 16 A. I'm not sure if those words would have been  
 17 used, but the whole picture wasn't out there  
 18 and I guess that's the point that was made.  
 19 CHAYTOR, Q.C.:  
 20 Q. Continues on the next bullet, "the CEO held a  
 21 press conference on the ER/PR on Friday, May  
 22 18th and media statement and Q and As were  
 23 provided."  
 24 MS. JONES:  
 25 A. Um.

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1 CHAYTOR, Q.C.:  
 2 Q. And that's the you just mentioned about Mr.  
 3 Tilley -  
 4 MS. JONES:  
 5 A. Tilley's.  
 6 CHAYTOR, Q.C.:  
 7 Q. - offering an apology?  
 8 MS. JONES:  
 9 A. Yeah.  
 10 CHAYTOR, Q.C.:  
 11 Q. Did you attend that press conference?  
 12 MS. JONES:  
 13 A. Yes, I did.  
 14 CHAYTOR, Q.C.:  
 15 Q. And was that the first time that you attended  
 16 anything in the way of a public event for the  
 17 ER/PR issue? You weren't at the December,  
 18 2006?  
 19 MS. JONES:  
 20 A. No, I wasn't at the December, 2006. And this  
 21 was a press conference and we were there to  
 22 support Mr. Tilley. Pat Pilgrim and myself  
 23 sat in the audience with the--while the press  
 24 conference was going on.  
 25 CHAYTOR, Q.C.:

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1 Q. For personal support to Mr. Tilley?  
 2 MS. JONES:  
 3 A. Personal support to Mr. Tilley.  
 4 CHAYTOR, Q.C.:  
 5 Q. Because you had not been involved, I  
 6 understood, in the -  
 7 MS. JONES:  
 8 A. Absolutely. And the next meeting I also felt  
 9 it was important to be there for personal -  
 10 CHAYTOR, Q.C.:  
 11 Q. The meeting with the MHAS?  
 12 MS. JONES:  
 13 A. MHAS. Pat Pilgrim and myself actually sat in  
 14 that meeting, as well.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay. And why did you go to that meeting with  
 17 the MHAS?  
 18 MS. JONES:  
 19 A. Because again, the same thing, for personal  
 20 support. We had Mr. Tilley and we had Nash  
 21 Denic, Oscar Howell and that and so it was  
 22 really to just be there and be a friendly face  
 23 and to hear the kinds of questions that were  
 24 being asked by the press and as well as the  
 25 MHAS.

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1 CHAYTOR, Q.C.:

2 Q. Okay. And then there's reference to the

3 judicial inquiry having been -

4 MS. JONES:

5 A. Announced.

6 CHAYTOR, Q.C.:

7 Q. Announced?

8 MS. JONES:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. So I take it in terms of meeting with the MHAS

12 you didn't answer any questions?

13 MS. JONES:

14 A. No. We sat at the corner of the table and

15 were just there.

16 CHAYTOR, Q.C.:

17 Q. And if you had been called upon, would you

18 have been able to answer any questions on the

19 issue?

20 MS. JONES:

21 A. Not particularly. It was a can (phonetic)

22 presentation that they had. Maybe if they had

23 asked specific issue on fixation, I might have

24 been able to answer that, because that was one

25 that I was aware of and had, but that was not

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1 the nature of it. It was really almost like a

2 technical briefing.

3 CHAYTOR, Q.C.:

4 Q. And then there's, under the class action,

5 there's reference to Mr. Tilley having written

6 a letter to the editor of, that should be,

7 "The Globe and Mail" challenging the article

8 printed in relation to ER/PR, and did you know

9 that he was going to be writing a letter to

10 "The Globe and Mail?"

11 MS. JONES:

12 A. We wouldn't have known that until probably

13 after the fact.

14 CHAYTOR, Q.C.:

15 Q. And do you recall being told why Mr. Tilley

16 felt the need to write a letter to "The Globe

17 and Mail?"

18 MS. JONES:

19 A. I have no recall on that, and I'm not sure

20 what the article was.

21 CHAYTOR, Q.C.:

22 Q. So you had no involvement -

23 MS. JONES:

24 A. There was many articles that were written over

25 the period of time.

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1 CHAYTOR, Q.C.:

2 Q. So you had no involvement in drafting the

3 letter?

4 MS. JONES:

5 A. No.

6 CHAYTOR, Q.C.:

7 Q. And did not have the letter run past you

8 before it was sent?

9 MS. JONES:

10 A. No.

11 CHAYTOR, Q.C.:

12 Q. And the full letter, it says did not get

13 published. This is another example of the

14 misrepresentation of the message. The Board

15 chair has agreed to bring the full letter and

16 the articles to--what's CHA?

17 MS. JONES:

18 A. Canadian Hospital Association.

19 CHAYTOR, Q.C.:

20 Q. At their meetings in June. Do you know if

21 that happened?

22 MS. JONES:

23 A. If Ms. Dawe would have brought that with her,

24 and had discussion with her counterparts, if

25 that was written there, and Joan was very good

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1 about doing that, making sure that this issue

2 was understood.

3 CHAYTOR, Q.C.:

4 Q. You don't remember any follow up though when

5 Ms. Dawe back?

6 MS. JONES:

7 A. I was not at the CHA meetings and I'm not sure

8 on what vehicle she would have done it, but

9 she sits on the board of the CHA.

10 CHAYTOR, Q.C.:

11 Q. And the full letter not having been published

12 by "The Globe and Mail" and it's indicated

13 here this is another example of the

14 misrepresentation of the message. Who is

15 saying this at this point in time?

16 MS. JONES:

17 A. Well, it's -

18 CHAYTOR, Q.C.:

19 Q. The report, update on ER/PR receptor issue,

20 and in brackets is GT, George Tilley.

21 MS. JONES:

22 A. Yeah.

23 CHAYTOR, Q.C.:

24 Q. So would that be Mr. Tilley who's saying this?

25 MS. JONES:



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1 A. It could have been conversations around the  
 2 table to say that a message is not getting  
 3 out, you know, there's parts of the message.  
 4 If you go back to the top and let's see who  
 5 else is here? Generally we wouldn't associate  
 6 it with any one particular person, but we do  
 7 have Susan Bonnell as well who's here. So it  
 8 may be a general conversation about our  
 9 message not getting out and parts of the  
 10 message not being picked up by the media. So  
 11 you would not be able to attribute that to any  
 12 one individual. There is a group of  
 13 individuals there.

14 CHAYTOR, Q.C.:

15 Q. Was it the consensus then of the group that  
 16 this was indicative of a misrepresentation of  
 17 the message?

18 MS. JONES:

19 A. It was--all of us would have had some more  
 20 understanding of the ER/PR issue and we knew  
 21 that facts around the ER/PR issue,  
 22 particularly the issue of false negative, was  
 23 not out there and was not understood, and  
 24 that's one -

25 CHAYTOR, Q.C.:

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1 Q. What is it about the issue of false negative  
 2 not being out there?

3 MS. JONES:

4 A. The test is not a perfect test, I guess, is  
 5 the point and -

6 CHAYTOR, Q.C.:

7 Q. I guess most tests--there's no perfect test, I  
 8 would take it.

9 MS. JONES:

10 A. There's no perfect test, but people don't--  
 11 people generally take things as being an  
 12 absolute. You know, you get your hemoglobin  
 13 done and it is an actual number. In this one,  
 14 there was a lot of--it wasn't an absolute.  
 15 There's a false negative rate. We do get that  
 16 with PAP smears as well, but people kind of  
 17 don't understand that, in that sense, and the  
 18 other thing is that it would have been one of  
 19 many pieces of information that led to  
 20 decisions that oncologists made around  
 21 treatment options. So it was being portrayed  
 22 as a single issue and this was the reason why  
 23 decisions were made, and the issue was that,  
 24 as well as the patient history, as well as the  
 25 pathology that was going on, as well as

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1 whether in fact the patient had many other--  
 2 what their clinical history was. So it's one  
 3 of many factors, and that piece was not being--  
 4 that piece wasn't being clearly picked up and  
 5 portrayed in the media.

6 CHAYTOR, Q.C.:

7 Q. With your hemoglobin though, I take it the  
 8 number that you get might not be an accurate  
 9 number.

10 MS. JONES:

11 A. It generally--more accurate than a range of  
 12 numbers that you would see, and in this one,  
 13 this was one of the areas where it was one of  
 14 many things, just like hemoglobin is one of  
 15 many things. If you're not symptomatic, you  
 16 may not have anything done.

17 CHAYTOR, Q.C.:

18 Q. Right, same sort of issues would go into that  
 19 as well.

20 MS. JONES:

21 A. Yeah, and not understood.

22 CHAYTOR, Q.C.:

23 Q. Right, and needing to know the clinical  
 24 picture. So I was just -

25 MS. JONES:

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1 A. Needing to know the clinical picture.

2 CHAYTOR, Q.C.:

3 Q. I wasn't understanding the distinction that  
 4 was being drawn there. Okay, so it was, I  
 5 take it then, the general consensus, is that  
 6 what you're saying, in the room that somehow  
 7 the message was being misrepresented?

8 MS. JONES:

9 A. That the entire message was not out there, and  
 10 that there was--and that we had to find a way  
 11 of imparting the entire message.

12 CHAYTOR, Q.C.:

13 Q. And the use again, for a second time in these  
 14 minutes, of the word "misrepresentation," I  
 15 take it that means the entire message and the  
 16 full story not being out there -

17 MS. JONES:

18 A. That's right.

19 CHAYTOR, Q.C.:

20 Q. - is considered to be a misrepresentation?

21 MS. JONES:

22 A. In this instance, yes.

23 CHAYTOR, Q.C.:

24 Q. Canadian Cancer Society then is mentioned here  
 25 and Ms. Pilgrim will be meeting with Mr. Dawe.

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1 What was that about? What did she have to  
 2 meet with Mr. Dawe about?  
 3 MS. JONES:  
 4 A. I have no idea in the context of that. You'll  
 5 have to ask Ms. Pilgrim what that was about.  
 6 CHAYTOR, Q.C.:  
 7 Q. You don't recall the discussion around that at  
 8 the meeting?  
 9 MS. JONES:  
 10 A. No.  
 11 CHAYTOR, Q.C.:  
 12 Q. Did that have to do with any concerns that the  
 13 executive had about any speakings that Mr.  
 14 Dawe may have had or any discussion Mr. Dawe  
 15 may have had in the media?  
 16 MS. JONES:  
 17 A. I can't answer that question.  
 18 CHAYTOR, Q.C.:  
 19 Q. Do you recall ever being present when Mr.  
 20 Dawe's involvement on the issue was discussed?  
 21 MS. JONES:  
 22 A. Only to the extent that people were--the media  
 23 were going to Mr. Dawe, as part of the  
 24 Canadian Cancer Society, looking for  
 25 information or response, probably because we

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1 weren't as responsive or readily accessible as  
 2 Peter Dawe, and so in that context,  
 3 occasionally we would be saying "how come  
 4 we're not out there as fast as Mr. Dawe is out  
 5 there?" and so in this instance, that may not  
 6 have anything to do with the discussion that  
 7 was had there, but you asked the question was  
 8 there any discussion about Peter.  
 9 CHAYTOR, Q.C.:  
 10 Q. Yes.  
 11 MS. JONES:  
 12 A. And being out there, and it was the  
 13 responsiveness of Peter. Sometimes we would--  
 14 there may have been a phone call from Pat  
 15 Pilgrim, I would be aware not the exact nature  
 16 of, saying "Peter, if you want information  
 17 from us or you want to understand it, give us  
 18 a call and we'll provide you with whatever  
 19 resource on a particular issue."  
 20 CHAYTOR, Q.C.:  
 21 Q. So the question was posed at the executive  
 22 level as to why Eastern Health wasn't being as  
 23 responsive on the issue as the Canadian Cancer  
 24 Society?  
 25 MS. JONES:

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1 A. Or not being able to get the message out to  
 2 the same--when we respond, it's the executive  
 3 director who doesn't have the exact knowledge.  
 4 We would be looking at physicians or some  
 5 other spokesperson. Those people have full-  
 6 time work. The oncologists would have been in  
 7 clinics. They cannot respond when the media  
 8 are calling at 11:00 in the day and that. So  
 9 generally we would always be able to provide  
 10 some kind of a response, but it wouldn't have  
 11 been in the news cycle that the news media  
 12 were really wanting us to respond to. We  
 13 would always get back to them, but by that  
 14 time, other people who are much more  
 15 accessible had already spoken.  
 16 CHAYTOR, Q.C.:  
 17 Q. So if there's any issue in terms of timeliness  
 18 or lack of response by Eastern Health, it's  
 19 because there's delay in trying to get the  
 20 appropriate spokesperson out there? Is that  
 21 the issue?  
 22 MS. JONES:  
 23 A. Sometimes, not all the time, but many -  
 24 CHAYTOR, Q.C.:  
 25 Q. Around this issue?

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1 MS. JONES:  
 2 A. In many instances, it was access to  
 3 individuals who already have a clinical load  
 4 and are working, you know, every day, and you  
 5 know, physicians do lots of work for us before  
 6 8:00 in the morning and after 5:00 in the day  
 7 and that's not kind of a cycle that the media  
 8 is into.  
 9 CHAYTOR, Q.C.:  
 10 Q. So was the lack, if any, of responsiveness  
 11 ever due to Eastern Health making the  
 12 deliberate decision not to speak to the media?  
 13 MS. JONES:  
 14 A. I can't respond to that because I wouldn't  
 15 have been making the decision about whether we  
 16 were out there or whether we were not out  
 17 there. If, in fact, we had answered questions  
 18 in the past and provided information, we may  
 19 have very well, or not me personally, said  
 20 "we've answered that yesterday. That's the  
 21 same question." I'm not--you know, but that  
 22 would have been in that -  
 23 CHAYTOR, Q.C.:  
 24 Q. So Ms. Jones, this is where I want to be clear  
 25 in what the evidence is and the information

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1 that's going forward to the Commissioner. So  
 2 if the answer is you don't know, is that the  
 3 answer? Or is the answer well, it's because  
 4 of the physicians and having to arrange them  
 5 and working around their schedule?  
 6 MS. JONES:  
 7 A. There would be multiple factors, Ms. Chaytor,  
 8 and it would have depended on the individual,  
 9 time of the day and the request that was  
 10 coming forward and what kind of information  
 11 was being asked about, and therefore, in some  
 12 instances, it would have been much more  
 13 appropriate for physicians to respond, because  
 14 they have that level of detail. In other  
 15 times, it may very well have been appropriate  
 16 and we could have had administrative people  
 17 respond. So depending on the nature of the  
 18 actual request, who was the most appropriate  
 19 response person would have been dealt with on  
 20 that particular issue base.  
 21 CHAYTOR, Q.C.:  
 22 Q. And my question in terms of whether or not,  
 23 and at the executive level and you're sitting  
 24 in on the meetings when the issue is being  
 25 discussed, at the executive level, was there

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1 ever any discussion of not responding or not  
 2 going out to the media on the issue?  
 3 MS. JONES:  
 4 A. Not to my knowledge, in terms of making a  
 5 conscious decision. Remember, we, as  
 6 executive, meet every two weeks. So there's  
 7 lots of interaction with the media on a daily  
 8 basis, on an hourly basis.  
 9 CHAYTOR, Q.C.:  
 10 Q. But on this issue. On this issue, I'm asking  
 11 you was it discussed at executive that we are  
 12 getting calls, at any point in time along the  
 13 way, we're getting calls on the issue, but we  
 14 are not speaking?  
 15 MS. JONES:  
 16 A. Not in the way that you would just explain it.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay. Well tell me it in the way that you  
 19 would explain it.  
 20 MS. JONES:  
 21 A. It would be more in relation to what we knew  
 22 about the issue. If we could answer the  
 23 question, we would answer the question. If  
 24 there was a spokesperson that would be most  
 25 appropriate and there was trouble accessing

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1 that particular spokesperson and sometimes we  
 2 were not in the news cycle and maybe it might  
 3 have been the next day or sometimes the media  
 4 are very good in that maybe they don't go with  
 5 the story that day and they will wait. So  
 6 those kinds of things happen on a daily basis.  
 7 CHAYTOR, Q.C.:  
 8 Q. And those things were discussed at executive  
 9 management level in dealing with the ER/PR  
 10 issue?  
 11 MS. JONES:  
 12 A. In a general terms, not in an individual  
 13 specific issue. We've had a call today and,  
 14 you know, we can't get a Kara Laing or we  
 15 can't get a Nash Denic or whatever, so  
 16 therefore we're not able to respond. That  
 17 wouldn't have happened.  
 18 CHAYTOR, Q.C.:  
 19 Q. Was it ever said that "we are getting calls,  
 20 but we're not speaking?"  
 21 MS. JONES:  
 22 A. No, it was never--that was never said in that  
 23 absolute.  
 24 CHAYTOR, Q.C.:  
 25 Q. I know it wasn't said in those words, but you

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1 know the message that I'm trying to convey  
 2 here.  
 3 MS. JONES:  
 4 A. Yeah, and that was never ever said.  
 5 CHAYTOR, Q.C.:  
 6 Q. So the only thing you heard at executive was  
 7 "we're not able to get out there today, or in  
 8 as timely a manner as we may wish to, because  
 9 there aren't physicians or appropriate  
 10 spokespeople available to address the issue?"  
 11 MS. JONES:  
 12 A. That's right, and we may not be able to answer  
 13 the question that they're actually asking  
 14 because we don't have an answer.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and what questions would they have been?  
 17 MS. JONES:  
 18 A. The error rate, okay. We had lots of  
 19 discussion around can we calculate, and you  
 20 saw that in an ATIPP response from Mark Quinn,  
 21 and so therefore, there was no--and we talked  
 22 about that the other day, in being that this  
 23 was a subset of ER/PR testing and not really  
 24 looking at an error rate. So you know, there  
 25 is no answer to that question. There's

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1 multiple ways of looking at that, but you  
 2 would have to understand the whole issue  
 3 around it.  
 4 CHAYTOR, Q.C.:  
 5 Q. You still think there's no answer to that  
 6 question?  
 7 MS. JONES:  
 8 A. I think that there is a--there's no question  
 9 that there was a change in results from what  
 10 was happening in our lab to what was happening  
 11 to the results, results that we've got in  
 12 Mount Sinai. There's also much documented  
 13 literature that in fact a percentage of tests  
 14 will have, if on retest, a change and what the  
 15 difference was or how many of the tests that  
 16 were retested would have been naturally  
 17 changing as part of that false negative, I  
 18 don't believe that we have sight on that.  
 19 There's no question that we had changes and we  
 20 acknowledge those changes and there is change  
 21 -  
 22 CHAYTOR, Q.C.:  
 23 Q. To the extent of 42 percent.  
 24 MS. JONES:  
 25 A. To the extent of 42 percent in this particular

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1 category that we're looking at.  
 2 CHAYTOR, Q.C.:  
 3 Q. Is there anything in the literature to suggest  
 4 that that is up to the range of error being 42  
 5 percent?  
 6 MS. JONES:  
 7 A. No, there is nothing in the literature to  
 8 suggest that that high.  
 9 CHAYTOR, Q.C.:  
 10 Q. Right, okay. This also then talks about "a  
 11 message to all staff from the CEO will be  
 12 circulated. Executive is fully aware that the  
 13 events of the past several days are playing  
 14 heavy on the staff and anxiety has been  
 15 heightened since the announcement of the  
 16 Inquiry."  
 17 MS. JONES:  
 18 A. Of the Inquiry.  
 19 CHAYTOR, Q.C.:  
 20 Q. And Dr. Howell is to deal with that?  
 21 MS. JONES:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. Why would that be, in terms of the message to  
 25 the staff, Dr. Howell dealing with it, as

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1 opposed to Mr. Dodge?  
 2 MS. JONES:  
 3 A. Can you just -  
 4 CHAYTOR, Q.C.:  
 5 Q. Sure, sorry, yes. You can control the mouse  
 6 too, if you wish.  
 7 MS. JONES:  
 8 A. And I'm not sure, but this one here, "it's  
 9 playing heavily on staff, particularly  
 10 pathologists and lab technicians," and given  
 11 that Dr. Howell actually is--the lab reports  
 12 to him, this may have been a particular  
 13 message to lab and pathologists, not  
 14 necessarily to the entire Eastern Health, and  
 15 it would have been around the Commission of  
 16 Inquiry and all of those kinds of things.  
 17 Yes, there it is, okay.  
 18 CHAYTOR, Q.C.:  
 19 Q. Thank you. Mr. Coffey was telling me to scroll  
 20 down. "Follow up with the director of  
 21 laboratory and the staff in this regard."  
 22 Thank you.  
 23 MS. JONES:  
 24 A. Thank you.  
 25 CHAYTOR, Q.C.:

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1 Q. If we could have, please, P-0488, page 96?  
 2 And this, we're back to November now.  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. So we'll try and stay a little bit in  
 7 chronological order here. And this again is  
 8 executive management meeting, November 14th  
 9 2007, and of course, you are interim president  
 10 and we have Dr. Howell present and Ms.  
 11 Pilgrim.  
 12 MS. JONES:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And Susan Bonnell is also in attendance. Next  
 16 page talks about the judicial inquiry, ER/PR.  
 17 "Executive was provided an update at the  
 18 regional quality council meeting held 13th  
 19 November 2007." So the executive was provided  
 20 an update at the Regional Quality Council  
 21 meeting on the issue of ER/PR?  
 22 MS. JONES:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. Or the judicial inquiry?

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. Or both?  
 5 MS. JONES:  
 6 A. It would have been both. It would have been  
 7 underneath--in Regional Quality Council, we  
 8 would have had ER/PR been referenced and  
 9 probably said this is what's going on, the  
 10 Commission of Inquiry. This is where they  
 11 are, whatever. And so it would have been an  
 12 update there.  
 13 CHAYTOR, Q.C.:  
 14 Q. So does the executive also attend the Regional  
 15 Quality Council meetings?  
 16 MS. JONES:  
 17 A. Yes, they do.  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, and how often do they meet?  
 20 MS. JONES:  
 21 A. So there was no need to reiterate it? What?  
 22 CHAYTOR, Q.C.:  
 23 Q. How often do they meet?  
 24 MS. JONES:  
 25 A. Regional Quality Council meets about once a

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1 month or so, so it is executive plus other  
 2 members. It would have the chair for  
 3 infection control. There are three physicians  
 4 who sit with that.  
 5 CHAYTOR, Q.C.:  
 6 Q. That's fine. I was just wondering how often  
 7 they meet. So all the executive would attend  
 8 that, so there's no need to do an update -  
 9 MS. JONES:  
 10 A. No need to update it there.  
 11 CHAYTOR, Q.C.:  
 12 Q. - because that was yesterday.  
 13 MS. JONES:  
 14 A. That was yesterday.  
 15 CHAYTOR, Q.C.:  
 16 Q. The day before this meeting.  
 17 MS. JONES:  
 18 A. Yeah.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and who would be providing the update at  
 21 the Regional Quality Council meeting?  
 22 MS. JONES:  
 23 A. More than likely Mrs. Pilgrim, and she chairs  
 24 the regional -  
 25 CHAYTOR, Q.C.:

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1 Q. She chairs that committee?  
 2 MS. JONES:  
 3 A. She chairs the Regional Quality Council.  
 4 CHAYTOR, Q.C.:  
 5 Q. And then the NLCHI Database, re: ER/PR, "a  
 6 meeting will be held with key players to  
 7 review the data in the NLCHI file and produce  
 8 a final report that will be utilized on a go-  
 9 forward basis. The organization prefers to  
 10 validate the information rather than comment  
 11 on the data haphazardly." What does that  
 12 mean?  
 13 MS. JONES:  
 14 A. It means that we were getting data sheets  
 15 every single day about validating or  
 16 clarifying inside of the database. So we  
 17 really wanted the database to be completed so  
 18 that we could actually look at it. We were  
 19 clearly understanding we were working with  
 20 NLCHI on a daily basis around completing that,  
 21 but having it come over in bits and pieces and  
 22 then the next day, the database being updated  
 23 and changes to it because of new information,  
 24 we really did want to get to the end of the  
 25 road to say "NLCHI, okay, thank you. Now is

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1 everything in there? What's left?"  
 2 CHAYTOR, Q.C.:  
 3 Q. And is that what was being asked of your  
 4 organization?  
 5 MS. JONES:  
 6 A. What was being asked of the organization,  
 7 because we had a lot of the information, we  
 8 did have information from some of the other  
 9 regional health authorities, yes, we were  
 10 dealing with--you'll see many times lists are  
 11 coming that both Terry Gulliver and the  
 12 manager of pathology, as well as Heather  
 13 Predham, are meeting on a daily basis or there  
 14 are phone calls on a daily basis from NLCHI or  
 15 from Deborah Gregory, who works with Robert  
 16 Thompson, to clarify things that were inside  
 17 of that database.  
 18 CHAYTOR, Q.C.:  
 19 Q. So Terry Gulliver is now back in the picture  
 20 then at this point in time, because I  
 21 understood when I'd asked around the ethics  
 22 consult, and him not being there, you had said  
 23 that he was involved early on.  
 24 MS. JONES:  
 25 A. Yeah.

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1 CHAYTOR, Q.C.:

2 Q. But Terry Gulliver is still in the picture?

3 MS. JONES:

4 A. It's on the database. It's on the numbers and

5 the slides that are gone out and when do they

6 come back and the results and those kinds of

7 things.

8 CHAYTOR, Q.C.:

9 Q. So Mr. Gulliver is still actively involved in

10 the issue at that point in time?

11 MS. JONES:

12 A. That's right.

13 CHAYTOR, Q.C.:

14 Q. Next page, 98, 3.6 CEO performance objectives

15 2007/2008. "Louise Jones advised that the CEO

16 performance objectives were approved by the

17 Board of Trustees at their October 24th 2007

18 meeting and the areas of focus include

19 formalizing and adopting the medical staff

20 structure in Eastern Health." What does that

21 mean?

22 MS. JONES:

23 A. That means the bylaws, as well as the new

24 regionalized structure versus the individual

25 legacy organization structure would be put in

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1 place in the next year.

2 CHAYTOR, Q.C.:

3 Q. Okay, and that's still in progress, I take it?

4 MS. JONES:

5 A. That's still in progress, waiting on

6 provincial bylaws.

7 CHAYTOR, Q.C.:

8 Q. Initiatives, number two, is "initiatives to

9 develop a safety culture, inclusive of staff

10 and patients."

11 MS. JONES:

12 A. Yes.

13 CHAYTOR, Q.C.:

14 Q. What does that mean?

15 MS. JONES:

16 A. That means that we have to do work in terms of

17 planning on culture, okay, and that will occur

18 over a period of time. So it's a lot of

19 education. It's a lot of input into how we

20 develop that safety culture so that the staff

21 understand, and you've been at it a number of

22 times, in terms of their role in safety or

23 their advocacy role, those kinds of things,

24 and what role that the patients individually

25 have to play in their own safety. We've had

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1 things such as, and these would have been in

2 October, the hand hygiene campaign where, you

3 know, we had buttons that say to clients "ask

4 us did I wash my hands," those kinds of

5 things. So there are things that patients can

6 play in ensuring that we have--that we care

7 for them in the best way possible. So that's

8 part of the development of the safety culture.

9 CHAYTOR, Q.C.:

10 Q. And these are the five areas of focus given to

11 you to do your job over the next year.

12 MS. JONES:

13 A. From the Board.

14 CHAYTOR, Q.C.:

15 Q. From the Board.

16 MS. JONES:

17 A. That's right.

18 CHAYTOR, Q.C.:

19 Q. So I take it these are what have been

20 identified as being the key issues overall for

21 the organization to work on?

22 MS. JONES:

23 A. These are performance objectives and lining up

24 with these performance objectives would also

25 be the Board's new strategic plan. So some of

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1 these would be inside of the strategic plan

2 from '08 to '11 and some of those would be not

3 necessarily inside of what they would put in a

4 strategic plan, but medical staff organization

5 and safety culture, although represented in

6 different words, are both inside of the plan

7 for '08 to '11.

8 CHAYTOR, Q.C.:

9 Q. And are these in any particular order of

10 priority?

11 MS. JONES:

12 A. No.

13 CHAYTOR, Q.C.:

14 Q. Okay. So all of them are equally important?

15 MS. JONES:

16 A. Yes.

17 CHAYTOR, Q.C.:

18 Q. Number three is "formalizing and adopting a

19 health human resources plan, including

20 leadership development."

21 MS. JONES:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. What does that mean?

25 MS. JONES:

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1 A. That means having an entire plan for the  
 2 entire organization that looks at everything  
 3 from physicians all the way to housekeepers,  
 4 what is the recruitment strategies, what is  
 5 our attrition, our retirement rates, what is  
 6 it that we need to move forward in terms of  
 7 the organization, in terms of initiatives to  
 8 government that we anticipate shortages in  
 9 particular areas, all of those kinds of  
 10 things. Including leadership development, we  
 11 have a very thin leadership. Recruitment into  
 12 leadership positions is difficult, so it is  
 13 how are we going to look at succession  
 14 planning so that there is a set of leaders  
 15 that are available to take over and willing to  
 16 take over as people exit and our leadership  
 17 group is fairly old, in terms of age range.  
 18 So this is the whole idea of succession  
 19 planning.  
 20 CHAYTOR, Q.C.:  
 21 Q. So succession planning for everyone, including  
 22 physicians?  
 23 MS. JONES:  
 24 A. Everyone including physicians and -  
 25 CHAYTOR, Q.C.:

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1 Q. And recruitment of appropriate people.  
 2 MS. JONES:  
 3 A. And recruitment, retention. What is it that  
 4 the mandate of the organization is and what is  
 5 it that we're going to need now and into the  
 6 future with respect to ensuring that we're  
 7 able to meet the mandate.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and number four, "identifying and  
 10 reporting on performance indicators (outcomes)  
 11 that are acceptable to the Board." What does  
 12 that mean?  
 13 MS. JONES:  
 14 A. That is in terms of the executive limitations,  
 15 we are reporting on some indicators and we're  
 16 developing them more. I referenced yesterday  
 17 that outcome indicators are problematic in  
 18 health care. We can give you a lot of  
 19 process, how many of stuff we did, but does it  
 20 have an ultimate outcome for clients,  
 21 particularly when you talk about population  
 22 health. So when you look at this, it is what  
 23 is it that the Board--what indicators does the  
 24 Board want to receive on a regular basis and  
 25 that have meaning for them and so therefore,

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1 we need to then start putting in processes  
 2 behind that to produce those for them on a  
 3 regular basis. We produce things for the  
 4 Board now, but you know, they're on occupancy  
 5 and utilization and finance and some of the  
 6 newer initiatives with the Canadian CIHI,  
 7 which is the main holder of clinical data  
 8 information, there are some indicators that  
 9 are coming out there, hospitalized  
 10 standardized mortality rate, which is a new  
 11 one. So it is what is it that the Board wants  
 12 to receive and are they acceptable to them,  
 13 and then how do we work them into the  
 14 monitoring reports.  
 15 CHAYTOR, Q.C.:  
 16 Q. And the fifth is "initiation of strategies to  
 17 develop," and I take it that should be  
 18 "confidence?"  
 19 MS. JONES:  
 20 A. Confidence, yeah.  
 21 CHAYTOR, Q.C.:  
 22 Q. "In the services provided by Eastern Health.  
 23 Strategies will be directed both internally  
 24 and externally."  
 25 MS. JONES:

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1 A. That's right.  
 2 CHAYTOR, Q.C.:  
 3 Q. And I take it that has to do with what we were  
 4 discussing this morning, in terms of any loss  
 5 of confidence in Eastern Health and the image  
 6 of Eastern Health?  
 7 MS. JONES:  
 8 A. As well as stakeholders and partnerships and  
 9 so, it's a really broad ranging, and it's the  
 10 initiation of strategies to work in that area.  
 11 CHAYTOR, Q.C.:  
 12 Q. And that has been worked on as we've  
 13 discussed.  
 14 MS. JONES:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay. If we could have page 99? Page 99  
 18 refers to 3.8, CEO meeting with Don Keats, the  
 19 new deputy minister.  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. What does the A in brackets mean?  
 24 MS. JONES:  
 25 A. Acting.

1 CHAYTOR, Q.C.:

2 Q. Acting, so he's acting deputy minister?

3 MS. JONES:

4 A. Yes.

5 CHAYTOR, Q.C.:

6 Q. On November 14th '07. "Louise Jones met with

7 Don Keats to update him on a number of

8 initiatives, issues in Eastern Health. She

9 particularly expressed the concerns of the

10 organization with the request from the

11 department to re-rank capital equipment

12 following our internal process. Louise Jones

13 further emphasized with the deputy minister

14 the 23 items of the operating budget being

15 critical to move forward. Other areas that

16 were discussed included," I don't know what

17 that is, but COI, I guess, is the "Commission

18 of Inquiry, task force on adverse health

19 events, long-term care owner board, cancer

20 control strategy, surgeon recruitment issues,

21 including a number of different types of

22 surgeons, and then the development of space at

23 the cancer bunkers." So was this your first

24 meeting with Mr. Keats?

25 MS. JONES:

1 MS. JONES:

2 A. In a generic sense, yes. Normally more

3 related to Commission of Inquiry and what is

4 going on, at least since I've been on the

5 system, that it's more Commission of Inquiry

6 Task Force on Adverse Events discussion.

7 CHAYTOR, Q.C.:

8 Q. And what would be discussed about the

9 Commission of Inquiry on the conference call?

10 MS. JONES:

11 A. Just that it is now up and running, hearings

12 are starting at a particular point in time.

13 CHAYTOR, Q.C.:

14 Q. So the logistics?

15 MS. JONES:

16 A. Logistics kinds of things.

17 CHAYTOR, Q.C.:

18 Q. The issue or the discussion that you had on

19 this date with Mr. Keats, was there anyone

20 else in attendance by the way?

21 MS. JONES:

22 A. No, not on this meeting.

23 CHAYTOR, Q.C.:

24 Q. Okay, and what was discussed in terms of the

25 ER/PR issue on that date?

1 A. Yes, it was.

2 CHAYTOR, Q.C.:

3 Q. And do you meet regularly with Mr. Keats?

4 MS. JONES:

5 A. No, but we do have meetings when there are

6 issues and that has not been a practice where

7 the individual CEO meets with the deputy

8 minister on a regular basis. We do meet with

9 the deputy minister through the Newfoundland

10 and Labrador Health Boards Association. The

11 four CEOs, as well as the CEO of the

12 Newfoundland and Labrador Health Board

13 Association, come together every two weeks and

14 the deputy minister or somebody from the

15 department is there.

16 CHAYTOR, Q.C.:

17 Q. And so that's done by a conference call, I

18 take it?

19 MS. JONES:

20 A. That's done by a conference call, and on a

21 certain number of times a year, there's face-

22 to-face meetings.

23 CHAYTOR, Q.C.:

24 Q. And then during those conference calls, has

25 the issue of ER/PR been addressed?

1 MS. JONES:

2 A. I don't see that reference there and I

3 probably, just the Commission of Inquiry, that

4 probably would have come up there only in

5 terms of the issues that we may have had with

6 staff burn out and their ability to be able to

7 meeting all of the people who were requiring

8 information from us. So that would have been-

9 -the real issue here for us was Don was new

10 back into the system, he had been a previous

11 CEO in the central region. We had a budget

12 process that was going on and we had a major

13 issue with being asked to rank our capital

14 equipment issues, we had a whole process

15 inside of Eastern Health where we had

16 identified a way of categorizing -

17 CHAYTOR, Q.C.:

18 Q. Yes, okay, I don't need to go there -

19 MS. JONES:

20 A. Yes, anyways, so that was the real issue, but

21 I took that opportunity to talk about budget

22 and being that it was critical for us to have

23 the 23 items and then the other issues that

24 you -

25 CHAYTOR, Q.C.:



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1 Q. Yes, I just want to focus in on what we're  
 2 here to discuss -  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. You might get to your meeting, you might not.  
 7 MS. JONES:  
 8 A. That's fine.  
 9 CHAYTOR, Q.C.:  
 10 Q. The issue of ER/PR then, Mr. Keats--did Mr.  
 11 Keats have any indication or did he ever speak  
 12 to you about the issue of ER/PR on any  
 13 occasion?  
 14 MS. JONES:  
 15 A. No, because if you remember earlier on what we  
 16 were saying is that Mr. Thompson took that  
 17 issue with and when he moved over to the--  
 18 whatever.  
 19 CHAYTOR, Q.C.:  
 20 Q. Right, so your discussions would be with Mr.  
 21 Thompson.  
 22 MS. JONES:  
 23 A. My discussions would be with Mr. Thompson.  
 24 CHAYTOR, Q.C.:  
 25 Q. Yes, but Mr. Keats would have been in the

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1 system as a CEO.  
 2 MS. JONES:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. During this and you would have been a COO in  
 6 the system.  
 7 MS. JONES:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. But you had no occasion on which to speak with  
 11 Mr. Keats regarding the ER/PR issue?  
 12 MS. JONES:  
 13 A. No, no, that--and the discussion here would  
 14 have been, my understanding is that ER/PR  
 15 would move with Robert to the new job.  
 16 CHAYTOR, Q.C.:  
 17 Q. So any discussion you're having with Mr. Keats  
 18 regarding the Commission of Inquiry you're  
 19 saying would involve workload levels for your  
 20 staff?  
 21 MS. JONES:  
 22 A. Absolutely.  
 23 CHAYTOR, Q.C.:  
 24 Q. Did you include in your budget submission  
 25 additional staff in that regard, to address

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1 those issues?  
 2 MS. JONES:  
 3 A. We did not anticipate, well when we put the  
 4 budget in, in the fall, the hearings were  
 5 supposed to have been starting in January, so  
 6 it would not have been anything that we would  
 7 have put in as anticipated that the report  
 8 would have been available in July. This  
 9 budget submission was for starting April of  
 10 this year into '08/'09.  
 11 CHAYTOR, Q.C.:  
 12 Q. And whether the budget or not, though, have  
 13 you requested any additional funding? You've  
 14 requested additional funding for other issues,  
 15 have you requested any additional resources if  
 16 need be for your staff around those workload  
 17 issues?  
 18 MS. JONES:  
 19 A. Around the workload issues, the only  
 20 individuals who can do the work are the people  
 21 who are currently doing that work, plus their  
 22 own jobs.  
 23 CHAYTOR, Q.C.:  
 24 Q. Right, so what about someone else doing their  
 25 own jobs?

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1 MS. JONES:  
 2 A. There is no redundancy in the system to be  
 3 able to find a manager who can come in and run  
 4 the immunohistochemistry lab, nor the director  
 5 of laboratory. We've gone down that road,  
 6 we've actually looked and at the end of the  
 7 day, when we had an individual who went off on  
 8 sick leave, we had to take from Carbonear on a  
 9 part-time basis to move that person in St.  
 10 John's to do some of that work, so the work is  
 11 very specialized and we have added resources  
 12 around it, but there are very few individuals--  
 13 the people who were doing the work have to  
 14 continue to do the work and that's  
 15 unfortunate.  
 16 CHAYTOR, Q.C.:  
 17 Q. And those individuals, though, Ms. Pilgrim is  
 18 gathering the documentation for the inquiry.  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And she's the liaison, I understand for the  
 23 inquiry, in terms of Mr. Simmons' role.  
 24 MS. JONES:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. And so the people in the lab, the IHC lab as

3 you mentioned as your example -

4 MS. JONES:

5 A. Yes.

6 CHAYTOR, Q.C.:

7 Q. I mean, those people, other than come in for

8 an interview, they're not doing work -

9 MS. JONES:

10 A. They're doing much work in relation to the

11 class action suit in terms of pulling slides

12 and blocks and sending things to Mount Sinai.

13 With respect to Ms. Pilgrim, I would have said

14 that we rearranged her portfolio to allow her

15 to be able to carry on this role and so other

16 members of the executive team have taken parts

17 of that portfolio.

18 THE COMMISSIONER:

19 Q. The people would pull the slides, would they

20 be technicians or are you saying pathologists

21 have to pull slides?

22 MS. JONES:

23 A. It would be the people who are working in the

24 immunohistochemistry who know these slides and

25 what it is, so it would have been the

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1 technologists who were pulling the slides and

2 pulling the blocks, and then the people in the

3 area would be packaging it up and sending it

4 to--so it has to be people who understand this

5 kind of work.

6 CHAYTOR, Q.C.:

7 Q. And none of your--well we've met three of your

8 technologists in your IHC and they all still

9 in their positions?

10 MS. JONES:

11 A. They're all still in their positions.

12 CHAYTOR, Q.C.:

13 Q. Page 100 of the document, 3.13 ER/PR.

14 MS. JONES:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. With respect to the retesting of ER/PR,

18 "Eastern Health, St. John's unilaterally

19 decided, i.e. director and manager, to go back

20 to January 1997 when the first testing was

21 carried out. However, in correspondence from

22 the clinical chief (Dr. Don Cook) to the other

23 boards, it referenced May, 1997. Pat Pilgrim

24 and Oscar Howell are following up on the

25 reasons why Eastern Health managers retested

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1 back to January 1997." Do you recall that

2 discussion at executive management?

3 MS. JONES:

4 A. Yes, because that came out of the database.

5 CHAYTOR, Q.C.:

6 Q. And what's the concern, what was that about?

7 MS. JONES:

8 A. And the concern there is the direction to the

9 other regions was, I'm not sure--well it says

10 May, it was May. We had to make a

11 determination at what point in time in this

12 process did we move from bioassay to

13 immunohistochemistry, so there was a period of

14 time when there was parallel processes going

15 on and so it was ultimately decided that the

16 slides that were going back to the regions, it

17 would have been May--because we didn't have an

18 exact date of moving from the old method to

19 the new method, although we knew that the

20 optimization and that and the work to move us

21 to the DAKO and the work to move us to

22 immunohistochemistry staining verses bioassay

23 was in the winter of 1997, so we had to

24 clarify that because the database, we needed

25 to know if there was anything else that we

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1 needed to go back to, so that was ultimately

2 clarified with NLCHI and that as to what was

3 the exact date of sending of samples and when

4 did we actually start immunohistochemistry to

5 the best of their ability, going back looking

6 at when the work was being done and that.

7 CHAYTOR, Q.C.:

8 Q. And what was the answer?

9 MS. JONES:

10 A. The answer--I can't, Ms. Chaytor -

11 CHAYTOR, Q.C.:

12 Q. So Ms. Pilgrim will know or Dr. Howell.

13 MS. JONES:

14 A. Yeah and they will know exactly, but the

15 discussion was in St. John's, but there was

16 no--I think and you know, but you'll have to

17 clarify, that the slides that were going back

18 to--and it wasn't even slides going back

19 because in '97 we were reading them all.

20 CHAYTOR, Q.C.:

21 Q. What did it mean here when it says that

22 "Eastern Health, St. John's unilaterally

23 decided, i.e. director and manager" who is the

24 director and manager?

25 MS. JONES:

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1 A. The director and manager would have been Barry  
 2 Dyer and Terry Gulliver.  
 3 CHAYTOR, Q.C.:  
 4 Q. So this is saying that Mr. Dyer and Mr.  
 5 Gulliver unilaterally decided.  
 6 MS. JONES:  
 7 A. Yeah, they decided, even though what we had  
 8 seen in correspondence from Don Cook after the  
 9 fact was, is that they were asked to pull all  
 10 of the work from May of 1997.  
 11 CHAYTOR, Q.C.:  
 12 Q. But they actually pulled from January of 1997.  
 13 MS. JONES:  
 14 A. In St. John's, they did.  
 15 CHAYTOR, Q.C.:  
 16 Q. So yes, so Dr. Cook asked the other regions  
 17 from May -  
 18 MS. JONES:  
 19 A. To pull from May.  
 20 CHAYTOR, Q.C.:  
 21 Q. Of 1997 and this says that -  
 22 MS. JONES:  
 23 A. We pulled from January.  
 24 CHAYTOR, Q.C.:  
 25 Q. But Ms. Pilgrim and Dr. Howell are going to go

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1 back to find out why Mr. Dyer and Mr. Gulliver  
 2 went back all the way to January.  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. So do I take it there was an understanding  
 7 that the IHC testing had come in, in fact in  
 8 May, that the correct date was May and not  
 9 January?  
 10 MS. JONES:  
 11 A. There is nowhere in the documentation that  
 12 says May 1st or whatever. There was parallel  
 13 processes going on for a period of time  
 14 through the winter of, so the actual date of  
 15 move is not documented anywhere that we moved  
 16 on March 31st or February 28th or whatever, so  
 17 that was what that was all about.  
 18 CHAYTOR, Q.C.:  
 19 Q. So it wasn't a bad thing to go back to January  
 20 because the IHC testing must have been  
 21 happening back to January.  
 22 MS. JONES:  
 23 A. In the bioassay.  
 24 CHAYTOR, Q.C.:  
 25 Q. In bioassay only.

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. So what date--but you said it's parallel  
 5 process, so was IHC testing also going on as  
 6 of January, 1997?  
 7 MS. JONES:  
 8 A. Parallel process means that they were getting  
 9 all of the--they were doing it as a bioassay,  
 10 but they were preparing themselves and doing  
 11 testing to validate the way of moving to  
 12 immunohistochemistry.  
 13 CHAYTOR, Q.C.:  
 14 Q. But the results were coming out of the  
 15 bioassay means, as opposed to the IHC?  
 16 MS. JONES:  
 17 A. Yes, that's right and at what point in time  
 18 did they totally move over to just doing  
 19 immunohistochemistry? At that date of  
 20 transition, stop one, now start the other,  
 21 that was an open question.  
 22 CHAYTOR, Q.C.:  
 23 Q. I assume if Mr. Gulliver and Mr. Dyer has  
 24 records to go back to January of 1997, there  
 25 must have been reports being generated on

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1 ER/PR through the IHC method back to January?  
 2 MS. JONES:  
 3 A. I can't answer that question.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay. So whether or not the May date or the  
 6 January date was the correct date, you don't  
 7 know?  
 8 MS. JONES:  
 9 A. And at the end of the day, that was what the--  
 10 when we talked about all of these questions  
 11 coming from the database, it was why was--why  
 12 was the rest of the province said May when  
 13 there appears to be results in your database  
 14 from January to May?  
 15 CHAYTOR, Q.C.:  
 16 Q. I guess in my--my concern would be is there  
 17 any question that there are other people out  
 18 there who were tested from other regions,  
 19 between January and May of 1997 who haven't  
 20 been -  
 21 MS. JONES:  
 22 A. And that's what they went to check on.  
 23 CHAYTOR, Q.C.:  
 24 Q. Just says they're going to check why they went  
 25 back to January.

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1 MS. JONES:  
 2 A. Yes, and that would have been resolved in that  
 3 discussion.  
 4 CHAYTOR, Q.C.:  
 5 Q. So to your knowledge, that has been resolved -  
 6 MS. JONES:  
 7 A. Uh-hm.  
 8 CHAYTOR, Q.C.:  
 9 Q. And if there were other people from outside  
 10 the St. John's region between January and May  
 11 of 1997 who were tested, that issue has been  
 12 addressed?  
 13 MS. JONES:  
 14 A. That would have been addressed, yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. If we could have 0743 please? Okay, now we  
 17 touched on this yesterday, Ms. Jones. This is  
 18 your letter of November 16th, 2007.  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. To Mr. Thompson and this is the--this is  
 23 looking for the information management, I  
 24 believe this is your actual, the presentation  
 25 would be included here.

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. Or your briefing note.  
 5 MS. JONES:  
 6 A. Uh-hm.  
 7 CHAYTOR, Q.C.:  
 8 Q. And this refers to your meeting earlier this  
 9 week, was indeed beneficial, and that's the  
 10 meeting, I take it, that we discussed.  
 11 MS. JONES:  
 12 A. That we just talked about.  
 13 CHAYTOR, Q.C.:  
 14 Q. "With respect to Eastern Health's information  
 15 management and decision support requirements,  
 16 you may be aware that the board chair has been  
 17 attempting and is still attempting to get a  
 18 meeting with the minister in relation to the  
 19 premier's comments regarding providing  
 20 resources to Eastern Health to ensure that we  
 21 are able to address our information management  
 22 and decision support requirements." So this  
 23 was your follow up, you indicated yesterday  
 24 you had heard the premier make comments along  
 25 those lines.

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. So this is your follow up and seizing that  
 5 opportunity, as you may.  
 6 MS. JONES:  
 7 A. Absolutely.  
 8 CHAYTOR, Q.C.:  
 9 Q. And you indicate here, "I have also sent a  
 10 copy of the same documents to the deputy  
 11 minister, Don Keats, and your chair, Joan Dawe  
 12 was continuing to follow up with the minister  
 13 to try and get together and Eastern Health has  
 14 requested 16.5 million in the 2008/2009 budget  
 15 with this briefing note prioritizing 3  
 16 million. Eastern Health will have to move  
 17 forward with a portion of these costs  
 18 immediately, but does not have the financial  
 19 capacity to take on an additional 3 million,  
 20 given our current financial position." And I  
 21 left this discussion for today because now you  
 22 can tell me how did you make out? How much  
 23 money was given in -  
 24 MS. JONES:  
 25 A. I don't know.

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1 CHAYTOR, Q.C.:  
 2 Q. You don't know!  
 3 MS. JONES:  
 4 A. I don't know, last night I spent an hour and a  
 5 half with the board chair, but there was  
 6 budget letters that had come in at the late  
 7 day yesterday, 5:00, but you really have to go  
 8 through the detail of those budget letters to  
 9 see what's actually in there.  
 10 CHAYTOR, Q.C.:  
 11 Q. Well in November--or February, sorry, I  
 12 believe you said there had been a pre-  
 13 announcement -  
 14 MS. JONES:  
 15 A. There was a pre-announcement and -  
 16 CHAYTOR, Q.C.:  
 17 Q. So you assume you got at least was announced  
 18 at that point in time.  
 19 MS. JONES:  
 20 A. Absolutely.  
 21 CHAYTOR, Q.C.:  
 22 Q. But whether or not there was more or less -  
 23 MS. JONES:  
 24 A. It will be another -  
 25 CHAYTOR, Q.C.:

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1 Q. You'll find out later today, I guess.  
 2 MS. JONES:  
 3 A. Yes, by the time the way that the budget is,  
 4 it doesn't come in in like this particular  
 5 proposal, you'd have to go down through all of  
 6 the individual line items to find out what's  
 7 there.  
 8 CHAYTOR, Q.C.:  
 9 Q. In terms of what you were requesting at this  
 10 point in time was an additional 3 million.  
 11 MS. JONES:  
 12 A. Uh-hm.  
 13 CHAYTOR, Q.C.:  
 14 Q. And the pre-announcement that came out in  
 15 February, was that 3 million?  
 16 MS. JONES:  
 17 A. No, it was specific to Eastern Health was 1.2  
 18 or 3 and I'm not quite sure with respect to  
 19 the clinical consolidation, okay, so number  
 20 one on here, which was clinical consolidation,  
 21 that was approved at 1.3.  
 22 CHAYTOR, Q.C.:  
 23 Q. I think it was about half of what you had--or  
 24 probably less than half of what you had  
 25 requested.

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1 MS. JONES:  
 2 A. The 1.3, the enterprise content management and  
 3 document support, there was \$500,000 in the  
 4 February 22nd announcement, but that was for a  
 5 provincial study and to move forward in that  
 6 document.  
 7 CHAYTOR, Q.C.:  
 8 Q. That's something different than the 3 million  
 9 you had identified.  
 10 MS. JONES:  
 11 A. That's right. So we would get partial or some  
 12 consideration in that and on the decision  
 13 support, we were looking for \$880,000 and  
 14 there were five positions announced, in terms  
 15 of decision support of February 22nd, Eastern  
 16 Health was to get two.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, so in terms of how realistic was your  
 19 number 3 million in terms of what you needed  
 20 to go forward and deal with the deficiencies  
 21 you recognized in your information management?  
 22 Was it a situation where you do, you know, a  
 23 wish list and then -  
 24 MS. JONES:  
 25 A. No, it's not a wish list. The wish list is--

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1 and it's not even the wish list, it's 16.5 -  
 2 CHAYTOR, Q.C.:  
 3 Q. Because you also have 16.5 million indicated.  
 4 MS. JONES:  
 5 A. 16.5 million are in the information management  
 6 decision support area, so inside of the 16.5  
 7 we would have ended up having to prioritize, but  
 8 those are all of the issues that we needed to  
 9 move forward on to be able to move us to  
 10 consolidated integrated systems and to move  
 11 electronic health record. This is a phase one  
 12 of the--the 16.5 would be a phase one of a 50  
 13 million dollar information technology plan  
 14 that we would need to move forward.  
 15 CHAYTOR, Q.C.:  
 16 Q. So why did you express any concern in  
 17 February, February 22nd or afterwards, that  
 18 you didn't get your 3 million. Did you ask  
 19 why not the full 3 million and did you express  
 20 any concern around that?  
 21 MS. JONES:  
 22 A. I was out of the province when that  
 23 announcement was made, but I did follow up  
 24 with Mr. Thompson the next week asking for  
 25 clarification because it was not really clear.

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1 CHAYTOR, Q.C.:  
 2 Q. Would that be Mr. Thompson or would that be  
 3 Mr. Keats?  
 4 MS. JONES:  
 5 A. It was Mr. Thompson because the ER/PR file was  
 6 there and he was sitting with the minister  
 7 when--well he was part of the development of  
 8 that particular press release and that, so I  
 9 knew that he was doing the work on it and he  
 10 had also said earlier, in November, that the  
 11 ER/PR and the budget issues were really going  
 12 to be managed by his office, that's the reason  
 13 why this particular report was sent to him, as  
 14 well as through to the deputy minister. The  
 15 other thing that was in here, in the February  
 16 22nd was the \$175,000 that we had asked that  
 17 was not referenced in this particular proposal  
 18 because as I said yesterday, we were looking  
 19 for education funds all compiled together  
 20 inside of Eastern Health, so it was a 1.2  
 21 million ask.  
 22 CHAYTOR, Q.C.:  
 23 Q. So you did follow up with Mr. Thompson and  
 24 what was the answer?  
 25 MS. JONES:

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1 A. The answer on the content management was that  
 2 there needed to be work done provincially and  
 3 one of--and if I recall correctly, it was in  
 4 discussion with the chief information officer  
 5 for the province, there was a lot of work that  
 6 needed to be done and therefore, they would  
 7 want to do it as a province verses moving  
 8 Eastern Health forward. The 880 that we had  
 9 or the 800 that we had was the actual cost to  
 10 implement it inside of Eastern Health, so  
 11 there was \$500,000 there for planning and on  
 12 the decision support, there really wasn't an  
 13 answer. They had gone and recognized that we  
 14 needed to move forward with decision support  
 15 and Eastern Health would get two out of the  
 16 five positions. That was the only  
 17 explanation.  
 18 CHAYTOR, Q.C.:  
 19 Q. And how confident are you that the resources  
 20 you've now been provided are adequate to  
 21 address the concerns that you identified in  
 22 your information management systems, arising--  
 23 that you learned about through the ER/PR  
 24 experience?  
 25 MS. JONES:

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1 A. Well we absolutely need to see if in fact the  
 2 content management is there, which is the  
 3 tools to be able to get at some of the  
 4 information that's inside of databases and we  
 5 do need resources to be able to work at  
 6 decision support and decision management. The  
 7 two recourse, if I was to put them into the  
 8 IHC lab area, that might very well be fine,  
 9 but really this particular proposal is for  
 10 decision support, you know, we've handled the  
 11 issue--the issue with the IHC lab and where  
 12 that is, but, you know, if we were to avoid a  
 13 situation like this in the future for some  
 14 other issue, then these are the kind of  
 15 resources that we need.  
 16 CHAYTOR, Q.C.:  
 17 Q. The issue in terms of the IHC lab itself,  
 18 wasn't a whole lot of issue around that, I  
 19 understand, in terms of being under resourced,  
 20 this issue of information management was more  
 21 the issue--now whether it's under resourced in  
 22 other areas, I'm talking information  
 23 management right now, but this issue of  
 24 information management was more the,  
 25 connecting with the patients, wasn't that the

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1 issue?  
 2 MS. JONES:  
 3 A. No, the issue of information management is  
 4 being able to generate that list.  
 5 CHAYTOR, Q.C.:  
 6 Q. Being able to identify them and connect with  
 7 that.  
 8 MS. JONES:  
 9 A. And that's exactly it.  
 10 CHAYTOR, Q.C.:  
 11 Q. Identifying the patient and connecting with  
 12 them.  
 13 MS. JONES:  
 14 A. Yes, and the decision support piece, it is  
 15 having a set of skills that you could put  
 16 around the table, clinical epidemiology, you  
 17 notice in here, as well as bio-statistician,  
 18 which is a set of skills that we don't have  
 19 currently inside of a 1 billion dollar  
 20 organization, you would say why, but -  
 21 CHAYTOR, Q.C.:  
 22 Q. You don't have an epidemiologist.  
 23 MS. JONES:  
 24 A. We don't have them, that we would be using in  
 25 this particular way, they have a set of skills

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1 that if in fact you have an issue like this,  
 2 you put a group of individuals, a project team  
 3 around it to tease out all of the aspects of  
 4 it. They know the methodology, you may not be  
 5 able to get at it this way, but because of the  
 6 way they think and the way that they've been  
 7 trained, you may be able to get at things in  
 8 different ways to be able to get you to a  
 9 point. So there were sets of skills that we  
 10 have that look at populations and health and  
 11 factors and research and methodologies that we  
 12 don't have inside of Eastern Health.  
 13 CHAYTOR, Q.C.:  
 14 Q. So being able to track trends and for example,  
 15 how many lobular invasive breast cancers had  
 16 ER negatives, ER positive -  
 17 MS. JONES:  
 18 A. What's the outcome, yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. Being able to track those kinds of trends.  
 21 MS. JONES:  
 22 A. That's right.  
 23 CHAYTOR, Q.C.:  
 24 Q. So the money that you're seeking would be to  
 25 put someone in place who would be able to do

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1 that type of work?  
 2 MS. JONES:  
 3 A. The systems in place identify which are the  
 4 most important--we referenced earlier on the  
 5 board objectives of having outcome indicators  
 6 that were acceptable to the board. How do you  
 7 collect that data, what's the most appropriate  
 8 format, is there other ways to get at it, is  
 9 there evidence based kind of practices out  
 10 there, what are the things that we really  
 11 should be looking at that have an impact on  
 12 health. So that's the kind of resource and  
 13 structures that we need.  
 14 CHAYTOR, Q.C.:  
 15 Q. So, there's nobody in the organization right  
 16 now who carries out that function?  
 17 MS. JONES:  
 18 A. No, there's not. We have, since the fall of  
 19 this year we have a clinical epidemiologist  
 20 who is with us from Health Canada on the  
 21 community side for communicable diseases and  
 22 we may have individuals who may have some of  
 23 those skill sets, but they are not in a  
 24 function where they would use those and that  
 25 would be the ones that you would use on a

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1 daily basis or to develop a decision support  
 2 system for your organization.  
 3 CHAYTOR, Q.C.:  
 4 Q. So, this money in information management, that  
 5 money though wasn't to hire an epidemiologist?  
 6 MS. JONES:  
 7 A. No, but the decision support money, the eight  
 8 hundred thousand -  
 9 CHAYTOR, Q.C.:  
 10 Q. That money is, okay.  
 11 MS. JONES:  
 12 A. Yeah. And really at the end of the day, until  
 13 we can get to a single system, a single  
 14 platform inside of eastern health to have same  
 15 data dictionaries, to have the same processes,  
 16 those kinds of things, it's still going to get  
 17 us patient information, but with other kinds  
 18 of resources, other kinds of tools around it,  
 19 you may very well be able to get at population  
 20 based and outcome measures. And that's where  
 21 those other individuals will help you in  
 22 establishing that.  
 23 CHAYTOR, Q.C.:  
 24 Q. And I understand part of this issue though  
 25 was, part of the difficulty was that there was

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1 no standardized reporting on the pathology  
 2 reports.  
 3 MS. JONES:  
 4 A. That's right.  
 5 CHAYTOR, Q.C.:  
 6 Q. And that's something that, that had that been  
 7 occurring perhaps in terms of the system that  
 8 you have in place right now, it may have been  
 9 easier then to retrieve the information -  
 10 MS. JONES:  
 11 A. They have been easier to retrieve the  
 12 information and those systems that we have  
 13 have evolved over time. And they really need  
 14 to, as you move towards to a single  
 15 consolidated system, they need to be set up in  
 16 a fashion os that you're going to be able to  
 17 get out, not individual patient pieces of  
 18 information that there is a database that is  
 19 able to be generated and to be used for things  
 20 like we're talking about, positivity rates or  
 21 any of those kinds of things.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay. If we could just move on then to page 2  
 24 of your proposal, there's just a couple of  
 25 points I'd like to address with you here. And

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1 your issue is that there is a deficiency of  
 2 tools and resources dedicated to the creation  
 3 analysis and interpretation of information.  
 4 MS. JONES:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And you start with background and you say,  
 8 "over the past two years, eastern health has  
 9 been reviewing its clinical and administrative  
 10 support system as it moves forward in its  
 11 integration". So, this is something that  
 12 eastern health has been looking at for a  
 13 couple of years?  
 14 MS. JONES:  
 15 A. That's right.  
 16 CHAYTOR, Q.C.:  
 17 Q. And under context, "in 2001/2002 the Health  
 18 Care Corporation of St. John's underwent an  
 19 operational review. As part of its analysis,  
 20 the Hay Group identified that there are major  
 21 efficiencies that could be achieved,  
 22 particularly related to the health care  
 23 corporation's use of inpatient resources". It  
 24 also recommended that "significant investment  
 25 be made in the area of increasing the level of

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1 analytical and decision support within the  
 2 organization prior to the establishment of  
 3 Eastern Health. Significant investment was  
 4 made within health care corporation in the  
 5 areas of information management. The purchase  
 6 of decision support tools and the  
 7 establishment of a clinical efficiency unit.  
 8 Additionally cost reduction in the vicinity of  
 9 22 million and the elimination of  
 10 approximately 222 full-time equivalents was  
 11 accomplished". And the word accomplished is  
 12 there, whether it's an accomplishment or not,  
 13 I guess, is for someone else to debate.

14 MS. JONES:  
 15 A. That's right.

16 CHAYTOR, Q.C.:  
 17 Q. "During the creation of eastern health, it was  
 18 noted that none of the other six boards  
 19 possessed decision support tools similar to  
 20 those that were available in the health care  
 21 corporation and there were limited resources  
 22 associated with financial and/or health record  
 23 analysis". So, since 2005, eastern health has  
 24 attempted to use the tools and/or expertise  
 25 that was available inside health care

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1 corporation and extend these tools and  
 2 knowledge throughout eastern health. So, I  
 3 take it what you're referring to there is--  
 4 when I read this, it appears that the health  
 5 care corporation had already invested in its  
 6 information management structures. Eastern  
 7 health is now taking over other areas such as  
 8 Burin, Clarendville and Carbonear. And that  
 9 there hadn't been the same investment  
 10 information management systems throughout the  
 11 entire region.

12 MS. JONES:  
 13 A. Yes.

14 CHAYTOR, Q.C.:  
 15 Q. Outside of St. John's?  
 16 MS. JONES:  
 17 A. Yes, but eastern--old health care corporations  
 18 still had a lot of work to do, even though we  
 19 had made investments, there was still a lot  
 20 more work to do. We did--if you go back to  
 21 your first--we had decision support tools  
 22 which was a cognizant (phonetic) tool that we  
 23 had that we were working on and developing  
 24 over time. And these were all related to  
 25 making efficiencies in the system. They were

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1 not related to all of the other parts of  
 2 decision support that you would be looking at,  
 3 best practice, like the clinical epidemiology,  
 4 all of those kinds of things. So, they were  
 5 all focused on making the organization as  
 6 efficient as it possibly could such that it  
 7 was able to meet a 22 million dollars target  
 8 that the Hay had identified.

9 CHAYTOR, Q.C.:  
 10 Q. Now, my question, I guess, was, when I read  
 11 this was that whether or not the information  
 12 management issues that you're going forward  
 13 with to government at this point in time, was  
 14 it aimed more at St. John's or was it your  
 15 outlying regions?

16 MS. JONES:  
 17 A. It was--there were deficiencies in St. John's,  
 18 continue to be deficiencies in the old health  
 19 care corporation. We were becoming more  
 20 sophisticated in the use of some of our tools,  
 21 but also included--because we're a regional  
 22 health authority--also outside St. John's.  
 23 The parts of the organization though and I  
 24 think references further on, there's parts of  
 25 our organization that have no computerization

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1 or limited computerization.

2 CHAYTOR, Q.C.:  
 3 Q. The identification and the notification of the  
 4 patients -  
 5 MS. JONES:  
 6 A. Yes.

7 CHAYTOR, Q.C.:  
 8 Q. - for eastern health, the eastern health's  
 9 portion anyhow, that happened with St. John's  
 10 resources.

11 MS. JONES:  
 12 A. That's right.

13 CHAYTOR, Q.C.:  
 14 Q. That was done in St. John's, not--in terms of  
 15 identifying who needed to be retested. So,  
 16 that was done within St. John's. So, was any  
 17 of the information management deficiencies  
 18 that you had identified and that you go  
 19 forward in your proposal on here, did any of  
 20 those deficiencies contribute to the problems  
 21 encountered in identifying and/or notifying  
 22 the patients?  
 23 MS. JONES:  
 24 A. We didn't have the sophistication, we had to  
 25 use a manual process. So, if we had had some



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1 of the tools that are referenced in here like  
 2 the content management kind of tool that could  
 3 sit on top of our existing hardware like  
 4 Meditec and CRMS, but it's meditec in this  
 5 instance. There may very well have been a  
 6 more in-depth way to be able to get at the  
 7 information that we were looking for. It  
 8 still would have been not, from '97 to 2005,  
 9 would not have been in a format, you know, a  
 10 standard format, wasn't keyed in a field. But  
 11 the other thing that you have to remember is a  
 12 lot of the information wasn't inside of  
 13 eastern health. We were relying on--you  
 14 referenced -  
 15 CHAYTOR, Q.C.:  
 16 Q. Yes, that's -  
 17 MS. JONES:  
 18 A. - and as well as Gander and Grand Falls and  
 19 Corner Brook and those kinds of things.  
 20 CHAYTOR, Q.C.:  
 21 Q. Yes, I just spoke to you about the area within  
 22 your jurisdiction and what other areas did how  
 23 they identified. But in terms of within  
 24 eastern health, did Carbonear then identify  
 25 their own patients or -

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1 MS. JONES:  
 2 A. Carbonear identified their own patients, the  
 3 same as we did in St. John's going through the  
 4 pathology reports.  
 5 CHAYTOR, Q.C.:  
 6 Q. And did that, to your knowledge, because we  
 7 know there were, I think, some 14 patients  
 8 were listed in Carbonear.  
 9 MS. JONES:  
 10 A. More than that.  
 11 CHAYTOR, Q.C.:  
 12 Q. More than that.  
 13 MS. JONES:  
 14 A. Yeah.  
 15 CHAYTOR, Q.C.:  
 16 Q. Did that have anything to do with lack of or  
 17 deficiencies in information management?  
 18 MS. JONES:  
 19 A. Well, they couldn't have gone into their  
 20 meditec system and found it any better than we  
 21 could. So, they had to go to a manual based  
 22 process to identify.  
 23 THE COMMISSIONER:  
 24 Q. Sorry, but I'm not understanding the answer to  
 25 the question here. In respect of those--

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1 let's, for the moment, forget Carbonear and  
 2 Burin.  
 3 MS. JONES:  
 4 A. Yes.  
 5 THE COMMISSIONER:  
 6 Q. But otherwise the groups that you would have  
 7 been identifying would have been within what  
 8 is the old St. John's Health Care Corp.  
 9 MS. JONES:  
 10 A. Yes.  
 11 THE COMMISSIONER:  
 12 Q. And can we come back to the original question  
 13 which was, whether any of those deficiencies  
 14 that had been identified in the communications  
 15 here, contributed to the difficulties in  
 16 respect of ER/PR. And what I heard you to say  
 17 was maybe it took us longer to do it.  
 18 MS. JONES:  
 19 A. There would be no way that we could have fully  
 20 identified because the meditec system is based  
 21 upon an individual order. It's not a database  
 22 management system. So, unless we had an  
 23 individual field inside of meditec that was  
 24 set up initially, what were looking at was  
 25 pathology reports of which in the text of the

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1 report, ER/PR was within the text of a  
 2 pathology report. So, the becomes your  
 3 problem. And so therefore, every pathology  
 4 report would have to come out and there's no  
 5 way inside of a computerized system that we  
 6 have, that you could say, ER/PR--spit out  
 7 every ER/PR test that was done.  
 8 CHAYTOR, Q.C.:  
 9 Q. So, what happened instead?  
 10 MS. JONES:  
 11 A. That's where the manual process came in.  
 12 Every pathology report associated with breast  
 13 -  
 14 CHAYTOR, Q.C.:  
 15 Q. In that time period from 1997, whether it's  
 16 January in St. John's to 2005 were pulled.  
 17 MS. JONES:  
 18 A. Were pulled.  
 19 CHAYTOR, Q.C.:  
 20 Q. And manually looked at.  
 21 MS. JONES:  
 22 A. And manually looked at.  
 23 THE COMMISSIONER:  
 24 Q. So, the answer really is what technology you  
 25 had was of no assistance at all in the process

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1 that you had to go through for the purpose of  
 2 identifying patients?  
 3 MS. JONES:  
 4 A. For the specific ER/PR.  
 5 THE COMMISSIONER:  
 6 Q. Yes.  
 7 MS. JONES:  
 8 A. That's right.  
 9 THE COMMISSIONER:  
 10 Q. That's what I'm interested in in the sense of-  
 11 -at least that's what I understood the  
 12 question which was being proposed to you, was  
 13 that how did the deficiency in your operation  
 14 contribute, as it were, to the problems that  
 15 have been identified over the period of time  
 16 with ER/PR. Any my understanding of the  
 17 response is the technology which you used  
 18 within your operation--leaving aside for the  
 19 moment, Carbonear and Burin, which I'm sure  
 20 came with their own individual problems--did  
 21 not permit you to search for particularly  
 22 identifiable, in fields which had been set up  
 23 for the purposed of identifying path report or  
 24 whatever.  
 25 MS. JONES:

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1 A. That's right.  
 2 THE COMMISSIONER:  
 3 Q. And therefore, the only way of getting at the  
 4 information was the old fashion manual, pull  
 5 the files and look at it system.  
 6 MS. JONES:  
 7 A. Yes.  
 8 THE COMMISSIONER:  
 9 Q. Okay.  
 10 MS. JONES:  
 11 A. And there's nuances in there because you can  
 12 order an ER/PR test, but not always was an  
 13 ER/PR test ordered. So, you could line that  
 14 particular piece up, but it wouldn't--we knew  
 15 from the way our database worked and from the  
 16 pathology reports that that wouldn't give you  
 17 a complete listing.  
 18 CHAYTOR, Q.C.:  
 19 Q. So you couldn't search under ER/PR?  
 20 MS. JONES:  
 21 A. We could search under ER/PR, but that would  
 22 give you a limited search. It wouldn't be a  
 23 complete search. And so that -  
 24 CHAYTOR, Q.C.:  
 25 Q. And why was that?

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1 MS. JONES:  
 2 A. Because in order to--you had to enter the  
 3 order in, but you didn't necessarily need an  
 4 order to do the tests because if the  
 5 pathologist was looking at, they would have  
 6 said, do ER/PR on this particular test, not  
 7 always entered into the computer system. So,  
 8 there's not a system -  
 9 CHAYTOR, Q.C.:  
 10 Q. So it wasn't that the system couldn't find.  
 11 It's that it may not have been recorded in a  
 12 standardized format on the pathology report.  
 13 MS. JONES:  
 14 A. And that was only the order, there was no  
 15 results in--because you also know that from,  
 16 after a period of time the slides went back to  
 17 be reread. So, we did the technical piece.  
 18 And we didn't know the actual result for  
 19 Gander, you know, for all of the other  
 20 pathologists who read the reports. Our  
 21 pathology reports inside St. John's would have  
 22 only had the ER/PR numbers that were read  
 23 inside of St. John's. So, we had a  
 24 potentially had an order that says, do ER/PR,  
 25 but not all of the specimens would have had

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1 that order on it and the tests would have been  
 2 done.  
 3 CHAYTOR, Q.C.:  
 4 Q. Right, and so what I'm trying to ascertain  
 5 here is whether or not the system you had in  
 6 place was, in fact, adequate, but -  
 7 MS. JONES:  
 8 A. It wasn't.  
 9 CHAYTOR, Q.C.:  
 10 Q. - the information hadn't been put in in a  
 11 format which would enable retrieval from the  
 12 system.  
 13 MS. JONES:  
 14 A. It is set up as an individual patient basis.  
 15 It's not set up on a database basis. And  
 16 therefore you have to overlay different tools  
 17 on it to be able to extract it from meditec to  
 18 be able to get at it. So, it was not set up.  
 19 Meditec is not set up in that fashion, to be  
 20 able to drill down that far. We had not set  
 21 it up inside of our system. It had not been  
 22 set up. And therefore we were not able to get  
 23 it out in that fashion.  
 24 CHAYTOR, Q.C.:  
 25 Q. So, it was done manually.

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1 MS. JONES:  
 2 A. It was done manually.  
 3 CHAYTOR, Q.C.:  
 4 Q. And do you know if any of the people that were  
 5 not identified were missed manually? Was that  
 6 the problem?  
 7 MS. JONES:  
 8 A. Obviously that was part of the problem because  
 9 you're doing a manual search of all of the--  
 10 Carbonear is a good example, where there was a  
 11 manual search of pathology records for the  
 12 ER/PR. And as late as the fall of 2007 there  
 13 were other people who were identified.  
 14 CHAYTOR, Q.C.:  
 15 Q. Right, but you don't know the reason for that.  
 16 MS. JONES:  
 17 A. No, I don't know the reason.  
 18 CHAYTOR, Q.C.:  
 19 Q. Whether or not it had anything to do with cut  
 20 offs or years or timing, you don't know.  
 21 MS. JONES:  
 22 A. Don't know.  
 23 CHAYTOR, Q.C.:  
 24 Q. All right. The bottom paragraph says that  
 25 the--actually, before we skip to that I did

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1 have a question for you on the Hay Report  
 2 because this talks about certain efficiencies  
 3 that were to be achieved or is recommended  
 4 through the Hay Report. You would have been  
 5 part of the executive in that time period.  
 6 MS. JONES:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. Do you have any knowledge as to whether or not  
 10 those efficiencies were achieved? For  
 11 example, here where it talks about the  
 12 reduction 220 full time equivalents. That was  
 13 accomplished.  
 14 MS. JONES:  
 15 A. The cost reduction in the vicinity of 22  
 16 million and 220, yes. It actually started out  
 17 being from Hay close to 30 million dollars  
 18 that they had expected that we would cut. We  
 19 agreed at the end of the day based upon going  
 20 back and forth with consultants that it was 22  
 21 million that the government and ourselves  
 22 agreed. And we didn't quite reach the 22  
 23 million, but it was somewhere in the vicinity  
 24 of around 18 million.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And I had read in one of the old  
 2 executive management meeting minutes, I think  
 3 was back in June of '05, June 6th, 7th, '05  
 4 that you had been tasked with cataloguing the  
 5 recommendations from the Hay report and giving  
 6 a brief to executive management. Do you  
 7 recall that and did you actually do that?  
 8 MS. JONES:  
 9 A. I was very familiar with the Hay report  
 10 because during that particular time I ended up  
 11 taking the lead on the data issues that were  
 12 in there in terms of the MIS. So, I worked  
 13 particularly closely with Sharon Lear who was  
 14 our finance person at the time, worked with  
 15 Hay to identify their discrepancies on our  
 16 workload and all of those as well as in our  
 17 clinical information that would have been  
 18 going to the Canadian Institute for Health and  
 19 Information. So, that's where we had moved  
 20 from the 29 to 30 million that Hay had said  
 21 that we could save down to the 22 million.  
 22 So, these recommendations were lots in the  
 23 area of decreasing your flexibility in the  
 24 organization and moving to a casualized  
 25 workforce, particularly within your nursing.

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1 As well as moving managers out of the system  
 2 because they believe that there could be  
 3 collapsing of some of the programs. There was  
 4 issues that we didn't agree with which was a  
 5 single emergency in St. John's and the closing  
 6 of our acute care beds on Bell Island. So,  
 7 there were some issues that, at the end of the  
 8 day, the organization didn't agree with and  
 9 went forward to government and said, this is  
 10 things we can't agree with.  
 11 CHAYTOR, Q.C.:  
 12 Q. Maybe we can focus in on some that may or may  
 13 not be relevant to this issue, but what about  
 14 the decrease. Were there any decreases in  
 15 managers in the quality department?  
 16 MS. JONES:  
 17 A. In this area they wouldn't have been looking  
 18 at it in Hay.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay. What about in terms of in the lab?  
 21 Were there -  
 22 MS. JONES:  
 23 A. There was workload decreases in the lab that  
 24 would have looked decreasing the number of  
 25 FTES, but they were related to workload.

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1 Automation that would allow more tests to be  
 2 done in that particular area.  
 3 CHAYTOR, Q.C.:  
 4 Q. So, was there anything in, with your knowledge  
 5 and background of this exercise through the  
 6 Hay Group, was there anything that could have  
 7 contributed to the problems that ultimately  
 8 come out of the lab in terms of the ER/PR  
 9 issue?  
 10 MS. JONES:  
 11 A. At the end of the day there was very little  
 12 that was referenced and I don't see it here,  
 13 there was very little reference with respect  
 14 to the lab. There was some cuts and there was  
 15 some efficiencies and that kind of thing.  
 16 They referenced in the lab that we were well  
 17 automated, one of the better labs across the  
 18 country from an automation perspective. So,  
 19 from a clinical efficiency perspective, there  
 20 wasn't very much there. And what they really  
 21 pushed was to get support tools, utilization  
 22 and decision support tools in for the entire  
 23 organization that would then allow us to move  
 24 forward. A lot of the focus was on in-patient  
 25 beds. We were 25 - 30 percent above the

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1 national average for length of stay in a bed.  
 2 So, if somebody -  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay.  
 5 MS. JONES:  
 6 A. - came in, and that is where -  
 7 CHAYTOR, Q.C.:  
 8 Q. That's fine.  
 9 MS. JONES:  
 10 A. - the savings were mostly attributed to.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay, all right. So, nothing that would  
 13 really jump out, in your mind, in terms of  
 14 what could be relevant to this issue?  
 15 MS. JONES:  
 16 A. No.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay. So, during the creation (unintelligible  
 19 - coughing) eastern health, it was noted that  
 20 none of the six boards and I think I took you  
 21 through that.  
 22 MS. JONES:  
 23 A. Um-hm.  
 24 CHAYTOR, Q.C.:  
 25 Q. I'm sorry, it's the next paragraph, "with the

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1 creation of Eastern Health in 2005, government  
 2 identified 98" -  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. - "positions". And I take it that's an  
 7 additional 98 on top of, we had 220 before.  
 8 MS. JONES:  
 9 A. Well, the Hay implementation was done by 2004.  
 10 So, Hay was long, but this was really just to  
 11 give a history of what we had been doing.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay. So, the accomplishment of 220 full time  
 14 equivalents had already taken place.  
 15 MS. JONES:  
 16 A. That's right.  
 17 CHAYTOR, Q.C.:  
 18 Q. And now government has identified an  
 19 additional--this is new people.  
 20 MS. JONES:  
 21 A. New people.  
 22 CHAYTOR, Q.C.:  
 23 Q. Ninety-eight positions.  
 24 MS. JONES:  
 25 A. That's right.

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1 CHAYTOR, Q.C.:  
 2 Q. With an associated savings of 5.7 million to  
 3 be achieved as a result of regionalization.  
 4 MS. JONES:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And of the 98 positions, 13.5 were to be  
 8 reduced in information management. Sixteen  
 9 positions in human resources and two in  
 10 quality and approximately 15 related to  
 11 financial and accounting.  
 12 MS. JONES:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. The organization did reduce approximately 37  
 16 positions with the savings of 1.6 million.  
 17 Were any of those 37 positions in information  
 18 management or quality?  
 19 MS. JONES:  
 20 A. They would have been from a directorship  
 21 perspective in that area.  
 22 CHAYTOR, Q.C.:  
 23 Q. In information management?  
 24 MS. JONES:  
 25 A. That's right. And we've actually put more

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1 people in quality versus taking them out. And  
 2 on the financial management there would have  
 3 been some losses there. So, they would have  
 4 been in the 37--most of the 37 would have been  
 5 in higher level management positions, but I  
 6 would say to you in that, then you're taking  
 7 out a condry (sic.) of support that was inside  
 8 the organization. So, the CEOs, you know  
 9 there were seven CEOs, now we have one. There  
 10 were management teams in all of the seven.  
 11 So, a lot of them were at the senior executive  
 12 management, but there were individuals, but  
 13 they weren't in quality, we added in quality.  
 14 Human resources would have been at that  
 15 executive level and there was a couple of  
 16 financial -  
 17 CHAYTOR, Q.C.:  
 18 Q. And information management, there was a  
 19 director that came out.  
 20 MS. JONES:  
 21 A. The director, they ended up staying inside the  
 22 organization, but not at the director level.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay. So, in terms of where the plan is to go  
 25 from here on, is there still any plan to

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1 reduce in the areas of information management  
 2 or quality?  
 3 MS. JONES:  
 4 A. We have said now. We accomplished 1.6. We  
 5 have no direction been given to us that we  
 6 have to go to the 5.7. We ask every year  
 7 about that particular issue.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay. And then you have a graph that you  
 10 present. And what you indicate here is that  
 11 this graph has been utilized by eastern health  
 12 in presentations over the past two years to  
 13 point out the fact the organization is  
 14 underinvested and you reference a database  
 15 there, in the area of administration, support  
 16 and information management.  
 17 MS. JONES:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. And so in the past two years, who had this  
 21 presentation been made to?  
 22 MS. JONES:  
 23 A. It had been made to the department. If you  
 24 reference some of the budget submissions. We  
 25 started it in 2005. As we came out of the old

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1 health care corporation of St. John's, there  
 2 were different graphs that we were using, but  
 3 we were having--even though we had put a major  
 4 investment in terms of information technology,  
 5 we were still way under what the Canadian  
 6 average would have been in information  
 7 technology. So, yes, we've come a long way,  
 8 but we had a long way to go. So, we were  
 9 using and trying to use the Canadian  
 10 benchmarks and we know that Canada is well  
 11 under the rest of the world with respect to  
 12 investment and health information technology.  
 13 And that's why we have Canada Infoway and that  
 14 moving forward. So these graphs that you see  
 15 attached here were used in 2005 and in 2006  
 16 and again in 2007, so at times there would  
 17 have been where ministers were in place, with  
 18 the minister of health at a particular time  
 19 and we've also utilized them for the minister  
 20 of treasury board in the past, in terms of  
 21 presentations.  
 22 CHAYTOR, Q.C.:  
 23 Q. So this is not the first time, my point being  
 24 that Eastern Health has gone to the department  
 25 and said we need this money for this purpose.

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1 MS. JONES:  
 2 A. Absolutely, information management has been on  
 3 the agenda for awhile and I would, you will  
 4 look there and you say, we've also, just in  
 5 the Eastern Health point there around bring  
 6 out 98 positions, we have many times when  
 7 people talk about us being over invested in  
 8 management and support systems and in fact, we  
 9 are way under invested and if in fact we had  
 10 the management and the support systems, then  
 11 we may very well be able to have avoided some  
 12 of these things because we would have had  
 13 supports, we would have had managers who would  
 14 have been able to really get to the meat of  
 15 some of the work that you expect managers to  
 16 get to.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, thank you. P-0488 please? Page 106,  
 19 okay, just bear with me because this is a  
 20 situation where our page numbers have changed  
 21 so, here we go, December 12th, 2007.  
 22 MS. JONES:  
 23 A. Uh-hm.  
 24 CHAYTOR, Q.C.:  
 25 Q. And this again is the executive management

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1 committee meeting and you are chairing the  
 2 meeting.  
 3 MS. JONES:  
 4 A. Uh-hm.  
 5 CHAYTOR, Q.C.:  
 6 Q. Judicial Inquiry, ER/PR and there's under the  
 7 Inquires Act, the NLHBA, Newfoundland and  
 8 Labrador Hospital Board Association.  
 9 MS. JONES:  
 10 A. Health Boards Association.  
 11 CHAYTOR, Q.C.:  
 12 Q. "Health Boards Association will be pursuing  
 13 the minister of health and the minister of  
 14 justice as it relates to the Inquiries Act and  
 15 the implications for the health care system."  
 16 What is that all about?  
 17 MS. JONES:  
 18 A. This was in December?  
 19 CHAYTOR, Q.C.:  
 20 Q. December 12th.  
 21 MS. JONES:  
 22 A. Yeah, this was in reference to the decision  
 23 that we had made to go to court around the  
 24 Evidence Act and the Inquiries Act with  
 25 respect to the peer reviews and looking for

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1 clarification.  
 2 CHAYTOR, Q.C.:  
 3 Q. And the NLHBA, who would sit on that from  
 4 Eastern Health?  
 5 MS. JONES:  
 6 A. The NLHBA, their board chairs and CEOs, so the  
 7 CEOs meet with the deputy every two weeks and  
 8 then the board chairs meet on every couple of  
 9 months to talk about, you know, the entire  
 10 system.  
 11 CHAYTOR, Q.C.:  
 12 Q. So you and Mrs. Dawe would sit on that?  
 13 MS. JONES:  
 14 A. Mrs. Dawe, that's right.  
 15 CHAYTOR, Q.C.:  
 16 Q. And did you do that? Did the NLHBA pursue the  
 17 minister of health and justice on the issue?  
 18 MS. JONES:  
 19 A. I'm not sure about the minister of justice,  
 20 but we did have discussion with the minister  
 21 of health around the Inquiries Act and more  
 22 specifically around the Evidence Act and the  
 23 Inquiries Act that provision around the  
 24 information.  
 25 CHAYTOR, Q.C.:

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1 Q. So you did do that?  
 2 MS. JONES:  
 3 A. Yes, we did.  
 4 CHAYTOR, Q.C.:  
 5 Q. And were you involved in those discussions?  
 6 MS. JONES:  
 7 A. There was a meeting, probably the latter part  
 8 of November where the minister came in,  
 9 usually comes in for supper and along with a  
 10 number of issues that we would have had on the  
 11 agenda that night, we did talk about the peer  
 12 review and the need to protect peer review, so  
 13 that was really in the context of the  
 14 discussion, that I was with where the minister  
 15 was.  
 16 CHAYTOR, Q.C.:  
 17 Q. And the implication for the health care system  
 18 being the need to protect peer review.  
 19 MS. JONES:  
 20 A. Peer review.  
 21 CHAYTOR, Q.C.:  
 22 Q. And without going down that long road again  
 23 because I know the Commissioner had some  
 24 questions with you around that a couple of  
 25 days ago, but what are the implications for

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1 the health care system? What exactly are  
 2 they?  
 3 MS. JONES:  
 4 A. We've not had a discussion around peer review,  
 5 I don't believe here.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay.  
 8 THE COMMISSIONER:  
 9 Q. I think I raised peer review in the context of  
 10 -  
 11 CHAYTOR, Q.C.:  
 12 Q. Patient safety.  
 13 MS. JONES:  
 14 A. Okay.  
 15 CHAYTOR, Q.C.:  
 16 Q. Remember the Commissioner put to you about the  
 17 issues of about, you know, the whole original-  
 18 -the whole intent for peer review was patient  
 19 safety.  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. So in today's modern world and the issue of  
 24 patient safety seemingly to be first and  
 25 foremost in people's minds.

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1 MS. JONES:  
 2 A. Yes, okay.  
 3 CHAYTOR, Q.C.:  
 4 Q. What could be the implications for the health  
 5 care system?  
 6 MS. JONES:  
 7 A. Ultimately when we look at a peer review, peer  
 8 review is the way that the health care system  
 9 has worked in and the issues that is  
 10 identified and the review process that takes  
 11 place, has generally been protected inside of  
 12 this province for the mid--since at least the  
 13 mid 80s, in other provinces for longer than  
 14 that, and our professionals are used to  
 15 working inside of that system. This is this  
 16 issue of having open and honest discussion  
 17 with experts or reviewers that come in to try  
 18 to uncover issues and then to put resolutions  
 19 in place or recommendations in place to be  
 20 able to move forward on that issue so that it  
 21 doesn't happen again. So there has been lots  
 22 of discussion inside of the health  
 23 professions. I've been at MACs, sitting at  
 24 MACs for years, there's always been,  
 25 especially when we had the first legislation

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1 in the 80s, there's always been a discussion  
 2 about what it is, where it is, the need for  
 3 that protection so that that open and honest  
 4 discussion actually happens. And that has  
 5 been a way that the health professions have  
 6 evolved, it is something that for them, allows  
 7 them in some way to feel as if, that they have  
 8 that safety to be able to have that discussion  
 9 and to have experts to be able to talk to them  
 10 that they may not have had an ability to be  
 11 able to talk to in the past.  
 12 So it's just been one of those things  
 13 that has been there. It's the way we operate.  
 14 We do our work inside of it. The discussions  
 15 stay inside of there. There's learnings.  
 16 There's education that comes out of it and  
 17 that's essentially the ethos of how health  
 18 care has operated.  
 19 CHAYTOR, Q.C.:  
 20 Q. Yes, to date.  
 21 MS. JONES:  
 22 A. To date.  
 23 CHAYTOR, Q.C.:  
 24 Q. And the discussion with the minister around  
 25 that, did you speak?

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1 MS. JONES:  
 2 A. All of the CEOs would have had something to  
 3 say in terms of -  
 4 CHAYTOR, Q.C.:  
 5 Q. So did you?  
 6 MS. JONES:  
 7 A. Yes, yeah.  
 8 CHAYTOR, Q.C.:  
 9 Q. And what position did you advocate?  
 10 MS. JONES:  
 11 A. In terms of our physicians, as well as our  
 12 staff inside, had said to us that really on  
 13 peer review, that that was a critical  
 14 component of the way that the health system  
 15 works and that we needed to move forward with  
 16 that particular approach.  
 17 CHAYTOR, Q.C.:  
 18 Q. And had you read the reports at that point in  
 19 time?  
 20 MS. JONES:  
 21 A. I had.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and so you were still advocating that  
 24 those reports should be protected under the  
 25 legislation?

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1 MS. JONES:  
 2 A. These reports were done underneath the  
 3 auspices of peer review and our physicians  
 4 were very clear with this, as well as our  
 5 staff, that that was the way that they were  
 6 set up, and if, in fact, these particular  
 7 reviews were opened in any single way, that  
 8 the protection of the principle of peer review  
 9 under the Evidence Act would have been damaged  
 10 in some way.  
 11 CHAYTOR, Q.C.:  
 12 Q. And did you have any concerns about the  
 13 protection of patients if that information was  
 14 not forthcoming?  
 15 MS. JONES:  
 16 A. At that point in time, when I read those  
 17 reviews, we were back redoing IHC testing.  
 18 The issues that were identified in those  
 19 reviews, the recommendations that were in  
 20 those reviews were already actioned. So from  
 21 the perspective of patients on the go-forward  
 22 basis, there was not an issue.  
 23 CHAYTOR, Q.C.:  
 24 Q. And they had been actioned where? The  
 25 information in those reports had been actioned

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1 where?  
 2 MS. JONES:  
 3 A. The recommendations in those reports had been  
 4 actioned.  
 5 CHAYTOR, Q.C.:  
 6 Q. Within Eastern Health?  
 7 MS. JONES:  
 8 A. Within Eastern Health.  
 9 CHAYTOR, Q.C.:  
 10 Q. Had there been disclosure to the other health  
 11 authorities? This is December 2007.  
 12 MS. JONES:  
 13 A. Yeah, the IHC lab is the--the working of that  
 14 lab, the producing of the slides is internal  
 15 to Eastern Health. There would have--you're  
 16 probably going to suggest the fixation issue  
 17 and I'm not sure how much of that had been  
 18 actioned outside of. There had already been  
 19 discussion by Mr. Tilley in terms of raising  
 20 the issue nationally to look at best practices  
 21 or benchmarks or standards or whatever,  
 22 because there was nothing in the Canadian  
 23 system. So there was a move to--there was an  
 24 attempt by Eastern Health to raise that  
 25 profile of an issue to try to, at least,

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1 develop standards, benchmarks and that so that  
 2 it was well aware across the country that we  
 3 had experienced issues inside our lab, and  
 4 that the Canadian Pathology Association,  
 5 through Don Cook, in their meetings early,  
 6 along after we had identified this issue, had  
 7 discussions to say "look, there are no  
 8 standards here. This is what we're dealing  
 9 with, in terms of the results that we were  
 10 getting."  
 11 CHAYTOR, Q.C.:  
 12 Q. And at this point in time, December of 2007,  
 13 when you're advocating that position that the  
 14 recommendations and whether or not the  
 15 recommendations had all been implemented, are  
 16 you saying that all the recommendations were  
 17 implemented?  
 18 MS. JONES:  
 19 A. The recommendation that's not implemented is  
 20 the system that has nothing to do with the  
 21 quality. It's the processing, the quickness  
 22 of the processing.  
 23 CHAYTOR, Q.C.:  
 24 Q. In December of 2007?  
 25 MS. JONES:

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1 A. In December of 2007.  
 2 CHAYTOR, Q.C.:  
 3 Q. And in terms of what had happened, in terms of  
 4 education or any education that may have been  
 5 required for the individuals involved, what  
 6 had happened along those lines?  
 7 MS. JONES:  
 8 A. You'll have to talk to Dr. Howell or Dr.  
 9 Williams specifically about that, but I do  
 10 know that there was pathologists that availed  
 11 of additional education in the way of  
 12 workshops through that outside of the province  
 13 and that we had also sent technologists to  
 14 other labs. So the actual detail of that,  
 15 you'll have to find from them, but the  
 16 education of the technologists and the  
 17 pathologists in this particular area is more  
 18 best suited for those individuals to talk to  
 19 you about.  
 20 CHAYTOR, Q.C.:  
 21 Q. Ms. Jones, the idea that all but one of the  
 22 recommendations have been implemented, is that  
 23 in writing anywhere?  
 24 MS. JONES:  
 25 A. No. There's a spreadsheet of recommendations

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1 that says ongoing for education and those  
 2 kinds of things, a compiling of them, but that  
 3 one around--and I can't even pronounce it, but  
 4 the machine. I've seen the machine in there.  
 5 CHAYTOR, Q.C.:  
 6 Q. Yes, we've seen the spreadsheets and I assume  
 7 we have the latest spreadsheet, and I would  
 8 suggest to you that that spreadsheet, if  
 9 that's what you're talking about, has other  
 10 things ongoing or in the process besides  
 11 education pieces.  
 12 MS. JONES:  
 13 A. The ongoing ones, education will never be  
 14 completed.  
 15 CHAYTOR, Q.C.:  
 16 Q. No, and I'm not talking about those.  
 17 MS. JONES:  
 18 A. Yeah.  
 19 CHAYTOR, Q.C.:  
 20 Q. Have you seen any documentation that says all  
 21 but one of the recommendations has been  
 22 implemented?  
 23 MS. JONES:  
 24 A. That's been--I've seen documentation. Now  
 25 whether it says ongoing or whatever, but in



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1 discussion with Dr. Howell, and that is the  
 2 only recommendation that remains outstanding.  
 3 CHAYTOR, Q.C.:  
 4 Q. So that's what Dr. Howell tells you?  
 5 MS. JONES:  
 6 A. Yeah.  
 7 CHAYTOR, Q.C.:  
 8 Q. Have you seen anything in writing?  
 9 MS. JONES:  
 10 A. No. I've probably seen early versions of the  
 11 52 on the page with the spreadsheet, just like  
 12 you have.  
 13 CHAYTOR, Q.C.:  
 14 Q. Which would clearly have ongoing on it.  
 15 MS. JONES:  
 16 A. On many of those, yeah.  
 17 CHAYTOR, Q.C.:  
 18 Q. On many of those.  
 19 MS. JONES:  
 20 A. And many of those would be always continued to  
 21 be ongoing.  
 22 CHAYTOR, Q.C.:  
 23 Q. Well, some of them, I'd suggest to you. I  
 24 think I went through that process with the  
 25 minister and was able to identify, at that

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1 point in time, the latest spreadsheet we have,  
 2 12 or 13 that weren't complete, and weren't  
 3 necessarily things that -  
 4 MS. JONES:  
 5 A. Would have been that they would never be  
 6 completed.  
 7 CHAYTOR, Q.C.:  
 8 Q. No, it was dated, but if there's something  
 9 more--you know, I think it was back, but it's  
 10 in 2007, but if there's something more recent,  
 11 I'm wondering if you've seen it.  
 12 MS. JONES:  
 13 A. I can't attest to seeing that.  
 14 CHAYTOR, Q.C.:  
 15 Q. I think it was June 2007.  
 16 MS. JONES:  
 17 A. I've seen a spreadsheet, yeah.  
 18 CHAYTOR, Q.C.:  
 19 Q. June 2007, I think, is the most recent one we  
 20 have and what you're saying here is in  
 21 December.  
 22 MS. JONES:  
 23 A. And I'm thinking we'll check to see if there  
 24 is an updated--because that spreadsheet does  
 25 get updated. I'm not sure what date I would

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1 have seen.  
 2 CHAYTOR, Q.C.:  
 3 Q. But as of December 2007, there was only one  
 4 recommendation that hadn't been implemented?  
 5 MS. JONES:  
 6 A. To my knowledge, that would have been, and  
 7 that was around the efficiency versus the  
 8 quality piece.  
 9 THE COMMISSIONER:  
 10 Q. Ms. Chaytor, it's five to one.  
 11 CHAYTOR, Q.C.:  
 12 Q. Oh.  
 13 THE COMMISSIONER:  
 14 Q. Do you want to take the luncheon break?  
 15 CHAYTOR, Q.C.:  
 16 Q. Yes, thank you.  
 17 THE COMMISSIONER:  
 18 Q. 2:10, thank you.  
 19 (LUNCH BREAK)  
 20 CHAYTOR, Q.C.:  
 21 Q. I think, Registrar, we're at 0488, page 106.  
 22 Good afternoon, Ms. Jones.  
 23 MS. JONES:  
 24 A. Good afternoon.  
 25 CHAYTOR, Q.C.:

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1 Q. Sorry, Commissioner, just trying to find where  
 2 were left off. We were with the December  
 3 12th, 2007 minutes.  
 4 THE COMMISSIONER:  
 5 Q. Yes. And Dr. Howell and Dr. Williams were  
 6 going to speak to the education element.  
 7 CHAYTOR, Q.C.:  
 8 Q. Um-hm. Here we are, okay. Back before this.  
 9 Here we go, yes. That's right. Yes, it was  
 10 the meeting with oncologists and pathologists  
 11 under 2.1. "Dr. Howell, Pat Pilgrim, Stephen  
 12 Dodge and Heather Predham meet with several of  
 13 the oncologists and pathologists on Monday,  
 14 10th of December, 2007. The physicians have  
 15 requested that Eastern Health go public with a  
 16 statement of support for its physicians.  
 17 Bristol Communication will be engaged to  
 18 develop both internal and external  
 19 communication strategies that will guide the  
 20 organization in the coming weeks as the  
 21 organization moves through the COO." What was  
 22 the purpose of the meeting with Dr. Howell and  
 23 the others with the oncologists and the  
 24 pathologists?  
 25 MS. JONES:

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1 A. Exactly as it's listed there in that they  
 2 wanted Eastern Health to publicly make a  
 3 statement about support for the work that they  
 4 do.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay. And in terms of--and has that happened  
 7 or is that happening?  
 8 MS. JONES:  
 9 A. We did not do that. We basically had  
 10 discussions with them about what really was  
 11 their intent of that and that as we go through  
 12 the Commission of Inquiry that they had to go  
 13 through the Commission of Inquiry and those  
 14 things would come out during that particular  
 15 point in time. We weren't sure what that  
 16 would actually do, like, what would a support  
 17 or a communication of a support for  
 18 pathologists and oncologists do in the public  
 19 realm. We were trying to support them  
 20 internally in the best way we could with  
 21 looking at their workload and what we could do  
 22 to allow them to continue on and do the best  
 23 work that they could.  
 24 CHAYTOR, Q.C.:  
 25 Q. What did it mean they were looking for Eastern

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1 Health's support or to go public with a  
 2 statement of support, a statement of support  
 3 for physicians in what respect?  
 4 MS. JONES:  
 5 A. Well, that was what we wanted clarified from  
 6 them. And that's when Dr. Howell and Pat and  
 7 Steve actually did go and talk to them and  
 8 say, "What is it that you're looking to in  
 9 that particular realm, what is the outcome  
 10 that you actually want? You know that we  
 11 support you, you know that we value the work  
 12 that you're doing." So those were the  
 13 discussions. "So what is it that you want out  
 14 there in the public forum?" And I wasn't at  
 15 that meeting so I'm not sure what the  
 16 individual input, but they were feeling fairly  
 17 demoralized as a result of all of the exposure  
 18 and that that was going in.  
 19 CHAYTOR, Q.C.:  
 20 Q. Did they report back to you, Dr. Howell and  
 21 the others, did they report back to you and/or  
 22 the executive as to the outcome of that  
 23 meeting?  
 24 MS. JONES:  
 25 A. Only to the point that we had indicated that

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1 really, you know, going out with a paid ad or  
 2 whatever really wouldn't achieve what it is  
 3 that they were looking for.  
 4 CHAYTOR, Q.C.:  
 5 Q. Did any of your other staff or personnel or  
 6 professional groups have a similar request of  
 7 Eastern Health?  
 8 MS. JONES:  
 9 A. The lab has also had--you know, they've been  
 10 in the media with the same pictures of the  
 11 pathology immunohistochemistry lab being  
 12 photographed and showed all along. And we had  
 13 actually run new footage ourselves in the fall  
 14 and shared that with the media so that, you  
 15 know, really to show the full breadth of the  
 16 lab and not every time they talked to show the  
 17 pathology lab. So, you know, we've been  
 18 working with them, as well.  
 19 CHAYTOR, Q.C.:  
 20 Q. That was the footage that I guess the media  
 21 took when the media was invited in in December  
 22 -  
 23 MS. JONES:  
 24 A. That's right.  
 25 CHAYTOR, Q.C.:

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1 Q. - or 2006?  
 2 MS. JONES:  
 3 A. That's right.  
 4 CHAYTOR, Q.C.:  
 5 Q. Yes. But have the technicians or the  
 6 technologists, have they asked that Eastern  
 7 Health go public with a statement of support  
 8 for them?  
 9 MS. JONES:  
 10 A. Not particularly in the way that the  
 11 physicians would have asked.  
 12 CHAYTOR, Q.C.:  
 13 Q. And then, "Bristol Communication will be  
 14 engaged to develop both internal and external  
 15 communication strategies to guide Eastern  
 16 Health" or "the organization in the coming  
 17 weeks as we move through the Commission of  
 18 Inquiry." What's that all about?  
 19 MS. JONES:  
 20 A. That is using an external lens to help us with  
 21 a communication strategy around a little bit  
 22 like what we were talking about this morning,  
 23 the crisis communication, what is it, what  
 24 would need to be part of it. And I think this  
 25 is early in December, so at that point in time

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1 they had not done the public polling to see  
 2 where Eastern Health was and what the public  
 3 felt about Eastern Health. So it wasn't on  
 4 ER/PR polling, it was just an overall image of  
 5 Eastern Health based upon the clients in our  
 6 region.  
 7 CHAYTOR, Q.C.:  
 8 Q. Yes. And so what strategy has been developed  
 9 to guide the organization through the Inquiry?  
 10 MS. JONES:  
 11 A. It is a, it's a document only to the--of what  
 12 we should be doing in the short term and in  
 13 the longer term. And then we talked about  
 14 elements of that, about stakeholder  
 15 engagement, partnerships, about interacting  
 16 with the media, to have stories other than  
 17 ER/PR out there, this issue that we talked  
 18 about earlier on this morning about public  
 19 confidence because Eastern Health is a very  
 20 large organization with large parts of our  
 21 organization that are not involved in this,  
 22 but--so those kinds of things, we have -  
 23 CHAYTOR, Q.C.:  
 24 Q. So putting good news stories out there about  
 25 good things that are happening -

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1 MS. JONES:  
 2 A. As well as -  
 3 CHAYTOR, Q.C.:  
 4 Q. - while the Inquiry is going on?  
 5 MS. JONES:  
 6 A. As well as managing -  
 7 CHAYTOR, Q.C.:  
 8 Q. That kind of thing?  
 9 MS. JONES:  
 10 A. - as well as internal communications, keeping  
 11 our own staff up to scratch on what was going  
 12 on both inside the organization -  
 13 CHAYTOR, Q.C.:  
 14 Q. That's internal, yes.  
 15 MS. JONES:  
 16 A. That's all internal.  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes, okay. And so the external piece would be  
 19 in terms of getting out that there's some good  
 20 things happening while this process is going  
 21 on -  
 22 MS. JONES:  
 23 A. And the messages and what--that kind of thing.  
 24 CHAYTOR, Q.C.:  
 25 Q. To help with the issue of the image of Eastern

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1 Health and the public's confidence?  
 2 MS. JONES:  
 3 A. Not just--the public's confidence, yeah.  
 4 CHAYTOR, Q.C.:  
 5 Q. Public's confidence in the -  
 6 MS. JONES:  
 7 A. Not image of Eastern Health, that's not really  
 8 the way we would talk about it. It's  
 9 confidence in the system.  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes.  
 12 MS. JONES:  
 13 A. In the entire system.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay. All right. If we continue on then,  
 16 there's the class action suit is referenced.  
 17 The statement of defence is anticipated to be  
 18 filed in December. And a meeting with a case  
 19 management judge. "Where HIROC will be  
 20 discussing the process of requirement with  
 21 respect to the potential naming of the third  
 22 party in the class action suit." Who is the  
 23 third party?  
 24 MS. JONES:  
 25 A. Well, I do believe that in terms of that, if

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1 there's anything other than Eastern Health  
 2 named or that has to be done within a  
 3 particular period of time.  
 4 CHAYTOR, Q.C.:  
 5 Q. Did you understand, though, was there  
 6 discussion around the potential of who that  
 7 third party would be?  
 8 MS. JONES:  
 9 A. There's always the discussion of whether  
 10 physicians would be named as a group.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay. So that would be referencing the  
 13 physicians?  
 14 MS. JONES:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. The laboratory workload?  
 18 MS. JONES:  
 19 A. Um.  
 20 CHAYTOR, Q.C.:  
 21 Q. "The services of DynaCare, a private pathology  
 22 lab in Ontario, will continue to be utilized  
 23 in the short term for non-complex pathology.  
 24 This is due in part to the impact of the  
 25 preparatory," I'm not sure if that word is

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1 right, "phase for the COI and subsequent  
 2 demands on the pathologists and staff in  
 3 preparing for same."  
 4 MS. JONES:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And how long have--the services of DynaCare, I  
 8 understand, is something that's been in place  
 9 for awhile in your organization?  
 10 MS. JONES:  
 11 A. Been in place for awhile. Off and on we had  
 12 taken back some of the work that we were  
 13 sending out to DynaCare and it really depend  
 14 on the number of pathologists. But in more  
 15 recently, especially with the resignations  
 16 that we've got and people off, we have  
 17 increased our service contract with DynaCare,  
 18 as well.  
 19 CHAYTOR, Q.C.:  
 20 Q. And the resignation that you've got from the  
 21 pathology lab, Dr. Carter, I take it, you're  
 22 referring to?  
 23 MS. JONES:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. But Dr. Carter is still in her position?  
 2 MS. JONES:  
 3 A. She's still in her position, but we do have  
 4 our other person who is in our breast group  
 5 who is off on stress leave.  
 6 CHAYTOR, Q.C.:  
 7 Q. Yes.  
 8 MS. JONES:  
 9 A. And we've also had a resignation in there  
 10 that, an exit earlier on since this winter.  
 11 So we have been increasing our reliance on  
 12 external resources to do the pathology work  
 13 and our pathologists in preparation for being  
 14 here at the Commission of Inquiry and that  
 15 also will require time. The other thing is  
 16 that we're still dealing with some of the  
 17 database and having to rely on pathologists  
 18 for samples that are coming back and rereads  
 19 and those kinds of things, so it's a  
 20 significant demand.  
 21 CHAYTOR, Q.C.:  
 22 Q. Yes. And is ER/PR still being done in St.  
 23 John's?  
 24 MS. JONES:  
 25 A. Yes, it is.

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1 CHAYTOR, Q.C.:  
 2 Q. Okay. ER/PR database. "The results of the  
 3 ER/PR database are in the process of being  
 4 finalized. The focus now is on the  
 5 communications, in particular, communications  
 6 with families of the deceased. Consideration  
 7 will be given to engaging an oncologist from  
 8 outside the province to meet with the families  
 9 of the deceased, however a process has not yet  
 10 been defined." And we spoke about this issue  
 11 yesterday about the deceased.  
 12 MS. JONES:  
 13 A. That's right.  
 14 CHAYTOR, Q.C.:  
 15 Q. And I take it that there was not an oncologist  
 16 engaged from outside the province?  
 17 MS. JONES:  
 18 A. No, there wasn't.  
 19 CHAYTOR, Q.C.:  
 20 Q. And that is no longer the plan to do that?  
 21 MS. JONES:  
 22 A. That's no longer the plan. We've made the  
 23 announcement and we will, if we have families  
 24 who call, we will talk to our local  
 25 oncologists. If, in fact, they have--there is

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1 a relationship with that family, they will  
 2 deal with it and then on an individual basis  
 3 we'll see how we manage it.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay. "The organization has panelled the sick  
 6 living patients. Of the two, there are two  
 7 patients that will," "Of the six," I'm sorry,  
 8 it's a mistake there in the minutes, but "Of  
 9 the six there are two patients that will have  
 10 their treatment changed."  
 11 MS. JONES:  
 12 A. Um.  
 13 CHAYTOR, Q.C.:  
 14 Q. And so I take it that the same panel came  
 15 together to panel those six patients. But was  
 16 there an issue that the oncologists weren't  
 17 prepared to meet with those people or why  
 18 would you have -  
 19 MS. JONES:  
 20 A. No, this -  
 21 CHAYTOR, Q.C.:  
 22 Q. - been looking at this point in time in having  
 23 someone outside the province -  
 24 MS. JONES:  
 25 A. This has nothing to do with the discussion

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1 that's above that, which is on the deceased.  
 2 This -  
 3 CHAYTOR, Q.C.:  
 4 Q. Oh, I'm sorry, yes, this is six living  
 5 patients.  
 6 MS. JONES:  
 7 A. Yeah, six living patients -  
 8 CHAYTOR, Q.C.:  
 9 Q. These were the six that were missed?  
 10 MS. JONES:  
 11 A. These were missed.  
 12 CHAYTOR, Q.C.:  
 13 Q. Right, okay.  
 14 MS. JONES:  
 15 A. And results back from Mount Sinai -  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, yes.  
 18 MS. JONES:  
 19 A. - so they have to be panelled and -  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay. Yes, okay. And those, I take it, the  
 22 communication to those two, the living  
 23 patients, those were done in the usual manner?  
 24 MS. JONES:  
 25 A. In the usual manner.

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1 CHAYTOR, Q.C.:  
 2 Q. And the strategic planning for a three-year  
 3 term, 2008 to 2005?  
 4 MS. JONES:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And I think most of these points we've talked  
 8 about in one way or another. There's, for  
 9 example, under "Safety" "Required to list out  
 10 the measures and indicators for the first  
 11 year." And I believe you mentioned that to us  
 12 in the goals that have been set or objectives  
 13 that have been set for you, as well, as the  
 14 CEO?  
 15 MS. JONES:  
 16 A. There's a template that the strategic plan  
 17 under the transparency and accountability has  
 18 to look for, so it's goals that have to be  
 19 identified over first year, second year and  
 20 third year. So this was we had come out of  
 21 the strategic planning session with the board  
 22 in November and this was completing the  
 23 document and getting it ready to go back to  
 24 board.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And that then goes on to government, I  
 2 take it?  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And accountability, "The need to identify more  
 7 concrete indicators. Suggestion that there be  
 8 quarterly or semi-annual meetings with the  
 9 department and the Eastern Health board."  
 10 MS. JONES:  
 11 A. Um.  
 12 CHAYTOR, Q.C.:  
 13 Q. Has that been happening?  
 14 MS. JONES:  
 15 A. There hasn't been on a formal basis, but this  
 16 is something that the board has listed as one  
 17 of the areas that it wants to have more  
 18 formalized relations with the minister and the  
 19 department.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay. If we could have 0752, please? This is  
 22 a series of e-mails, Ms. Jones, which are in  
 23 January of 2008?  
 24 MS. JONES:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. January 23rd, 2008?  
 3 MS. JONES:  
 4 A. Um.  
 5 CHAYTOR, Q.C.:  
 6 Q. And it seems to involve meeting or trying to  
 7 schedule a meeting with Mr. Thompson, which  
 8 would include oncologists Dr. Kara Laing and  
 9 Dr. McCarthy?  
 10 MS. JONES:  
 11 A. That's right.  
 12 CHAYTOR, Q.C.:  
 13 Q. What--did that meeting ever take place?  
 14 MS. JONES:  
 15 A. That meeting did take place, but Dr. McCarthy  
 16 wasn't there, Dr. Kara Laing was there.  
 17 CHAYTOR, Q.C.:  
 18 Q. And what was the purpose of that meeting? Who  
 19 attended, first of all?  
 20 MS. JONES:  
 21 A. It would have been Pat Pilgrim, myself, Robert  
 22 Thompson, Dr. Laing and Dr. Howell. I'm  
 23 thinking -  
 24 CHAYTOR, Q.C.:  
 25 Q. And what was the purpose?

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1 MS. JONES:  
 2 A. I'm thinking Dr. Howell was there. I would be  
 3 95 percent sure of that.  
 4 CHAYTOR, Q.C.:  
 5 Q. And I take it this meeting took place sometime  
 6 late January or -  
 7 MS. JONES:  
 8 A. It took place on a Friday afternoon, I think  
 9 maybe the following--maybe the Friday of that  
 10 week, the 25th or later on.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay. And what was the purpose of that  
 13 meeting?  
 14 MS. JONES:  
 15 A. The purpose of the meeting was to look at how  
 16 we were going to handle the notification of  
 17 families of the deceased.  
 18 CHAYTOR, Q.C.:  
 19 Q. And at whose request was this meeting?  
 20 MS. JONES:  
 21 A. That was at our request.  
 22 CHAYTOR, Q.C.:  
 23 Q. At your request.  
 24 MS. JONES:  
 25 A. So that because if you remember earlier on

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1 Robert was asking for communication protocols  
 2 -  
 3 CHAYTOR, Q.C.:  
 4 Q. Yes.  
 5 MS. JONES:  
 6 A. - and how we were going to deal with that.  
 7 And we had been having, Pat Pilgrim and Mr.  
 8 Thompson had been having some discussions  
 9 earlier on about us trying to get an  
 10 oncologist and those kinds of things and we  
 11 had gone down most of those routes. So this  
 12 was okay, here we are, this is what we've got.  
 13 Kara needs to be part of that conversation so  
 14 he understands why the oncologists definitely  
 15 will deal with their own patients, but if  
 16 they've not been part of any of the treatment  
 17 protocols or why particular treatments for  
 18 individual clients, then it really is  
 19 something that may or may not be  
 20 inappropriate. They may very well be able to  
 21 answer questions, but they wouldn't maybe be  
 22 able to answer all the questions the families  
 23 had.  
 24 CHAYTOR, Q.C.:  
 25 Q. Yes. Well, I take it nobody would be able to

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1 -  
 2 MS. JONES:  
 3 A. That's right.  
 4 CHAYTOR, Q.C.:  
 5 Q. - if that person's physician was no longer  
 6 around?  
 7 MS. JONES:  
 8 A. And didn't know what -  
 9 CHAYTOR, Q.C.:  
 10 Q. The next best thing would be another  
 11 oncologist?  
 12 MS. JONES:  
 13 A. That's right, you know. And at the end of the  
 14 day, but would not have been known the  
 15 background behind the treatment protocols that  
 16 were used on that particular patient and why  
 17 the decisions were made.  
 18 CHAYTOR, Q.C.:  
 19 Q. Right. And so what happened then at this  
 20 meeting, what was discussed?  
 21 MS. JONES:  
 22 A. It was--so there was really just an  
 23 understanding there at the end of the day that  
 24 we would move forward with a public  
 25 notification, which is where we had thought we

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1 were going to go, and that in what vehicle we  
 2 would move forward with that public  
 3 notification.  
 4 CHAYTOR, Q.C.:  
 5 Q. And what was Dr. Laing's position expressed at  
 6 the meeting?  
 7 MS. JONES:  
 8 A. The only position that Dr. Laing had, which  
 9 was the same as what the oncologists had had,  
 10 was the decision to retest all of the deceased  
 11 was an administrative decision, because it was  
 12 made by Mr. Tilley in May of 2005. So that  
 13 was the only--it was an administrative  
 14 decision. They would deal with -  
 15 CHAYTOR, Q.C.:  
 16 Q. May 2007.  
 17 MS. JONES:  
 18 A. In 2007, sorry about that, and as they moved  
 19 forward, they had been dealing with individual  
 20 families of the deceased because they had been  
 21 getting calls and they had been retesting  
 22 results, so they were dealing with them as it  
 23 went through, but there could not be an  
 24 expectation that they would deal with all of  
 25 the calls that would come in because of just

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1 what we talked about, they didn't have a  
 2 relationship. There was already a work load  
 3 issue and they really wouldn't have answers,  
 4 but you know, they would do what they could  
 5 for us.  
 6 CHAYTOR, Q.C.:  
 7 Q. And that decision you say was made by Mr.  
 8 Tilley in May of 2007, because originally, and  
 9 we looked a day or two ago at the ethics  
 10 consult, the original decision was that  
 11 Eastern Health was not going to retest all of  
 12 the deceased?  
 13 MS. JONES:  
 14 A. That's right.  
 15 CHAYTOR, Q.C.:  
 16 Q. Only if the families of the deceased came  
 17 forward requesting that?  
 18 MS. JONES:  
 19 A. That's right.  
 20 CHAYTOR, Q.C.:  
 21 Q. Mr. Tilley, in making--coming to a different  
 22 decision then about a year after the ethics  
 23 consult, was the executive part of that  
 24 decision?  
 25 MS. JONES:

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1 A. No.  
 2 CHAYTOR, Q.C.:  
 3 Q. Did he consult with anyone? Did he consult  
 4 with you on it?  
 5 MS. JONES:  
 6 A. No, he didn't consult with me.  
 7 CHAYTOR, Q.C.:  
 8 Q. And do you know whether or not--who he may  
 9 have consulted or whether or not he took  
 10 direction from anyone else on that?  
 11 MS. JONES:  
 12 A. No, you're going to have to ask Mr. Tilley on  
 13 that, but I do know that he did announce it  
 14 when he did the press conference in the May  
 15 time frame.  
 16 CHAYTOR, Q.C.:  
 17 Q. So there was no discussion at executive about  
 18 now testing all of the deceased?  
 19 MS. JONES:  
 20 A. No, not that I recall.  
 21 CHAYTOR, Q.C.:  
 22 Q. And if we could have, please, 0758? And this,  
 23 I think, Ms. Jones, is the copy of the press  
 24 release that goes out regarding the deceased  
 25 patients.

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1 MS. JONES:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. February 21st, 2008.  
 5 MS. JONES:  
 6 A. Yeah.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay, and I understand that you were out of  
 9 town, you said, when this happened?  
 10 MS. JONES:  
 11 A. That's right. I was out of town that entire  
 12 week.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay. It talks about "Eastern Health has  
 15 followed through on its commitment to retest  
 16 ER/PR results of all our deceased patients and  
 17 will provide these retest results to the next  
 18 of kin who would like to have them."  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And this is Mrs. Pilgrim speaking, and  
 23 "everyone at Eastern Health is very concerned  
 24 about the patients and their families that  
 25 have been impacted by the ER/PR testing

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1 issues. We understand that this has been a  
 2 long process for families of our deceased  
 3 patients and we believe it is important to  
 4 provide an opportunity for those next of kin  
 5 to contact us for the results," and then we've  
 6 talked about that process and the phone number  
 7 -  
 8 MS. JONES:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. - and so if anyone asks for a consult,  
 12 oncologists within Eastern Health, I believe  
 13 you told us, will meet with them?  
 14 MS. JONES:  
 15 A. I said that we would--if it was their own  
 16 patients, they would meet with their own  
 17 patients, and on an individual patient basis,  
 18 we would go to the clinical chief, Kara Laing,  
 19 and ask if there was an individual oncologist  
 20 who was willing to meet with this family,  
 21 based upon the questions.  
 22 CHAYTOR, Q.C.:  
 23 Q. And that hasn't come up yet?  
 24 MS. JONES:  
 25 A. Not that I'm aware of.

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1 CHAYTOR, Q.C.:

2 Q. You haven't had that issue yet?

3 MS. JONES:

4 A. Yeah.

5 CHAYTOR, Q.C.:

6 Q. Okay. But Kara Laing, as clinical chief, has

7 agreed to that process?

8 MS. JONES:

9 A. We would go and ask Kara Laing.

10 CHAYTOR, Q.C.:

11 Q. Okay, so -

12 MS. JONES:

13 A. Okay, so we went -

14 CHAYTOR, Q.C.:

15 Q. - Kara Laing hasn't necessarily agreed to the

16 process?

17 MS. JONES:

18 A. Kara Laing has not necessarily agreed to that

19 process, but they said they would help us out

20 in whatever way.

21 CHAYTOR, Q.C.:

22 Q. Yes, okay. So right now, the oncologists have

23 agreed that they will meet with their own--the

24 families of their own patients?

25 MS. JONES:

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1 A. Absolutely, yes.

2 CHAYTOR, Q.C.:

3 Q. And if and when the situation arises that it's

4 somebody -

5 MS. JONES:

6 A. They will look at the individual case.

7 CHAYTOR, Q.C.:

8 Q. - other than one of the current oncologists,

9 you're hoping you'll be able to go to the

10 clinical chief and arrangements will be made?

11 MS. JONES:

12 A. Absolutely, and they have, as I said to you

13 yesterday, they have been very accommodating

14 when requests have come forward to us.

15 CHAYTOR, Q.C.:

16 Q. If we could have 0754, please? I think the

17 issue around this e-mail, this is an e-mail

18 February 5th 2008 and we discussed yesterday

19 this e-mail. It's to Robert Thompson from

20 yourself, and it says from Joyce Penney, but

21 it's forwarded on your behalf?

22 MS. JONES:

23 A. Yes.

24 CHAYTOR, Q.C.:

25 Q. And this was the 175 that was put forward?

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1 MS. JONES:

2 A. That's right.

3 CHAYTOR, Q.C.:

4 Q. I believe at one point, we had looked at 178,

5 but in your e-mail here, it's actually 175.

6 MS. JONES:

7 A. 175, yeah.

8 CHAYTOR, Q.C.:

9 Q. For the additional funding, and just a couple

10 of questions about this. "Eastern Health has

11 allocated a full-time quality leader to the

12 regional lab who is spending a significant

13 amount of time working with staff on the

14 development of policies, procedures and

15 establishment of a QA program."

16 MS. JONES:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. I take it, is that Lynn Wade's position?

20 MS. JONES:

21 A. That's Lynn Wade.

22 CHAYTOR, Q.C.:

23 Q. Okay, and "we have done a significant amount

24 of work to educate staff and pathologists, but

25 this work needs to be ongoing if we are to

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1 ensure continued competence of staff and

2 pathologists."

3 MS. JONES:

4 A. Yes.

5 CHAYTOR, Q.C.:

6 Q. What exactly has been done in terms of "a

7 significant amount of work to educate the

8 staff and pathologists?"

9 MS. JONES:

10 A. I think we already answered that this morning,

11 that you would have to ask Dr. Williams and

12 Dr. Howell, but I referenced this morning that

13 our pathologists have been sent out to

14 conferences and our pathologists have actually

15 gone to labs, but I do know that the staff

16 have actually gone on site visits in other IHC

17 laboratories.

18 CHAYTOR, Q.C.:

19 Q. And I know I did ask you this morning, but I

20 know you also referred me to the others, but

21 you're writing this yourself.

22 MS. JONES:

23 A. Yes.

24 CHAYTOR, Q.C.:

25 Q. So I thought perhaps maybe this would jog your



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1 memory.  
 2 MS. JONES:  
 3 A. And that's the same as I gave you this  
 4 morning.  
 5 CHAYTOR, Q.C.:  
 6 Q. Yes, so have the staff, the technologists and  
 7 pathologists, received further education on  
 8 ER/PR specifically?  
 9 MS. JONES:  
 10 A. Yes, and the staff as well, the pathologists  
 11 continue to do work with the technologists  
 12 because we're looking to increase the scope of  
 13 the work that they do, about reading their own  
 14 internal--the controls on the slides and that,  
 15 so that work is ongoing.  
 16 CHAYTOR, Q.C.:  
 17 Q. And in terms of the work that Lynn Wade is  
 18 doing, the new quality leader, in the  
 19 development of policies and procedures, are  
 20 you aware of any difficulties that Ms. Wade  
 21 has encountered?  
 22 MS. JONES:  
 23 A. I wouldn't know that on a personal note with  
 24 Lynn.  
 25 CHAYTOR, Q.C.:

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1 Q. So you don't know that?  
 2 MS. JONES:  
 3 A. I don't know that.  
 4 CHAYTOR, Q.C.:  
 5 Q. So that hasn't made its way up to the  
 6 executive?  
 7 MS. JONES:  
 8 A. No.  
 9 CHAYTOR, Q.C.:  
 10 Q. And if we could have then, please, P-0755?  
 11 This is an e-mail from Pam Bennett to  
 12 yourself, along with the CEOs of the other  
 13 three regions, Susan Gillam, Boyd Rowe, Karen  
 14 McGrath.  
 15 MS. JONES:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. And it's dated February 6th 2008, and it's  
 19 with respect to a noon conference call, and  
 20 it's called "early lessons learned." Who's  
 21 Pam Bennett?  
 22 MS. JONES:  
 23 A. I have no idea. Must be somebody in Robert's  
 24 office, but I don't know.  
 25 CHAYTOR, Q.C.:

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1 Q. So this, you understood, is coming from  
 2 Robert's office or is it coming from Don  
 3 Keats? The next, if we look down, the  
 4 original meeting, Don Keats.  
 5 MS. JONES:  
 6 A. Yeah, but the original is from--my  
 7 understanding was it was Robert.  
 8 CHAYTOR, Q.C.:  
 9 Q. Robert Thompson to Don Keats and then on?  
 10 MS. JONES:  
 11 A. Yeah.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay, and so who was on the conference call on  
 14 February 6th?  
 15 MS. JONES:  
 16 A. We would have had the four people that were  
 17 listed here. We also had--I know that Oscar  
 18 Howell was with me. I know that Ken, the VP  
 19 for medicine in Western, Ken, and I don't  
 20 remember his last name, was there with Susan  
 21 Gillam.  
 22 CHAYTOR, Q.C.:  
 23 Q. Jenkins?  
 24 MS. JONES:  
 25 A. Ken Jenkins. Karen McGrath doesn't have a VP

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1 for medicine, so I'm not sure if there was  
 2 anybody with Karen. Boyd was on and I'm not  
 3 sure whether, in fact, his VP for medicine was  
 4 on or not.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, and -  
 7 MS. JONES:  
 8 A. And Mr. Thompson.  
 9 CHAYTOR, Q.C.:  
 10 Q. - and what was the purpose of this call?  
 11 MS. JONES:  
 12 A. If you go to the -  
 13 CHAYTOR, Q.C.:  
 14 Q. Next page?  
 15 MS. JONES:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. There you go.  
 19 MS. JONES:  
 20 A. Robert wanted to have discussion about this  
 21 particular document because they were getting  
 22 ready for to do the release of the database or  
 23 to talk about the database. The minister was  
 24 going to go out and he felt that he may very  
 25 well be able to announce some monies for some

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1 aspects of that. So they wanted to marry it  
 2 with if in fact they could make some  
 3 announcements, but there was no commitment  
 4 that they would be able to make any  
 5 announcements. And he wanted to talk about  
 6 the components that were in here.  
 7 CHAYTOR, Q.C.:  
 8 Q. And the early lessons learned and preliminary  
 9 responses, are they early lessons learned from  
 10 the ER/PR issue? Is that what this is about?  
 11 MS. JONES:  
 12 A. You'll have--this is Robert's document.  
 13 CHAYTOR, Q.C.:  
 14 Q. Yes.  
 15 MS. JONES:  
 16 A. So I'm assuming that he is talking about that.  
 17 He also had the task force on adverse events  
 18 at the same time. But our understanding was  
 19 it was around ER/PR.  
 20 CHAYTOR, Q.C.:  
 21 Q. Yes, and you would have read the document, I  
 22 take it? It's not--it's only less than a two-  
 23 page document.  
 24 MS. JONES:  
 25 A. That's right.

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1 CHAYTOR, Q.C.:  
 2 Q. And you participated in the conference call.  
 3 MS. JONES:  
 4 A. That's right.  
 5 CHAYTOR, Q.C.:  
 6 Q. So you understood it was around the ER/PR  
 7 issue?  
 8 MS. JONES:  
 9 A. That's right.  
 10 CHAYTOR, Q.C.:  
 11 Q. And the data management and tracking says  
 12 "better data management and tracking could  
 13 have provided greater certainty that all  
 14 negative ER/PR cases were identified and sent  
 15 to Mount Sinai on a timely basis and would  
 16 have aided the patient communication process."  
 17 MS. JONES:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. Do you agree with that statement?  
 21 MS. JONES:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And the preliminary response indicated, so  
 25 this is Robert's team drafting this?

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1 MS. JONES:  
 2 A. This is Robert's team drafting what  
 3 potentially may be recommendations from him as  
 4 they move forward.  
 5 CHAYTOR, Q.C.:  
 6 Q. "establish a new policy for the department and  
 7 the regional health authorities that whenever  
 8 there is an adverse event that requires  
 9 contact, testing or treatment for a group of  
 10 patients, a single official is to be charged  
 11 with clear, organization wide responsibility  
 12 for directing patient contact and data  
 13 management and that person must have access to  
 14 an appropriately skilled data manager, trained  
 15 to use or design an information system which  
 16 can require comprehensive data for all events  
 17 in the response process, provide timely  
 18 reports and can be audited."  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And did you and the other CEOs agree with  
 23 that?  
 24 MS. JONES:  
 25 A. Absolutely, because there is nobody tasked

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1 with that right now inside the organizations.  
 2 There was some question about whether we had  
 3 the skills to be able to do that.  
 4 CHAYTOR, Q.C.:  
 5 Q. So is this a situation where--and I think  
 6 there are three different lessons learned with  
 7 preliminary responses. Was this a situation  
 8 where this was being suggested by Robert or  
 9 Robert and his team, and he was seeking  
 10 feedback from you?  
 11 MS. JONES:  
 12 A. He was seeking feedback.  
 13 CHAYTOR, Q.C.:  
 14 Q. And do you recall, were any of these issues  
 15 contentious?  
 16 MS. JONES:  
 17 A. Only the third one. This first one was not  
 18 contentious and as Robert had said to me, if  
 19 you look at the three bullets that were  
 20 underneath here, they are very similar to the  
 21 ones that we had sent in the November  
 22 document.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay, and which includes approving of budget  
 25 allocation. The second one then is the

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1 quality assurance and monitoring the  
 2 immunohistochemistry laboratory.  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And I take it this would predominantly pertain  
 7 to Eastern Health?  
 8 MS. JONES:  
 9 A. Yes, but if you look down further, there is a  
 10 discussion that there is--what would the  
 11 system believe--was the system supportive if  
 12 we moved to laboratory accreditation for the  
 13 entire province, and everyone on the system  
 14 said absolutely a must.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay. Everybody wanted that?  
 17 MS. JONES:  
 18 A. Everybody wanted it.  
 19 CHAYTOR, Q.C.:  
 20 Q. Not only did they agree with it, they would  
 21 insist upon it?  
 22 MS. JONES:  
 23 A. That's right.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay. "Since 2005, the recommendations of the

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1 peer review have been implemented, including  
 2 the adoption of external review procedures.  
 3 Two external reviews were completed in 2007,"  
 4 and I take it that refers to the  
 5 accreditation?  
 6 MS. JONES:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And the QMPLS in December 2007?  
 10 MS. JONES:  
 11 A. That's right.  
 12 CHAYTOR, Q.C.:  
 13 Q. And the preliminary response, "the  
 14 recommendations of these reviews should be  
 15 implemented with budgetary appropriations."  
 16 The next one is "government should commit to  
 17 legislation that would make laboratory  
 18 accreditation a mandatory requirement as is  
 19 currently the case in Ontario."  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And is that what everybody was unanimous in  
 24 supporting?  
 25 MS. JONES:

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1 A. They were.  
 2 CHAYTOR, Q.C.:  
 3 Q. In seeking a change to the legislation?  
 4 MS. JONES:  
 5 A. That's right.  
 6 CHAYTOR, Q.C.:  
 7 Q. "And adopting a policy which clarifies where  
 8 the authority resides for quality control for  
 9 tests for which there is a single testing site  
 10 in the province." So adopt a policy which  
 11 clarifies where the authority resides for  
 12 quality control for tests for which there is a  
 13 single testing site in the province. So that  
 14 would be the ER/PR tests obviously -  
 15 MS. JONES:  
 16 A. That's right.  
 17 CHAYTOR, Q.C.:  
 18 Q. If it's to happen in St. John's or with  
 19 Eastern Health again. "A mechanism for the  
 20 testing site to specify standards, QA and  
 21 monitoring for all steps in the test should be  
 22 established."  
 23 MS. JONES:  
 24 A. That's right.  
 25 CHAYTOR, Q.C.:

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1 Q. Did the other three health care authorities  
 2 agree with that?  
 3 MS. JONES:  
 4 A. Yes, because they also have some provincial  
 5 program areas that they have responsibility  
 6 for.  
 7 CHAYTOR, Q.C.:  
 8 Q. And has such a policy been adopted?  
 9 MS. JONES:  
 10 A. No, these were recommendations that Robert  
 11 asked our input into and haven't gone  
 12 anywhere. Some of them ended up in terms of  
 13 announcements, but it hasn't happened.  
 14 CHAYTOR, Q.C.:  
 15 Q. And is anybody working on such a policy?  
 16 MS. JONES:  
 17 A. Not that I'm aware of right now. The  
 18 discussion around this was for all of those  
 19 areas where we have provincial programs that  
 20 really we needed to formalize the provincial  
 21 programs in a memorandum of understanding  
 22 about the entire program and the roles and  
 23 responsibilities of each one of the partners  
 24 in. So what was sent back to Robert was a  
 25 bigger issue around provincial programs.

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1 CHAYTOR, Q.C.:

2 Q. Okay. The government committing to

3 legislation to make laboratory accreditation a

4 mandatory requirement, if all of the four

5 health care authorities in the province are in

6 agreement and feel strongly about that, that

7 can happen without any change obviously in the

8 legislation.

9 MS. JONES:

10 A. It can happen without any change, but there

11 was also just a discussion to say that in

12 fact we're to move that way, we need to know

13 exactly what those standards would be, where

14 are the standards, those kinds of things. So

15 rather than individually--really, it needed to

16 be a provincial system. So Western Health

17 could go find somebody, a consultant to come

18 in. Eastern Health might have a different

19 consultant, and there really wouldn't be a

20 provincial standard. So it had to be a

21 provincial wide, but individually, we could.

22 There was nothing holding us individually

23 back.

24 CHAYTOR, Q.C.:

25 Q. And until such legislation, if it were to come

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1 to pass, until that happens, there could be

2 collaboration between the four authorities to

3 make sure you are using either the same

4 organization or at least the same standards?

5 MS. JONES:

6 A. Or at least the same standards.

7 CHAYTOR, Q.C.:

8 Q. And the communications protocols, you

9 indicated this was a little more contentious.

10 MS. JONES:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. "Communication protocols are needed for

14 adverse events that have an impact on large

15 groups of people. The principles to be

16 observed include a patient's right to know and

17 a patient's right to participate in the

18 management of their own care. Other important

19 principles of large group events include, as

20 appropriate, advising the media early to avoid

21 the anxiety and uncertainty associated with

22 uncoordinated information going to the media,

23 and allowing for effective patients to self

24 identify to the RHA when there is uncertainty

25 over whether internal databases will identify

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1 all patients in a timely manner. These

2 principles must respect the priority of the

3 patient-doctor relationship, the protection of

4 personal privacy and the urgency and

5 significance of the adverse event." Was there

6 anything contentious in that?

7 MS. JONES:

8 A. Not in the way that these are articulated, but

9 we were very clear to say that it was patients

10 first. That we wanted the opportunity to be

11 able to identify and to notify patients, and

12 then you have the other parts of this that

13 come into play, essentially after that, and

14 key to that, as well, is the one principle

15 that I don't think we've talked about in this

16 room, at least while I've been here, is the

17 priority of the doctor-patient relationship

18 being critical to--because that's where the

19 relationship and that's where the trust comes.

20 So this was the first time we had seen that

21 particularly articulated. So in terms of the

22 principles that are here, absolutely that the

23 patients are first, that the doctor-patient

24 relationship needs to be maintained and

25 protected. You have the issues of personal

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1 privacy, and then we get into the public

2 disclosure and the confidence in the system.

3 CHAYTOR, Q.C.:

4 Q. What did that mean in this context? What is

5 being talked about the priority of the

6 patient-doctor relationship?

7 MS. JONES:

8 A. Many times that if we use the example of

9 tests, the test is ordered by a physician.

10 The physician really needs to know that

11 there's a change in the test so that they can

12 appropriately inform their patients or

13 whatever about the change and understand that.

14 So -

15 CHAYTOR, Q.C.:

16 Q. And had that not happened?

17 MS. JONES:

18 A. And that's where the relationship actually

19 happens. It's not the health authority to the

20 patient in lots of way. It's the patient is

21 accessing services because a physician as

22 referred them on and they need to be critical

23 as we move forward on any issue.

24 CHAYTOR, Q.C.:

25 Q. And so what was the issue? How had that not

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1 happened, this is dealing with the ER/PR  
 2 issue, what was the concern? How had that not  
 3 happened?  
 4 MS. JONES:  
 5 A. I think the discussion that we had is that you  
 6 have to keep this in the broadest context,  
 7 that you cannot take the physician out of this  
 8 relationship when there are issues that the  
 9 patient and the physician have to be priority  
 10 and then we have the public disclosure and  
 11 those kinds of things. So the principles, all  
 12 of the points that were here were well  
 13 supported.  
 14 CHAYTOR, Q.C.:  
 15 Q. Yes, okay. So I just want to be clear whether  
 16 or not that was an issue in the handling of  
 17 the ER/PR issue. Was it, for example, was it  
 18 because of the panelling, that patients who  
 19 were patients of physicians other than those  
 20 on the panel, were put through the panelling  
 21 process, is that what the issue was?  
 22 MS. JONES:  
 23 A. It had nothing to do with the ER/PR or the  
 24 panelling issue.  
 25 CHAYTOR, Q.C.:

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1 Q. So that wasn't seen as being something that  
 2 wasn't respectful of the patient/doctor  
 3 relationship?  
 4 MS. JONES:  
 5 A. No, no.  
 6 CHAYTOR, Q.C.:  
 7 Q. That's not what is being discussed.  
 8 MS. JONES:  
 9 A. As we are going to move forward, this talked  
 10 about early lessons, but as a province and as  
 11 moving forward on this issue, you saw database  
 12 there being the first end and then you  
 13 happened to see lab accreditation and then  
 14 there was an issue around communication and  
 15 communication protocols. So it was more than  
 16 just -  
 17 CHAYTOR, Q.C.:  
 18 Q. So there was no issue on the ER/PR -  
 19 MS. JONES:  
 20 A. No.  
 21 CHAYTOR, Q.C.:  
 22 Q. - as to priority not being given to the  
 23 patient/doctor relationship?  
 24 MS. JONES:  
 25 A. No, no, it was just that that was an important

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1 one to maintain as we move forward.  
 2 THE COMMISSIONER:  
 3 Q. So there was really no controversy about  
 4 communication protocol?  
 5 MS. JONES:  
 6 A. Not in this, only make sure that the patients  
 7 are, the patient, the individual patient  
 8 contact happens first.  
 9 CHAYTOR, Q.C.:  
 10 Q. And in terms of the priority of the  
 11 patient/doctor relationship, the majority of  
 12 the patients in the ER/PR situation were in  
 13 fact not contacted by their doctor, is that  
 14 the issue?  
 15 MS. JONES:  
 16 A. That's right. No, I don't think you can't tie  
 17 the two of them together, there was no  
 18 discussion around how we hand handled that, it  
 19 was more in terms of communication protocols  
 20 and if you go to the bottom when we talk about  
 21 what the controversy was, it's more in what is  
 22 written in the bottom, not what's written in  
 23 the bullets on top.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, well let's read that because perhaps

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1 then I will understand.  
 2 MS. JONES:  
 3 A. Uh-hm.  
 4 CHAYTOR, Q.C.:  
 5 Q. "Preliminary response. The Department of  
 6 Health and the RHAs to adopt a communication  
 7 policy which recognize these principles."  
 8 MS. JONES:  
 9 A. Not a problem.  
 10 CHAYTOR, Q.C.:  
 11 Q. And I take it there was no problem.  
 12 MS. JONES:  
 13 A. Yeah.  
 14 CHAYTOR, Q.C.:  
 15 Q. "Through performance contracts, place an  
 16 obligation on the CEO to advise the department  
 17 about group adverse events so that  
 18 communications can be co-ordinated as  
 19 necessary and appropriate." And then the  
 20 issue becomes how to define the group, was  
 21 that controversial?  
 22 MS. JONES:  
 23 A. That was a huge issue in terms of what is the  
 24 group, is the group in some instances two  
 25 patients or three patients or is a group like

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1 what we were dealing with, 1000 patients. In  
 2 some small areas, like Labrador, a group may  
 3 very well be very small, in terms of something  
 4 like Eastern Health, you know, notification of  
 5 five or ten patients in a particular issue,  
 6 that may not be a big, because of the volume  
 7 that we do, so he had already flagged in on  
 8 what does group mean and is there flexibility  
 9 around group? What does it mean in the  
 10 context, is it anything more than one patient  
 11 is the question that we were asking.

12 CHAYTOR, Q.C.:

13 Q. Okay, so what I assume was being put forward  
 14 here for discussion purposes at least by  
 15 Robert Thompson -

16 MS. JONES:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. Was that in each of your contracts,  
 20 performance contracts, there would be an  
 21 obligation on you, as chief executive officer,  
 22 to advise the department when there is an  
 23 adverse event which involved a group of  
 24 people, whatever we're going to define group  
 25 as being -

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1 MS. JONES:

2 A. Yes, whatever we're going to define group.

3 CHAYTOR, Q.C.:

4 Q. But certainly ER/PR would have been one of  
 5 those instances.

6 MS. JONES:

7 A. One of those issues.

8 CHAYTOR, Q.C.:

9 Q. And so the idea that that would happen, that  
 10 was met with some resistance, was it?

11 MS. JONES:

12 A. And it was met only because this discussion  
 13 needed to happen with the board chairs as  
 14 well, because we're employee of the board, so  
 15 where was the Board of Trustees and where was  
 16 notification of our board with respect to  
 17 issues that were going on. Now was it going  
 18 to be dual notification or were we respecting  
 19 the relationship. We already have a contract  
 20 in the CEOs contract that is signed off by the  
 21 minister, as well as by the board chair. So  
 22 that wasn't an issue, we all have contracts in  
 23 that, but where is the discussion around this,  
 24 where does the board come into it, what is the  
 25 relationship, what is the obligation.

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1 CHAYTOR, Q.C.:

2 Q. And this is simply, as it is worded here,  
 3 anyhow, simply just to advise the department  
 4 if there's a group, which is fact legislation  
 5 in some provinces, that it's mandated in some  
 6 provinces.

7 MS. JONES:

8 A. And we also talked about in terms of where  
 9 does the work of the task force on adverse  
 10 events come in and the province, in terms of  
 11 mandatory reporting and that, if that is one  
 12 of the outcomes of the task force, would that  
 13 be something that you would want to see what  
 14 the outcomes of the task force were, but the  
 15 whole issue here was not a performance  
 16 contract issue, it was not a notification  
 17 issue, it was where does the board fit in to  
 18 the particular issue? What's a group, what,  
 19 you know, you would have to define it a little  
 20 bit more.

21 CHAYTOR, Q.C.:

22 Q. Yes, fair enough, but in terms of the  
 23 principle of what's being espoused here, do  
 24 you have a problem with the principle?

25 MS. JONES:

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1 A. I don't have a problem with the principle as  
 2 long as we know exactly what that boundaries  
 3 are.

4 CHAYTOR, Q.C.:

5 Q. So that when there's an adverse event that  
 6 involves a number of people that the  
 7 department, who ultimately is responsible for  
 8 the health of the people of the province would  
 9 be notified?

10 MS. JONES:

11 A. And that that discussion needs to -

12 CHAYTOR, Q.C.:

13 Q. And you have no problem with that principle?

14 MS. JONES:

15 A. I don't have a problem with that, but in terms  
 16 of this, the communication's protocol needs to  
 17 be board, as well as the department.

18 CHAYTOR, Q.C.:

19 Q. I'm sorry?

20 MS. JONES:

21 A. Communication protocol, because we were, we  
 22 are the employee of the board, there has to be  
 23 some recognition for the board in this as  
 24 well.

25 CHAYTOR, Q.C.:

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1 Q. But do you have any, have you had discussion  
 2 with your board around this idea?  
 3 MS. JONES:  
 4 A. No, because this came out as a feedback  
 5 document to them and it hasn't come back in  
 6 any other fashion to say this is where we want  
 7 to move forward?  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, so you're not aware that Mrs. Dawe or  
 10 others would be opposed to such an idea.  
 11 MS. JONES:  
 12 A. No, it was just one of those things, it was  
 13 for feedback. These are the points that you  
 14 need to think about as we're moving forward  
 15 with this.  
 16 CHAYTOR, Q.C.:  
 17 Q. And "through revision of job descriptions and  
 18 appropriate training, ensure that all  
 19 communication's personnel in government and  
 20 subordinate agencies understand the principles  
 21 and procedures of responding to group adverse  
 22 events." What was that about and what was the  
 23 discussion surrounding that idea?  
 24 MS. JONES:  
 25 A. There was very little discussion because if we

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1 have agreed with adopting principles that were  
 2 listed above, as well as a communication  
 3 policy in that, then it just really meant that  
 4 the individuals, whether they be in the  
 5 Department of Health on their communication's  
 6 staff and our staff would be educated in what  
 7 they were and the roles that they would each  
 8 have to play.  
 9 CHAYTOR, Q.C.:  
 10 Q. 0762 please? And this is correspondence to  
 11 you from Robert Thompson, March 6, 2008.  
 12 Contact with results of patients with no  
 13 original test conducted in the province, as  
 14 recorded in ER/PR database. And it looks like  
 15 he's bringing to your attention a number of  
 16 patients. He's saying he's "attached a  
 17 patient list containing the names of patients  
 18 that did not have an original ER/PR test  
 19 conducted in the province, but had a test sent  
 20 to Mount Sinai as part of the ER/PR recall and  
 21 for which documentation of contact with  
 22 results cannot be confirmed." And he's  
 23 looking to see whether or not, "while these  
 24 patients do not meet the inclusion criteria  
 25 for the retesting process, because original

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1 tests done in the province and retesting  
 2 completed at Mount Sinai and as such, are not  
 3 included in the database. Nevertheless, it is  
 4 my belief that the responsible RHA should  
 5 follow up with physicians and/or the patients  
 6 to confirm if the physician ordering the test  
 7 and/or patient had been contacted." And then  
 8 attached to that is a, was a number of people.  
 9 MS. JONES:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And most of whom, I think there was one, two--  
 13 can we turn that so that--can that be turned  
 14 please, Registrar? Here we go. So most of  
 15 those people, it's one, two, three, four,  
 16 five, six, seven, eight, nine, maybe nine or  
 17 ten people and the only one that we haven't  
 18 whited out or redacted the name is Janet  
 19 Andrews because Ms. Henley-Andrews, we  
 20 understand this to be, she has consented to us  
 21 discussing her situation.  
 22 MS. JONES:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And she's actually given evidence here.

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1 MS. JONES:  
 2 A. Uh-hm.  
 3 CHAYTOR, Q.C.:  
 4 Q. What did you do when you received this from  
 5 Mr. Thompson? What did you do with his  
 6 request?  
 7 MS. JONES:  
 8 A. This immediate request, as soon as it came in,  
 9 there's a couple of faxes over a period of  
 10 days, they immediately went to Pat Pilgrim and  
 11 Pat followed up directly with letters back to  
 12 Robert on each one of the questions that were  
 13 asked inside of the fax that had actually come  
 14 in.  
 15 CHAYTOR, Q.C.:  
 16 Q. So what you would do is pass it on to Pat  
 17 Pilgrim who has been tasked with it?  
 18 MS. JONES:  
 19 A. Has been tasked to do it and then there would  
 20 also be, Pat, when you've got this completed,  
 21 let me know.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and did Pat do that? Did she get back  
 24 to you and tell you it had been completed?  
 25 MS. JONES:

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1 A. I think that you have e-mails that will follow  
 2 up on these that says yes, all signed off, all  
 3 letters have gone forward.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and then if we have P-0763 please? So  
 6 this is Pat's letter, I take it.  
 7 MS. JONES:  
 8 A. This is the letter, that's right.  
 9 CHAYTOR, Q.C.:  
 10 Q. March 7th, 2008 back to Mr. Thompson.  
 11 MS. JONES:  
 12 A. Uh-hm.  
 13 CHAYTOR, Q.C.:  
 14 Q. So this was, he had written to you March 6th?  
 15 MS. JONES:  
 16 A. Uh-hm.  
 17 CHAYTOR, Q.C.:  
 18 Q. So she's promptly getting back, March 7th,  
 19 2008 and we have eight people.  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And Janet Andrews name is left there as well.  
 24 And she writes, "The following table of  
 25 information is in response to correspondence

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1 of March 6th, 2008 and please note patients 1,  
 2 4, 5, 6 and 7"--so that doesn't pertain to Ms.  
 3 Andrews, she's No. 3, and "four of them had  
 4 their specimens tested and Mount Sinai's  
 5 testing was not being conducted at Eastern  
 6 Health. The disclosure of these results was  
 7 handled as per any test results ordered by a  
 8 physician." Okay, the No. 3, Janet Andrews,  
 9 it says, "She was never tested for ER/PR as  
 10 she was diagnosed with DCIS. This specimen  
 11 was tested on her request and was disclosed to  
 12 the patient in September, 2005."  
 13 MS. JONES:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And what would the source of that information  
 17 be? Where would Ms. Pilgrim get that  
 18 information?  
 19 MS. JONES:  
 20 A. She would have gotten them out of chart  
 21 review.  
 22 CHAYTOR, Q.C.:  
 23 Q. Chart review.  
 24 MS. JONES:  
 25 A. Or if in fact maybe the communication logs

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1 because we're seeing stuff back as far as  
 2 September 2005, so if they weren't on the  
 3 communication logs that NLCHI already had,  
 4 they went back into chart reviews.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, so this is saying that she was never  
 7 tested for ER/PR, she was diagnosed with DCIS,  
 8 so I take it that means originally she wasn't  
 9 tested -  
 10 MS. JONES:  
 11 A. That's right.  
 12 CHAYTOR, Q.C.:  
 13 Q. And then her specimen was tested on her  
 14 request and was disclosed to the patient  
 15 September 2005.  
 16 MS. JONES:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. So her results of her retest.  
 20 MS. JONES:  
 21 A. No, results of a test because she was never  
 22 tested.  
 23 CHAYTOR, Q.C.:  
 24 Q. So results of her test.  
 25 MS. JONES:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. So she was then tested, the specimen was  
 4 tested on her request.  
 5 MS. JONES:  
 6 A. On her request.  
 7 CHAYTOR, Q.C.:  
 8 Q. And disclosed to her in September 2005?  
 9 MS. JONES:  
 10 A. Yes, that's what Pat replied to Robert on the  
 11 7th, yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay, if we could have C-0150 please? And do  
 14 you recognize this document? We understand  
 15 this comes from Nancy Parsons?  
 16 MS. JONES:  
 17 A. I don't recognize it, but -  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, and it pertains to Ms. Henley-Andrews.  
 20 MS. JONES:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And November 7th, 2005, we understand these  
 24 are Nancy's notes of conversations with people  
 25 who are calling in.



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1 MS. JONES:  
 2 A. Okay.  
 3 CHAYTOR, Q.C.:  
 4 Q. "This patient had DCIS but has requested that  
 5 she be retestd. I asked Dr. Cook, he will  
 6 send her sample for retesting."  
 7 MS. JONES:  
 8 A. Yes, okay.  
 9 CHAYTOR, Q.C.:  
 10 Q. And if we could see the date here, it's  
 11 November 7th, 2005.  
 12 MS. JONES:  
 13 A. Uh-hm.  
 14 CHAYTOR, Q.C.:  
 15 Q. So Ms. Henley-Andrews didn't request her test  
 16 to be done until November 7th, 2005.  
 17 MS. JONES:  
 18 A. Until November and this is September -  
 19 CHAYTOR, Q.C.:  
 20 Q. The document sent to Mr. Thompson says that  
 21 she was informed of her result -  
 22 MS. JONES:  
 23 A. In September.  
 24 CHAYTOR, Q.C.:  
 25 Q. - in September '05. If we could look at C-

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1 0151 please? And this, we understand to be  
 2 the test Mount Sinai conducted?  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. On Ms. Henley-Andrews, her name is over here.  
 7 MS. JONES:  
 8 A. Uh-hm.  
 9 CHAYTOR, Q.C.:  
 10 Q. And if you can see the date of the procedure  
 11 was November 16th, 2005. Date and time of  
 12 report is November 22nd, 2005.  
 13 MS. JONES:  
 14 A. 22nd, uh-hm.  
 15 CHAYTOR, Q.C.:  
 16 Q. So Ms. Henley-Andrews could not have been told  
 17 the result of her test in September of 2005.  
 18 If we could have C-0152 please? And this is  
 19 again a document from Eastern Health charts  
 20 for review. Actually, this may be from Dr.  
 21 Cook, physician review panel. And I don't  
 22 know if we can read that. It says with Janet  
 23 Henley-Andrews anyhow here.  
 24 MS. JONES:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. And the results are indicated to be over here.  
 3 MS. JONES:  
 4 A. Uh-hm.  
 5 CHAYTOR, Q.C.:  
 6 Q. And you can see that this is going to the  
 7 review panel on -  
 8 MS. JONES:  
 9 A. 1st of December.  
 10 CHAYTOR, Q.C.:  
 11 Q. - December 1st. And, of course, Ms. Henley-  
 12 Andrews has stated that she was not told her  
 13 results by Eastern Health and in fact, only  
 14 learned of it through the process of the  
 15 inquiry. I'm not sure if you were present  
 16 that day when she gave her evidence.  
 17 MS. JONES:  
 18 A. No, I wasn't.  
 19 CHAYTOR, Q.C.:  
 20 Q. So on March 7th, 2008, you're saying the  
 21 information on which Ms. Pilgrim would have  
 22 based -  
 23 MS. JONES:  
 24 A. For my understanding would have been a chart  
 25 review -

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1 CHAYTOR, Q.C.:  
 2 Q. - would have been from her chart.  
 3 MS. JONES:  
 4 A. - or a contact log. And it wouldn't have been  
 5 Ms. Pilgrim who would have done it, it would  
 6 have been people who work with her, doing the  
 7 chart reviews.  
 8 CHAYTOR, Q.C.:  
 9 Q. And who would that be?  
 10 MS. JONES:  
 11 A. What?  
 12 CHAYTOR, Q.C.:  
 13 Q. And who would that be?  
 14 MS. JONES:  
 15 A. I don't know on this particular issue. There  
 16 were a number of individuals who were working  
 17 on it because there was at least three faxes  
 18 in that week.  
 19 CHAYTOR, Q.C.:  
 20 Q. And I'd like to finish up then with a  
 21 discussion that I was going to start with  
 22 yesterday which was about the quality and risk  
 23 management framework, so I hope it's still  
 24 fresh in your mind. We understand there was a  
 25 director of quality care enhancement which was

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1 a new position formed in Eastern Health, I  
 2 think back in September of 2005.  
 3 MS. JONES:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. There's been Ms. Lynn Wade, she's also -  
 7 MS. JONES:  
 8 A. She's with the lab program.  
 9 CHAYTOR, Q.C.:  
 10 Q. With the lab in particular. Perhaps you can  
 11 tell us and explain to the Commissioner the  
 12 different structures in terms of we've heard  
 13 of many committees in terms of quality and  
 14 quality initiatives. So, perhaps you can  
 15 explain that structure to us.  
 16 MS. JONES:  
 17 A. The current structure?  
 18 CHAYTOR, Q.C.:  
 19 Q. The current structure, yes.  
 20 MS. JONES:  
 21 A. Okay. Current structure and I probably will  
 22 start the bottom as we work our way through  
 23 the safety and improvement committee of the  
 24 board. We have a number of committees. The  
 25 first one that we would have is every

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1 portfolio, meaning every COO or VP would have  
 2 a quality committee itself and they're called  
 3 portfolio quality committees. And inside of  
 4 those portfolio quality committees there will  
 5 be a number of teams that would go on.  
 6 Generally, there are old accreditation teams  
 7 that carry forward the accreditation mandate  
 8 and work on continuous improvement through  
 9 that process. So, there is a structure  
 10 around. There's terms of reference around the  
 11 portfolio quality committees and then there is  
 12 sub-committees and work that goes on on a  
 13 portfolio basis.  
 14 We have also a sentinel event review  
 15 committee that was started as part of the  
 16 original structure when we adopted the  
 17 framework. We've only had one meeting of that  
 18 particular committee at this point in time.  
 19 The terms of reference have been recommended  
 20 for change in the membership to include ethics  
 21 in there and as well as some other minor  
 22 points.  
 23 On that particular committee we have at  
 24 least three, if not four physicians as well as  
 25 representation from the various sectors, like

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1 somebody from our community, somebody from our  
 2 long term care and somebody from our acute  
 3 care sectors. So, the sentinel event review  
 4 committee, the idea behind that one was to  
 5 review sentinel events to make sure that they  
 6 were closed off, that the appropriate work had  
 7 been done, recommendation, actions, those  
 8 kinds of things. I understand from the  
 9 discussion that they've had that they want to  
 10 develop a template around the entire process  
 11 and that they want to come together as quickly  
 12 as they can at the point in time of a sentinel  
 13 event. They are not the investigating  
 14 committee, but they could come together at  
 15 the, pretty much in concurrently with the  
 16 event going on. And I'm not sure where their  
 17 thinking is at that point right now.  
 18 CHAYTOR, Q.C.:  
 19 Q. So, that's a new committee that's been set up.  
 20 MS. JONES:  
 21 A. That's a new committee. It's met once, going  
 22 to revise its terms of reference and talk  
 23 about a process for itself and how it's going  
 24 to do the work that was inside of the terms of  
 25 reference that we had. We have some special

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1 task force and committees and they can be  
 2 established by the regional quality council  
 3 that I'll talk about in a minute. And one  
 4 example of that that we have ongoing is the  
 5 work that we've been doing on biological  
 6 indicators. So, it covers the all portfolios.  
 7 It's an issue that we want investigated,  
 8 looked at best practice and then policy work  
 9 for the entire organization versus what goes  
 10 on in a specific area.  
 11 CHAYTOR, Q.C.:  
 12 Q. And that's the group, that the entire  
 13 executive sits on that -  
 14 MS. JONES:  
 15 A. No, no, that's regional quality.  
 16 CHAYTOR, Q.C.:  
 17 Q. Regional quality council.  
 18 MS. JONES:  
 19 A. I'm below the regional quality right now.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay.  
 22 MS. JONES:  
 23 A. We have an infection control committee that is  
 24 now regional, has been regional for a few  
 25 months that has site specific infection

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1 control committees, but really brings together  
 2 work that's regional and then feeds the  
 3 regional quality control committee. We have  
 4 pharmacy and therapeutics as well that looks  
 5 at medications and medication reconciliation  
 6 and, you know, adverse events related to meds.  
 7 The two, infection control and pharmacy and  
 8 therapeutics have traditionally always  
 9 reported up through the medical staff, MAC,  
 10 medical advisory committee to the board. So,  
 11 at this point in time we've left it and we  
 12 have a dual kind of reporting on those two  
 13 committees.  
 14 So, those are the base lines committees  
 15 underneath, in our quality structure. Above  
 16 that they all report into the regional quality  
 17 council which has all of executive plus other  
 18 members and mostly they are the chair of  
 19 regional infection control committee, at this  
 20 point in time and two other physician  
 21 representatives. So, that's the regional  
 22 quality council. That then brings together  
 23 all of the information and issues from around  
 24 the organization from the portfolio quality  
 25 committees and all of the rest of it into and

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1 produces reports for the safety and quality  
 2 committee of the board which is a sub-  
 3 committee of the board. And then that -  
 4 CHAYTOR, Q.C.:  
 5 Q. And then that's the top.  
 6 MS. JONES:  
 7 A. That's the top. Right now, at this point in  
 8 time, we have on the side--because we have not  
 9 put a regional medical staff in place and we  
 10 don't have regional bylaws at this point in  
 11 time. We have infection control, pharmacy and  
 12 therapeutics reporting into MAC and directly  
 13 reporting to the board. Right now, we're  
 14 showing a dotted line because until we get a  
 15 regional MAC, we want to have a relationship  
 16 with the regional MAC into the regional  
 17 quality council. At this point in time we  
 18 haven't cut the direct line for the board with  
 19 respect to the MAC which is advisory basically  
 20 to the board, but until the new bylaws are in  
 21 place, we've left the old structures in place.  
 22 But we are working on a process with our  
 23 medical staff around having all of the issues,  
 24 physician issues as well all other issues  
 25 coming into the regional quality council. So,

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1 that's kind of how we're structured right now.  
 2 The portfolio quality committees have been in  
 3 place for well over a year. In the fall of  
 4 2006 we would have started that work. Prior  
 5 to the adoption of a framework and working on  
 6 a framework, the original committees, quality  
 7 committees, would have been reporting in  
 8 through the CEOs office because there was not  
 9 structure from the old to get it to the board.  
 10 So, it would have come in through the CEO's  
 11 office. So, in my instance, the old health  
 12 care corporation of St. John's, Pat Pilgrim  
 13 maintained the regional quality committee with  
 14 all of the pieces reporting to it, until such  
 15 time as we put the portfolio quality  
 16 committees in place. Because there were parts  
 17 of things that reported in to St. John's that  
 18 now were part of a regional structure, not  
 19 just a local structure.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay. And the quality initiatives committee  
 22 that--there was a quality initiatives  
 23 committee?  
 24 MS. JONES:  
 25 A. There was a quality committee inside of the

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1 old health care corporation of St. John's that  
 2 came into eastern health and stayed there  
 3 until it was replaced by this structure.  
 4 CHAYTOR, Q.C.:  
 5 Q. And Ms. Pilgrim used to chair that?  
 6 MS. JONES:  
 7 A. Ms. Pilgrim used to chair the -  
 8 CHAYTOR, Q.C.:  
 9 Q. And I believe you used to chair it too at some  
 10 point?  
 11 MS. JONES:  
 12 A. At some point in time when we moved forward,  
 13 there would have been differently  
 14 chairpersons, but it was -  
 15 CHAYTOR, Q.C.:  
 16 Q. So, that old quality initiatives committee,  
 17 even though we have minutes of that going  
 18 right up through, that's still--is that now  
 19 the eastern health committee?  
 20 MS. JONES:  
 21 A. It would be the regional quality committee.  
 22 CHAYTOR, Q.C.:  
 23 Q. That would be regional quality council?  
 24 MS. JONES:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. Regional quality council?

3 MS. JONES:

4 A. That's right.

5 CHAYTOR, Q.C.:

6 Q. So the minutes of the quality initiatives

7 committee that morphs into the regional

8 quality council.

9 MS. JONES:

10 A. Yes, that's right.

11 CHAYTOR, Q.C.:

12 Q. Okay. And at the end of the day, overall

13 responsibility for quality then rests with the

14 board through the board's committee?

15 MS. JONES:

16 A. The board's committee really started

17 functioning in about February. They had done

18 some preliminary work.

19 CHAYTOR, Q.C.:

20 Q. February of this year.

21 MS. JONES:

22 A. February of '07.

23 CHAYTOR, Q.C.:

24 Q. Because they had originally not decided to

25 have -

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1 MS. JONES:

2 A. Right February of '07.

3 CHAYTOR, Q.C.:

4 Q. - a quality committee.

5 MS. JONES:

6 A. They started to have some discussion in the

7 fall of '06 into--and then started, I do

8 believe, probably their first minutes are in

9 February of '07. And that was the third sub-

10 committee that the board actually struck.

11 They had finance, they had planning and then

12 moved to a separate committee for safety and

13 quality improvement. But as I said to you,

14 all of the work that goes on in terms of the

15 monitoring and the accountability and the

16 executive limitations comes from that

17 committee, goes directly to the board.

18 CHAYTOR, Q.C.:

19 Q. Could we have P-0031, please, page 31.

20 THE COMMISSIONER:

21 Q. Are you asking for Exhibit 0031, page 31 or

22 page -

23 CHAYTOR, Q.C.:

24 Q. Yes, it's P-0031 and I believe it's also page

25 31.

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1 THE COMMISSIONER:

2 Q. Oh, okay.

3 CHAYTOR, Q.C.:

4 Q. 0031, 31.

5 THE COMMISSIONER:

6 Q. Yes, it is.

7 CHAYTOR, Q.C.:

8 Q. All right. And this was the--maybe this is

9 something different, is it? The corporate

10 quality initiatives committee. Is that

11 something different?

12 MS. JONES:

13 A. That would have been what we call the old

14 health care corporation, corporate quality

15 committee.

16 CHAYTOR, Q.C.:

17 Q. Okay, so the corporate quality committee.

18 MS. JONES:

19 A. Yeah.

20 CHAYTOR, Q.C.:

21 Q. So this committee itself no longer exists.

22 It's now the regional -

23 MS. JONES:

24 A. No, this committee would have morphed into

25 portfolio quality committees.

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1 CHAYTOR, Q.C.:

2 Q. Portfolio quality -

3 MS. JONES:

4 A. Because this essentially is a portfolio now.

5 Okay. Because there are many other portfolios

6 in the old health care -

7 CHAYTOR, Q.C.:

8 Q. Okay, so this is one of many quality

9 initiative committees.

10 MS. JONES:

11 A. That's right. In the old health care

12 corporation, this would have been our

13 committee before we went to board, inside of

14 eastern health, this is a level lower.

15 CHAYTOR, Q.C.:

16 Q. Right. But that's not the regional quality

17 council?

18 MS. JONES:

19 A. No. It's -

20 CHAYTOR, Q.C.:

21 Q. So, what purpose would this committee serve

22 and how does that differ from what the

23 regional quality council would do?

24 MS. JONES:

25 A. Until we got the regional quality council,

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1 this would have been the regional quality  
 2 council for the old health care corporation,  
 3 all structures left in place until such point  
 4 in time as the new structure has been put in  
 5 place.  
 6 CHAYTOR, Q.C.:  
 7 Q. Right. So this would be the equivalent of the  
 8 current regional quality council?  
 9 MS. JONES:  
 10 A. That's right.  
 11 CHAYTOR, Q.C.:  
 12 Q. This would be it?  
 13 MS. JONES:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay. And you were--on this particular day  
 17 anyhow, September 28, 2006, you were chairing  
 18 the meeting.  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. But this now with the regional quality  
 23 council, all of the executive would attend  
 24 those meetings.  
 25 MS. JONES:

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1 A. No, because what was left from the old  
 2 executive for health care corporation would  
 3 have been myself and Steve Dodge and a few  
 4 others. So the clinical components of it, we  
 5 left in place.  
 6 CHAYTOR, Q.C.:  
 7 Q. So, earlier though today I thought that there  
 8 was a note in the minutes for executive  
 9 management that the executive had been updated  
 10 the day before. Remember that back in  
 11 November, executive had been updated about the  
 12 ER/PR at the regional quality council. And  
 13 you said all of the executive attend the  
 14 regional quality council.  
 15 MS. JONES:  
 16 A. There--we may have had a regional quality  
 17 council in the new structure put in place  
 18 while all of these things were continuing to  
 19 feed.  
 20 CHAYTOR, Q.C.:  
 21 Q. So, who is the current regional quality  
 22 council? Who are they?  
 23 MS. JONES:  
 24 A. As I had said, Pat Pilgrim is the chair.  
 25 CHAYTOR, Q.C.:

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1 Q. Yes.  
 2 MS. JONES:  
 3 A. The executive sit on it and we have three  
 4 physicians who sit with it.  
 5 CHAYTOR, Q.C.:  
 6 Q. Right. So, the executive does sit on it?  
 7 MS. JONES:  
 8 A. Yes. And in the old health care corporation  
 9 it would have been the executive and if you  
 10 look at this one, we would have had some  
 11 program directors which is what Carol Chafe  
 12 would have been. We would have had  
 13 professional practice. And if you look at the  
 14 regrets here, we would have had physician  
 15 representation, John Harnet and Pat Pilgrim.  
 16 So, the two clinical people left from the old  
 17 health care corporation were Louise Jones and  
 18 Pat Pilgrim running the clinical programs.  
 19 So, that's what's left of--while we tease out  
 20 and set up structures for regional areas.  
 21 CHAYTOR, Q.C.:  
 22 Q. So, any issues regarding a particular program  
 23 from a quality perspective, the quality  
 24 initiative report for that program would come  
 25 through, today, to the Regional Quality

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1 Council?  
 2 MS. JONES:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay. And this talk at 2.5 about a new  
 6 quality reporting structure, now this is post  
 7 Eastern Health time?  
 8 MS. JONES:  
 9 A. That's right, yeah.  
 10 CHAYTOR, Q.C.:  
 11 Q. September of 2006?  
 12 MS. JONES:  
 13 A. Um.  
 14 CHAYTOR, Q.C.:  
 15 Q. And "Members were informed significant  
 16 discussions are still ongoing within executive  
 17 regarding a quality report structure."  
 18 MS. JONES:  
 19 A. Um.  
 20 CHAYTOR, Q.C.:  
 21 Q. "A framework for quality was compiled and  
 22 presented to executive as a response. A  
 23 discussion document for executive is being  
 24 developed for further discussion of issues  
 25 around performance reporting and components

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1 linkages for quality, human resources and  
 2 finance. With the retirement of Dr. Williams  
 3 Patricia Pilgrim has been appointed lead for  
 4 quality on an interim basis." And I  
 5 understand that is -  
 6 MS. JONES:  
 7 A. That continued.  
 8 CHAYTOR, Q.C.:  
 9 Q. That continued. So that's now -  
 10 MS. JONES:  
 11 A. That's right.  
 12 CHAYTOR, Q.C.:  
 13 Q. - a permeant basis, okay. And "The current  
 14 reporting schedule of departments will  
 15 continue until the new structure is in  
 16 place."?  
 17 MS. JONES:  
 18 A. That's right.  
 19 CHAYTOR, Q.C.:  
 20 Q. "Members were informed the Eastern Health  
 21 board met yesterday for the first time under  
 22 policy governance."?  
 23 MS. JONES:  
 24 A. Um.  
 25 CHAYTOR, Q.C.:

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1 Q. Is that saying that the board itself met  
 2 yesterday -  
 3 MS. JONES:  
 4 A. Under the -  
 5 CHAYTOR, Q.C.:  
 6 Q. - September 27th, '06 for the first time under  
 7 policy governance?  
 8 MS. JONES:  
 9 A. They had, remember I had said that they had  
 10 worked through to decide how they wanted to  
 11 structure themselves as a board, so they had  
 12 done your traditional thing and then moved to  
 13 policy governance with ELs and that, and this  
 14 was the first meeting according to this -  
 15 CHAYTOR, Q.C.:  
 16 Q. Under policy governance?  
 17 MS. JONES:  
 18 A. Under policy governance.  
 19 CHAYTOR, Q.C.:  
 20 Q. So September 27th, 2006?  
 21 MS. JONES:  
 22 A. Yes, if this is correct here, yeah.  
 23 CHAYTOR, Q.C.:  
 24 Q. So in 2005 what kind of board was it, what  
 25 kind of--how were they governing themselves?

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1 MS. JONES:  
 2 A. Issues would have been brought to the board  
 3 through the chief executive officer and  
 4 through the reports. They had already been  
 5 doing some work on, in their finance are, they  
 6 had directors liability statement which in  
 7 essence is like an EL that we haven't really  
 8 formatted over into an EL. So they were doing  
 9 the work. They had a planning committee.  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes.  
 12 MS. JONES:  
 13 A. They had a finance committee. So the needs  
 14 assessments and those kinds of work was being  
 15 directed through their planning committee and  
 16 then their finance committee. So all of the  
 17 other parts of the organization that weren't  
 18 reporting or bringing information into those  
 19 two committees were coming through the CEO's  
 20 office and the CEO was then feeding the board.  
 21 CHAYTOR, Q.C.:  
 22 Q. And in terms of actual, and we've heard a lot  
 23 about this is policy, this is operations, was  
 24 there any change in that once they started in  
 25 September of '06 formally being under policy

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1 governance?  
 2 MS. JONES:  
 3 A. They kept always, and I think they always were  
 4 talking about teasing out is that an  
 5 operational issue or is that a governance  
 6 issue, which issue should we be involved in.  
 7 So they were conscious right from the very  
 8 beginning about how they would operate as a  
 9 board given the breadth and depth of  
 10 everything that was going in inside of Eastern  
 11 Health and they did not want to be an  
 12 operational board.  
 13 CHAYTOR, Q.C.:  
 14 Q. But that didn't formally happen until  
 15 September, 2006?  
 16 MS. JONES:  
 17 A. Although they were working from a governance  
 18 perspective throughout 2005. This is just a  
 19 way of formatting the way information gets to  
 20 the board.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay. If we could look then at P-0031, page  
 23 28? No, I'm sorry, we just did that. P-0058,  
 24 please? And I don't want to take you through  
 25 this entire document, Ms. Jones. There may be

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1 someone else from quality here and perhaps Ms.  
 2 Pilgrim could better speak to it.  
 3 MS. JONES:  
 4 A. Yes, that's right.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay. But I take it the quality and risk  
 7 management framework it's dated January, 2007  
 8 and updated June, 2007, this is the document  
 9 that you were referring to?  
 10 MS. JONES:  
 11 A. Absolutely.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay. And do you remember what was--how was  
 14 it updated in June, 2007, were there any  
 15 significant changes?  
 16 MS. JONES:  
 17 A. I'm not sure, but there may have been  
 18 something to the terms of reference and maybe  
 19 in January of 2007 the safety and quality  
 20 committee would not have been reflected in  
 21 there, I don't believe.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay.  
 24 MS. JONES:  
 25 A. Because we would have been working on this

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1 starting the portfolio quality committees in  
 2 the fall of 2006, going into 2007.  
 3 CHAYTOR, Q.C.:  
 4 Q. And did this have to be approved, I appreciate  
 5 June, 2007, who would approve this framework?  
 6 MS. JONES:  
 7 A. We would have approved the framework in terms  
 8 of executive.  
 9 CHAYTOR, Q.C.:  
 10 Q. The executive, okay. And prior to January,  
 11 2007 was there a similar framework? This is -  
 12 MS. JONES:  
 13 A. Not for Eastern Health.  
 14 CHAYTOR, Q.C.:  
 15 Q. Not for Eastern Health. But for the Health  
 16 Care Corporation?  
 17 MS. JONES:  
 18 A. For the Health Care Corporation there would  
 19 have been the framework that we were working  
 20 under.  
 21 CHAYTOR, Q.C.:  
 22 Q. And would that have continued, then, until  
 23 from, it's about an 18 month or almost two-  
 24 year period?  
 25 MS. JONES:

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1 A. Yes. That's what I was referencing when you  
 2 saw the Corporate Quality Council and that,  
 3 the components of them were left in place.  
 4 And the reporting, the annual reporting and  
 5 the schedule of reporting for departments  
 6 continued on until we replaced it with a  
 7 portfolio.  
 8 CHAYTOR, Q.C.:  
 9 Q. And who sees this document within the  
 10 organization, where does this document go or  
 11 who would know about it?  
 12 MS. JONES:  
 13 A. This document would have went out for  
 14 feedback. We would have had our quality  
 15 people--the document would have originated in  
 16 quality with the director of quality, Pam  
 17 Elliott doing a lot of the legwork and doing a  
 18 lot of the work in there. Would have went out  
 19 for feedback through our program directors and  
 20 potentially down to our division managers  
 21 through the programs to identify, you know,  
 22 what else needs to be added in there, is this  
 23 realistic, how can we operate inside of the  
 24 organization. And there's reference in the  
 25 earlier discussion that we had today about

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1 feedback from executive. So we would have  
 2 seen earlier drafts and had a lot of  
 3 discussion around whether, in fact, we would  
 4 have site specific quality committees, whether  
 5 we would have portfolio quality committees,  
 6 how would we do it, did we want to have cross  
 7 sector, whatever. At the end of the day we  
 8 settled on having portfolio quality committees  
 9 and having the COO or the VP responsible for  
 10 the quality inside of the area that they were  
 11 responsible for.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay. And again, I'll have a number of other  
 14 questions around that, but perhaps best left  
 15 for others.  
 16 MS. JONES:  
 17 A. Yeah.  
 18 CHAYTOR, Q.C.:  
 19 Q. One other thing, I saw your name obviously  
 20 comes up a lot in the chief operating  
 21 officers' minutes.  
 22 MS. JONES:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And you attended those fairly, fairly

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1 religiously, those meetings?  
 2 MS. JONES:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. The chief operating officers of Eastern Health  
 6 before you assumed your current role would  
 7 have been you and -  
 8 MS. JONES:  
 9 A. Would have been Pat Pilgrim.  
 10 CHAYTOR, Q.C.:  
 11 Q. Pat Pilgrim.  
 12 MS. JONES:  
 13 A. We would have had Alice Kennedy from long-term  
 14 care and supportive services, Bev Clarke with  
 15 the community portfolio, children's and  
 16 women's now in St. John's, and mental health,  
 17 we would have had rural Avalon, which would  
 18 have been Fay Matthews, and Pat Coish-Snow in  
 19 the peninsulas areas, both the rural areas are  
 20 integrated portfolios.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay. The ER/PR issue, was that ever raised  
 23 at those meetings?  
 24 MS. JONES:  
 25 A. I can't recall. There may very well have been

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1 some discussion, but that wouldn't have been  
 2 the focus of those meetings. Those meetings  
 3 were around clinical issues, developing,  
 4 looking at policies, trying to get the work  
 5 done on in terms of working across the entire  
 6 organization.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay.  
 9 MS. JONES:  
 10 A. From a clinical perspective.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay. And the minutes that we've had or we've  
 13 just received them recently, but the  
 14 preliminary review we have and we have them  
 15 for almost a three-year period, about a two  
 16 and a half year period starting at some point  
 17 in 2005, up until 2008. And we didn't see any  
 18 reference to ER/PR.  
 19 MS. JONES:  
 20 A. No.  
 21 CHAYTOR, Q.C.:  
 22 Q. So that wouldn't surprise you?  
 23 MS. JONES:  
 24 A. No.  
 25 CHAYTOR, Q.C.:

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1 Q. That that didn't come up at all with the chief  
 2 operating officers?  
 3 MS. JONES:  
 4 A. No. Because there wouldn't have been a chief  
 5 operating officer who had had a, you know, a  
 6 responsibility. Bob Williams was originally  
 7 and that portfolio was not in the chief  
 8 operating officers. A lot of the issues in  
 9 the COOs are around nursing, recruitment,  
 10 service delivery, beds, those kinds of things.  
 11 Lots of other things come up there, but that  
 12 would be what you would see.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay. Thank you. That's it, Commissioner.  
 15 Thank you.  
 16 THE COMMISSIONER:  
 17 Q. Mr. Pritchard, I'm suggesting we take the  
 18 afternoon break and then we'll commence with  
 19 your cross-examination. That'll give us a  
 20 chance to move books and people. Thank you.  
 21 Fifteen minutes.  
 22 (RECESS)  
 23 THE COMMISSIONER:  
 24 Q. Mr. Pritchard?  
 25 MS. LOUISE JONES, CROSS-EXAMINATION BY MR. ROLF PRITCHARD

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1 MR. PRITCHARD:  
 2 Q. Thank you, Commissioner. Good afternoon, Ms.  
 3 Jones.  
 4 MS. JONES:  
 5 A. Good afternoon.  
 6 MR. PRITCHARD:  
 7 Q. Ms. Jones, I just have one question for you  
 8 this afternoon. I'm sure you're relieved to  
 9 hear that. On a number of occasions during  
 10 the last few days you've been fairly  
 11 consistent in saying that on disclosure  
 12 matters your policy or belief or the  
 13 organization's policy is that there has to be  
 14 disclosure to the individual before any sort  
 15 of public disclosure or disclosure en mass?  
 16 MS. JONES:  
 17 A. Yes.  
 18 MR. PRITCHARD:  
 19 Q. And we saw how in 2005 before that individual  
 20 disclosure was completed, of course, the media  
 21 disclosed the event on October 2nd.  
 22 MS. JONES:  
 23 A. Um.  
 24 MR. PRITCHARD:  
 25 Q. And I'm just wondering if your organization or



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1 you have had some time to give some thought to  
 2 that issue that where you have a number of  
 3 individuals that have to be contacted the  
 4 possibility always exists that that disclosure  
 5 can sort of overtake you and the public -  
 6 MS. JONES:  
 7 A. That's right.  
 8 MR. PRITCHARD:  
 9 Q. - finds out about it before you complete the  
 10 individual disclosure. Is that something that  
 11 you've had an occasion to consider, you or  
 12 your organization, and what, if any,  
 13 conclusions have you come to on that?  
 14 MS. JONES:  
 15 A. We've not made any conclusions at this time.  
 16 Obviously you've reiterated that we would  
 17 have--we've always said it needs to be  
 18 patients first and we would attempt in every  
 19 way to make that happen. Inevitably there  
 20 will eventually end up being public  
 21 disclosure, whether it is because the media  
 22 have picked up on it or whatever. And I guess  
 23 in some ways there needs to be contingency  
 24 plans to be able to react to that rather than  
 25 on a proactive because we really would want

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1 the front end of it done, which is individual  
 2 disclosure. We were waiting for the Canadian  
 3 Patient Safety Institute because we had asked,  
 4 they had guidelines that they were developing  
 5 on disclosure and in their consultation phase  
 6 Eastern Health had clearly asked them about  
 7 what--were there going to be any guidelines or  
 8 had they given any thought to public  
 9 disclosure. And we see that there's not very  
 10 much that has come out of that. And we also  
 11 know that through the task force on adverse  
 12 events, not really understanding where that or  
 13 the recommendations are going to come out in  
 14 that way, that there may be some opportunity  
 15 to have some discussion inside of that. So  
 16 Eastern Health has not taken a position on it,  
 17 but we're looking to things like the Canadian  
 18 Patient Safety Institute and when nothing came  
 19 out of that with their new guidelines that  
 20 have just recently been released, we will have  
 21 to turn our heads to that again.  
 22 MR. PRITCHARD:  
 23 Q. Thank you, Ms. Jones.  
 24 MS. JONES:  
 25 A. You're welcome.

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1 THE COMMISSIONER:  
 2 Q. Mr. Pritchard. Mr. Browne?  
 3 MS. LOUISE JONES, CROSS-EXAMINATION BY MR. PETER BROWNE  
 4 MR. BROWNE:  
 5 Q. Thank you, Commissioner. Good afternoon, Ms.  
 6 Jones.  
 7 MS. JONES:  
 8 A. Good afternoon, Mr. Browne.  
 9 MR. BROWNE:  
 10 Q. Now, I just want to go back over some of the  
 11 nomenclature that has been used throughout  
 12 your testimony this week. And I want to begin  
 13 by looking at some of the nomenclature that's  
 14 been used in relation to the organization  
 15 structure of the old Health Care Corporation  
 16 and Eastern Health. And the nomenclature I  
 17 want to focus on is accountability and  
 18 responsibility.  
 19 MS. JONES:  
 20 A. Yes.  
 21 MR. BROWNE:  
 22 Q. Those are concepts that I think existed under  
 23 both organizations, is that correct?  
 24 MS. JONES:  
 25 A. Yes.

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1 MR. BROWNE:  
 2 Q. And with regard to that I just want to focus  
 3 on physician and medical services and get an  
 4 understanding, if I could, about some of the  
 5 VP positions. I think it's very well  
 6 understood by everybody here that the VP of  
 7 medical affairs has a number of physician  
 8 responsibilities underneath that portfolio as  
 9 you -  
 10 MS. JONES:  
 11 A. Yes.  
 12 MR. BROWNE:  
 13 Q. The term you use. Are there other portfolios,  
 14 and I look at in particular your old  
 15 portfolio, the VP of adult acute care.  
 16 MS. JONES:  
 17 A. Yes.  
 18 MR. BROWNE:  
 19 Q. Did that have physician responsibilities under  
 20 that, as well?  
 21 MS. JONES:  
 22 A. We had co-leadership teams in those areas and  
 23 so would have been a clinical chief and a  
 24 program director. So physicians work in each  
 25 side of those programs, but from the physician

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1 accountabilities and that, it really is  
 2 through the other structures. So we--from a  
 3 planning perspective that's where we involve  
 4 the clinical chief and that and move forward  
 5 in that way. So we never, I never, ever had  
 6 responsibility for individual physician  
 7 actions.  
 8 MR. BROWNE:  
 9 Q. Okay. Thank you for clarifying that. What  
 10 about the VP of quality and clinical services,  
 11 again, would that be the same response for  
 12 that portfolio, would it still go under -  
 13 MS. JONES:  
 14 A. Yes.  
 15 MR. BROWNE:  
 16 Q. - medical. Thank you.  
 17 MS. JONES:  
 18 A. And the medical advisory committees in those  
 19 structures.  
 20 MR. BROWNE:  
 21 Q. Thanks. So effectively, then, responsibility  
 22 and accountability, that concept would  
 23 primarily rest with the VP of medical?  
 24 MS. JONES:  
 25 A. Yes, it would.

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1 MR. BROWNE:  
 2 Q. And you mentioned just a second ago of the  
 3 role of MAC.  
 4 MS. JONES:  
 5 A. Um.  
 6 MR. BROWNE:  
 7 Q. Would the VP medical affairs be the person  
 8 interfacing with MAC for that, for the notion  
 9 of accountability and responsibility?  
 10 MS. JONES:  
 11 A. The VP for medical affairs is the resource  
 12 person to the MAC.  
 13 MR. BROWNE:  
 14 Q. Right.  
 15 MS. JONES:  
 16 A. The MAC is a body that has its own chair and  
 17 reporting structure through to the board.  
 18 MR. BROWNE:  
 19 Q. Okay. Now, I want to go back again to the  
 20 various VPs and their role in planning and  
 21 prioritizing budget items.  
 22 MS. JONES:  
 23 A. Yes.  
 24 MR. BROWNE:  
 25 Q. Okay. We've, I think you weren't the only

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1 witness, but several witnesses, including  
 2 yourself, have talked about the Hay report and  
 3 the very obvious fact that's come out of, of  
 4 the Hay report, is the focus on efficiencies,  
 5 the emphasis on efficiencies.  
 6 MS. JONES:  
 7 A. Yes.  
 8 MR. BROWNE:  
 9 Q. Did or do--and again, looking at both Eastern  
 10 Health and its predecessor, did the VPs of the  
 11 various portfolios have a role in planning and  
 12 prioritizing budget items?  
 13 MS. JONES:  
 14 A. Yes, we did.  
 15 MR. BROWNE:  
 16 Q. Okay. And was there again an emphasis brought  
 17 to play both at that level and at lower levels  
 18 on efficiencies?  
 19 MS. JONES:  
 20 A. Absolutely.  
 21 MR. BROWNE:  
 22 Q. And I'm looking at program managers and so on.  
 23 MS. JONES:  
 24 A. Absolutely.  
 25 MR. BROWNE:

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1 Q. Okay. And I guess if we could, just looking  
 2 at that role, if we could, just look at the  
 3 clinical chiefs' role. Do they have a role in  
 4 the efficiencies of the budgetary planning  
 5 process or is that mostly with the program  
 6 managers?  
 7 MS. JONES:  
 8 A. The clinical chief would have been involved in  
 9 not necessarily the building of the budget but  
 10 the kinds of initiatives that were inside the  
 11 budget and understanding the budget and what  
 12 implications it would have on the service  
 13 delivery.  
 14 MR. BROWNE:  
 15 Q. Okay. Nevertheless, though, would the main  
 16 persons be in terms of the chain of command  
 17 the program managers and then the VPs in terms  
 18 of that greater input -  
 19 MS. JONES:  
 20 A. Around the staff piece, yes.  
 21 MR. BROWNE:  
 22 Q. Okay. Thank you. And in terms of the role  
 23 and responsibilities for monitoring the level  
 24 of training of staff members, in particular,  
 25 say technical staff or whoever may be under

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1 the respective portfolio, does that rest  
 2 primarily with the various VPs or is that  
 3 shared between the program managers and the -  
 4 MS. JONES:  
 5 A. The program managers. The VPs would not  
 6 really be into that level of detail.  
 7 MR. BROWNE:  
 8 Q. And I think you mentioned, I think it was  
 9 yesterday, that, in fact, the program  
 10 directors, program managers are responsible  
 11 for the day-to-day operations on the technical  
 12 side when we talk about the lab and the  
 13 clinical on the pathology side?  
 14 MS. JONES:  
 15 A. That's right.  
 16 MR. BROWNE:  
 17 Q. Again, looking at sort of the new Eastern  
 18 Health model and the previous, the predecessor  
 19 model of Health Care Corporation, do program  
 20 directors carry any clinical or technical  
 21 workloads?  
 22 MS. JONES:  
 23 A. Some program--not at the director level, but  
 24 some managers carry some technical  
 25 responsibilities, as well.

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1 MR. BROWNE:  
 2 Q. Okay. So would possibly at the manager, but  
 3 definitely not at the program director's?  
 4 MS. JONES:  
 5 A. Definitely not at the program director level.  
 6 MR. BROWNE:  
 7 Q. Okay. However, that is not the case for  
 8 clinical chiefs, they are required to have  
 9 clinical responsibilities, are they not?  
 10 MS. JONES:  
 11 A. At this point in time we don't have any full-  
 12 time clinical chief that does not carry a  
 13 clinical responsibility.  
 14 MR. BROWNE:  
 15 Q. Right. But their counterparts, program  
 16 directors do have full-time responsibility?  
 17 MS. JONES:  
 18 A. (No audible response).  
 19 MR. BROWNE:  
 20 Q. Now, is that partly due to, I guess, a number  
 21 of factors there, is it potentially the  
 22 expense potentially that may have to be paid  
 23 for salaries for physicians if they were in a  
 24 full-time administrative capacity?  
 25 MS. JONES:

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1 A. That has nothing to do with salaries.  
 2 MR. BROWNE:  
 3 Q. Would it have to do also or potentially with  
 4 the requirement on certain professionals that  
 5 they need to have so many hours for their  
 6 licensure and to maintain their licensure?  
 7 MS. JONES:  
 8 A. No. If we talk about physicians and in their  
 9 administrative role, we look at physicians in  
 10 their administrative role, the role that they  
 11 carry and the job description that we provide  
 12 them with and we look at the amount of time  
 13 that's required to do that. And that is a  
 14 joint agreement between the physician, the  
 15 role that we want them to play and that they  
 16 accept that role and then we determine how  
 17 they determine and talk to us about how much  
 18 time they need to take that role.  
 19 MR. BROWNE:  
 20 Q. In terms of the managers and program  
 21 directors, is there an expectation, apart  
 22 from, say, any professional regulation, that  
 23 they keep current on developments relevant to  
 24 their various services?  
 25 MS. JONES:

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1 A. To the extent that it's possible, yes, and  
 2 that would be going out of the province or at  
 3 least keeping current with the literature or  
 4 doing conferences, those kinds of things.  
 5 MR. BROWNE:  
 6 Q. And again, looking at the organizational  
 7 structure of both the old, and if there is a  
 8 distinction, please clarify that for me, but a  
 9 non sort of physician positions and--let me  
 10 make that broader, for the non-professionally  
 11 regulated positions, who would be responsible  
 12 for creating job descriptions, performance  
 13 evaluations, program policies, promotion,  
 14 those sorts of things?  
 15 MS. JONES:  
 16 A. That would be the administrative side.  
 17 MR. BROWNE:  
 18 Q. And at what levels? Would there be various  
 19 levels that would be involved there? Say,  
 20 managers, program directors.  
 21 MS. JONES:  
 22 A. The job descriptions generally there's a  
 23 classification issue and that comes underneath  
 24 the union. Like if we're talking lab, the LX.  
 25 So there is--from a pay perspective, there is

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1 various technicians, technologists, those  
 2 kinds of classifications. The duties and  
 3 responsibilities under that would have  
 4 developed over time and been part of job  
 5 descriptions that managers and as well as  
 6 classification pay inside of government would  
 7 have approved the level of compensation, based  
 8 upon the duties.  
 9 MR. BROWNE:  
 10 Q. What about promotions, job performance and  
 11 investigations of job performance?  
 12 MS. JONES:  
 13 A. That would be on the administrative side,  
 14 unless there was an issue where sometimes we  
 15 involved a clinical chief, depending on the  
 16 kind of investigation. If you're talking  
 17 staff, we sometimes even, in a program  
 18 leadership team, would have the clinical chief  
 19 as well as a program director do evaluations  
 20 if there happen to be issues in areas.  
 21 MR. BROWNE:  
 22 Q. Now yesterday you mentioned that, I think, the  
 23 statistics in your organization is that  
 24 probably only 25 to 30 percent of the  
 25 organization completes performance

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1 evaluations. Is that--did I get that right?  
 2 MS. JONES:  
 3 A. On a regular basis, and there was some  
 4 question about the standard in terms of CCHSA,  
 5 does that mean yearly or every -  
 6 MR. BROWNE:  
 7 Q. Right.  
 8 MS. JONES:  
 9 A. Well, we haven't made a stance to say regular,  
 10 but in our minds, it's a yearly basis, even  
 11 though regular doesn't necessarily mean a  
 12 year.  
 13 MR. BROWNE:  
 14 Q. And I think in answering Ms. Chaytor's  
 15 question, you said nevertheless, there was  
 16 still informal feedback?  
 17 MS. JONES:  
 18 A. That's right.  
 19 MR. BROWNE:  
 20 Q. Can I ask, how is that information channelled  
 21 back into the organization, especially in  
 22 relation to patient safety issues?  
 23 MS. JONES:  
 24 A. In terms of issues that may arise or  
 25 performance -

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1 MR. BROWNE:  
 2 Q. From a performance evaluation.  
 3 MS. JONES:  
 4 A. - from a performance--then it would end up  
 5 being back into the program director or to the  
 6 manager level and be resolved or issues, if it  
 7 meant additional education because there was a  
 8 skill set that we didn't have in an area, then  
 9 we would put the resources in place to address  
 10 that issue.  
 11 MR. BROWNE:  
 12 Q. So it would be focused on the program  
 13 director?  
 14 MS. JONES:  
 15 A. Focused on the area that we were talking  
 16 about.  
 17 MR. BROWNE:  
 18 Q. Thank you. As well, you mentioned in relation  
 19 to--and I don't propose to call it up, but it  
 20 is Exhibit P-0745 and that's the CCHSA  
 21 accreditation report. I think I got your  
 22 comment yesterday that in respect of  
 23 occurrence reports, there was a comment that  
 24 everyone will deal with an issue, but not  
 25 necessarily report it, I think was -

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1 MS. JONES:  
 2 A. Yes.  
 3 MR. BROWNE:  
 4 Q. - what I captured as part of your response.  
 5 Now in relation to that, is there--I guess, as  
 6 had been pointed out by yourself and Mr.  
 7 Tilley, Eastern Health is a large, very large  
 8 institution and part of what I received from  
 9 your answer was that there tends to be, at  
 10 some departmental levels, a microscopic or a  
 11 microanalysis of their own in a micro-  
 12 environment in which they operate and  
 13 therefore they respond to issues as they arise  
 14 within the department. But at the same time,  
 15 they may not recognize the implications on a  
 16 macro level or organizational level.  
 17 MS. JONES:  
 18 A. That's right.  
 19 MR. BROWNE:  
 20 Q. And do I understand there are now efforts  
 21 under way as part of your goals, current  
 22 goals, to address those and bring those  
 23 forward up as part of the organization?  
 24 MS. JONES:  
 25 A. I think Madame Justice Cameron asked that

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1 yesterday too, in terms of, you know, a caring  
 2 profession, if there is an incident that  
 3 occurs, we deal with the incident.  
 4 MR. BROWNE:  
 5 Q. Right.  
 6 MS. JONES:  
 7 A. And not necessarily sometimes go to the end  
 8 degree of completing an occurrence report and  
 9 that. Part of the quality department, in  
 10 their education around occurrence reports, is  
 11 emphasizing the importance of getting all of  
 12 that because that's where you get your trends  
 13 and your learnings and the bigger piece. So  
 14 yes, that is work that the quality  
 15 facilitators and the quality department do on  
 16 an ongoing basis to try to raise awareness on  
 17 that, and not just deal with the individual  
 18 issue.  
 19 MR. BROWNE:  
 20 Q. Okay. I'm going to refer to a document. I'm  
 21 starting to feel like I'm becoming the CPSI  
 22 man. IT is Exhibit 0161, if I could please,  
 23 Registrar? And this is the Canadian Patient  
 24 Safety Institute disclosure guidelines.  
 25 MS. JONES:

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1 A. Yes.  
 2 MR. BROWNE:  
 3 Q. And on Monday, you will recall there was a  
 4 series of questions from Commissioner Cameron,  
 5 I think to, as I understood the line of  
 6 questioning, the seemingly disconnect that she  
 7 saw between quality assurance peer review and  
 8 the disclosure adverse events, and I want to  
 9 sort of ask you some questions around that  
 10 exchange in light of the disclosure  
 11 guidelines.  
 12 One of the things that Commissioner  
 13 Cameron asked of you was is there a definition  
 14 of systems failure, and if I could begin  
 15 there, and ask you to turn to page 30 of that  
 16 document, and you will see as you scroll down--  
 17 -maybe I can scroll down here. In fact, there  
 18 is. You see the last definition.  
 19 MS. JONES:  
 20 A. Yes.  
 21 MR. BROWNE:  
 22 Q. And it's described as a "fault, breakdown or  
 23 dysfunction within the organization's  
 24 operational methods, processes or  
 25 infrastructure." And again, that is

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1 footnoted, just for further reference, and it  
 2 actually comes from a--if we go to the next  
 3 page, 31--sorry, let me--my apologies,  
 4 actually 33, Registrar. No, my apologies, 34.  
 5 That is from--I think it's footnote 31  
 6 and that is an international classification  
 7 for patient safety. So I understand that  
 8 definition is coming from an international  
 9 draft guideline.  
 10 MS. JONES:  
 11 A. Okay.  
 12 MR. BROWNE:  
 13 Q. Is that--just to ask you the question, is that  
 14 your general understanding of what constitutes  
 15 systems failure?  
 16 MS. JONES:  
 17 A. Systems failure is multiple issues that may  
 18 contribute to or may not contribute to.  
 19 You're not really--maybe it's along a process.  
 20 It's along multiple players as part of a  
 21 process. So the causation is very difficult,  
 22 in terms of a system, in systems issues or  
 23 systems failures.  
 24 MR. BROWNE:  
 25 Q. Okay, so you would sort of put that into what-

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1 -in addition to what's here in this  
 2 definition?  
 3 MS. JONES:  
 4 A. That's right.  
 5 MR. BROWNE:  
 6 Q. And as well, you used--if we can go back to--  
 7 my apologies, Registrar, for jumping around  
 8 here, page 30. The notion of root cause  
 9 analysis, that as well is defined here and you  
 10 can take a moment to read that, and it says  
 11 "an analytical tool that can be used to  
 12 perform a comprehensive system based review of  
 13 critical incidents. It includes  
 14 identification of the root and contributory  
 15 factors, identification of risk reduction  
 16 strategies and development of action plans  
 17 along with the measurement strategies to  
 18 evaluate the effectiveness of the plans."  
 19 MS. JONES:  
 20 A. Yes.  
 21 MR. BROWNE:  
 22 Q. Again, is that a definition that -  
 23 MS. JONES:  
 24 A. That we would use and there's a whole  
 25 methodology around root cause analysis that

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1 the quality people would be well aware of how  
 2 to use.  
 3 MR. BROWNE:  
 4 Q. Okay, and again, without going back through  
 5 the document, that definition comes from a  
 6 main document which is footnoted here as well.  
 7 MS. JONES:  
 8 A. Okay.  
 9 MR. BROWNE:  
 10 Q. I do want to just spend a bit more time with  
 11 this, these guidelines and have you go back to  
 12 the line of questioning from Madame Justice  
 13 Cameron, or Commissioner Cameron, on Monday.  
 14 Page 12, if we could please, Registrar?  
 15 This is entitled "Building the Foundation  
 16 for Disclosure" and it speaks to creating a  
 17 culture of patient safety, and just following  
 18 on those definitions, if you go down to the  
 19 third paragraph there, you'll see, beginning  
 20 with the sentence "many adverse events in  
 21 health care are now recognized as system  
 22 failures where safeguards to protect patient  
 23 safety were not in place or a series of  
 24 safeguards that were in place failed in  
 25 sequence which resulted in harm for the

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1 patient." Again, would you share that or  
 2 adopt that notion of adverse event?  
 3 MS. JONES:  
 4 A. Absolutely, and I think I may have made just  
 5 one or two comments about redundancy in the  
 6 system and having extra checks and balances in  
 7 the system so that if one--if there is an  
 8 issue in one area, then it's picked up in  
 9 another area.  
 10 MR. BROWNE:  
 11 Q. Okay, and I just want to drop down to the next  
 12 paragraph there, because again, there's a  
 13 reference to terminology that has been used, I  
 14 think, throughout the Commission in various  
 15 sectors, and that is the notion of just  
 16 culture and that says "a just culture is a key  
 17 element of broader patient safety culture that  
 18 seeks to reconcile professional accountability  
 19 and the need to create a safe environment in  
 20 which to report adverse events. Health care  
 21 providers in a just culture are fully aware of  
 22 the expectations of the organization and are  
 23 held professionally accountable for the  
 24 quality of the work." Again, is that  
 25 principles your organization subscribes to?

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1 MS. JONES:  
 2 A. When we talk about just and trusting culture,  
 3 those would be the things that we would be  
 4 looking to move forward and have our staff  
 5 understand what it means and to work with.  
 6 MR. BROWNE:  
 7 Q. Okay. I now want to move to--so that, I just  
 8 want to sort of deal with that in terms of the  
 9 disclosure component, and now talk about that,  
 10 how that fits in relation to the peer review.  
 11 And if we can turn now to page 21?  
 12 And you'll see in item E there what to  
 13 disclose, and they list a number of components  
 14 there, the first of which is the facts of the  
 15 harm and/or event known at the time and then  
 16 follows down with "including the steps taken,  
 17 the recommended options," and so on. At the  
 18 bottom of all that, and then finally ends with  
 19 "the plan for further investigation and  
 20 treatment, if required." Is it your  
 21 understanding, in terms of the relationship  
 22 between disclosure of adverse events and peer  
 23 review and quality assurance that peer review  
 24 and quality assurance doesn't protect the fact  
 25 that--or prevent facts from being disclosed to

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1 patients or from being disclosed to the  
 2 public?  
 3 MS. JONES:  
 4 A. Absolutely. That would be the same as if we  
 5 had incident reports or whatever. The issues  
 6 are documented in the patient chart and are  
 7 accessible in that fashion.  
 8 MR. BROWNE:  
 9 Q. Okay, and -  
 10 THE COMMISSIONER:  
 11 Q. So are we talking about the peer review under  
 12 the law of Newfoundland or peer review  
 13 generally?  
 14 MR. BROWNE:  
 15 Q. Peer review generally, and I would suggest  
 16 under the law in Newfoundland.  
 17 THE COMMISSIONER:  
 18 Q. Okay, I'm sure I will hear from you about that  
 19 later.  
 20 MR. BROWNE:  
 21 Q. Just dropping down there, "when conducting an  
 22 investigation such as root cause analysis in a  
 23 legally protected quality of care similar  
 24 committee," this is talking about peer review,  
 25 it goes on to say "providers and patients

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1 should be made aware that there are explicit  
 2 limitations to discussing some of the  
 3 investigative information, such as opinions,  
 4 speculation shared as defined in legislation  
 5 within the provinces or territories with  
 6 quality care protections." Is that your  
 7 understanding of the environment here in  
 8 Newfoundland?  
 9 MS. JONES:  
 10 A. Yes, that things are protected inside of that  
 11 report.  
 12 MR. BROWNE:  
 13 Q. But what is protected only relates to opinions  
 14 and speculation shared in the umbrella of peer  
 15 review?  
 16 MS. JONES:  
 17 A. That's what peer review is.  
 18 MR. BROWNE:  
 19 Q. Right. It's not the facts.  
 20 MS. JONES:  
 21 A. It's not the facts.  
 22 MR. BROWNE:  
 23 Q. What is protected are these components.  
 24 MS. JONES:  
 25 A. Is the opinions, these components.

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1 MR. BROWNE:  
 2 Q. Okay. Now just before Ms. Chaytor finished  
 3 today, in terms of her questioning, she had  
 4 you go over the framework for quality  
 5 assurance committees, and I think you spoke to  
 6 both the old Health Care Corporation structure  
 7 and the current Eastern Health structure.  
 8 Does your organization have a flow chart to  
 9 explain that in sort of a more -  
 10 MS. JONES:  
 11 A. The current one, yes, was what I was reading  
 12 from.  
 13 MR. BROWNE:  
 14 Q. Okay.  
 15 THE COMMISSIONER:  
 16 Q. Flow chart for?  
 17 MR. BROWNE:  
 18 Q. For how these committees -  
 19 THE COMMISSIONER:  
 20 Q. For the committees?  
 21 MR. BROWNE:  
 22 Q. Yes. I mean, I -  
 23 THE COMMISSIONER:  
 24 Q. The quality committee?  
 25 MR. BROWNE:

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1 Q. The quality committee.  
 2 MS. JONES:  
 3 A. The quality and--this was a one that I was  
 4 referencing. This is a January of '07 with  
 5 the committee structure. So that was my  
 6 reference point just to remind people.  
 7 MR. BROWNE:  
 8 Q. Is that an exhibit?  
 9 THE COMMISSIONER:  
 10 Q. I don't know. We all have to ask.  
 11 MS. JONES:  
 12 A. Is it attached to the quality and risk  
 13 management framework?  
 14 CHAYTOR, Q.C.:  
 15 Q. I don't think so.  
 16 MR. BROWNE:  
 17 Q. If it isn't, I'd appreciate that, if anybody -  
 18 CHAYTOR, Q.C.:  
 19 Q. It's not attached to this.  
 20 MS. JONES:  
 21 A. It's not attached to this, but this is -  
 22 CHAYTOR, Q.C.:  
 23 Q. It may be elsewhere (inaudible).  
 24 THE COMMISSIONER:  
 25 Q. Mr. Simmons, can we ask that you get us a copy

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1 of that?  
 2 MR. SIMMONS:  
 3 Q. No problem.  
 4 THE COMMISSIONER:  
 5 Q. Do you wish to see it before you ask the  
 6 further question?  
 7 MR. BROWNE:  
 8 Q. No, no, actually, I would just like it in  
 9 terms of the framework of the answer that it  
 10 may sort of make it a little bit easier to  
 11 understand.  
 12 MS. JONES:  
 13 A. Yes.  
 14 THE COMMISSIONER:  
 15 Q. Sure, yes. Well, I think Mr. Simmons is going  
 16 to arrange for us to get it, if I catch that  
 17 nod over there, Mr. Simmons?  
 18 MR. SIMMONS:  
 19 Q. Yes.  
 20 MR. BROWNE:  
 21 Q. Thank you, Mr. Simmons.  
 22 MS. JONES:  
 23 A. You don't want my written up copy.  
 24 MR. BROWNE:  
 25 Q. I hate to impose on you, but I will ask for

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1 that. And lastly, I just want to go and deal  
 2 with sort of the patient safety initiatives,  
 3 and I want to sort of ask some questions  
 4 regarding at the grass root level. Is there  
 5 any type of system within Eastern Health,  
 6 created within Eastern Health, at sort of the  
 7 bottom, at the bottom level, for staff, and it  
 8 could be anybody, it could be a janitor or it  
 9 could be a nurse, it could be a technician, it  
 10 could be a physician, to make positive  
 11 suggestions on patient safety initiatives? If  
 12 they see something that happens, say for  
 13 instance, a suggestion box -  
 14 MS. JONES:  
 15 A. Have an idea, I have an idea.  
 16 MR. BROWNE:  
 17 Q. They have an idea. Are those things--are  
 18 those sort of things in place?  
 19 MS. JONES:  
 20 A. In legacy organizations and including the  
 21 Health Care Corporation of St. John's, we had  
 22 "I have an idea" programs and occasionally, we  
 23 would do, through our newsletters, you know, a  
 24 contest and bring forward your issues and your  
 25 ideas. So yes, those things happened.

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1 MR. BROWNE:  
 2 Q. But are they directed strictly or specifically  
 3 toward patient safety?  
 4 MS. JONES:  
 5 A. When there is focus in education, patient  
 6 safety week, you would see activities such as  
 7 that to jog people's memory on those kinds of  
 8 things. So we don't do it throughout 365 days  
 9 of the year.  
 10 MR. BROWNE:  
 11 Q. And that was my question.  
 12 MS. JONES:  
 13 A. No, but we absolutely do those kinds of things  
 14 in terms of focused activities so that you can  
 15 create more momentum around a particular  
 16 issue, and patient safety week is a good  
 17 example of that because there's lots of  
 18 activities that go on throughout the entire  
 19 organization, in all sectors of the  
 20 organization, to raise awareness and to get  
 21 ideas around patient safety.  
 22 MR. BROWNE:  
 23 Q. As well, and this may not be sort of a  
 24 practical suggestion, but in terms again, at  
 25 the lower departmental levels, is there any

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1 sort of system in place for potentially a ten-  
 2 minute meeting once a month for people to come  
 3 forward with ideas and then put them up  
 4 through the chain of command?  
 5 MS. JONES:  
 6 A. Not regularly in every single, but we do have  
 7 just--and I wouldn't say 100 percent of our  
 8 departments have staff meetings and that that  
 9 would--where those kinds of things would be  
 10 brought forward and suggested and things like  
 11 that, but if you're talking about taking a  
 12 break ten minutes in one hour in a month or  
 13 whatever to do that, there isn't a formal  
 14 program like that.  
 15 MR. BROWNE:  
 16 Q. Thank you. I appreciate all that.  
 17 MS. JONES:  
 18 A. Thank you, Mr. Browne.  
 19 THE COMMISSIONER:  
 20 Q. Always somebody who just tries to -  
 21 MR. BROWNE:  
 22 Q. Well, there you go, try to steal the show.  
 23 THE COMMISSIONER:  
 24 Q. Before you leave, Mr. Browne, because I wanted  
 25 to ask a question regarding the Canadian

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1 Patient Safety Initiative, just in case  
 2 something arises out of my question. Mr.  
 3 Browne has taken you through a number of  
 4 definitions saying is that your understanding,  
 5 etcetera.  
 6 MS. JONES:  
 7 A. Yes.  
 8 THE COMMISSIONER:  
 9 Q. Now this is a relatively new document?  
 10 MS. JONES:  
 11 A. Yes.  
 12 THE COMMISSIONER:  
 13 Q. Has your organization adopted it as yours?  
 14 MS. JONES:  
 15 A. This document, there is not a lot of changes  
 16 from some of the guidelines that were earlier  
 17 and a lot of the definitions that are in there  
 18 come from Canadian Patient Safety work that  
 19 was done in the late 1990s, into the early  
 20 2000, so you would see them consistent in the  
 21 earlier document that we had in 2004 and '05.  
 22 As well -  
 23 THE COMMISSIONER:  
 24 Q. Which is still operative, is it?  
 25 MS. JONES:



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1 A. Well, the disclosure document is a new one of  
 2 August of this year, but the principles would  
 3 be consistent. Our quality department, in  
 4 terms of root cause analysis and FMEAs we  
 5 talked about yesterday.  
 6 THE COMMISSIONER:  
 7 Q. The long and short of what I'm trying to get  
 8 to is that my understanding is that this  
 9 document, being as new as it is, would not  
 10 have been yet--and you can correct me, adopted  
 11 by the organization as your policy.  
 12 MS. JONES:  
 13 A. No, but the earlier one was.  
 14 THE COMMISSIONER:  
 15 Q. My second question is if there is something  
 16 which is not defined in your document -  
 17 MS. JONES:  
 18 A. Yes.  
 19 THE COMMISSIONER:  
 20 Q. Can I take that definition as what you would  
 21 have interpreted it to be or should I go back  
 22 to the earlier document?  
 23 MS. JONES:  
 24 A. I think that there are not many changes, in  
 25 the ones that you went through, they really

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1 have not had any fundamental changes in those  
 2 definitions.  
 3 THE COMMISSIONER:  
 4 Q. But should I go to the current document or go  
 5 back the old document on which you have been  
 6 operating on -  
 7 MS. JONES:  
 8 A. Current document.  
 9 THE COMMISSIONER:  
 10 Q. - to determine what the definition is.  
 11 MS. JONES:  
 12 A. Current document.  
 13 THE COMMISSIONER:  
 14 Q. So while you haven't adopted it, you're using  
 15 the definition in the current document, which  
 16 maybe the same as before, but may have some  
 17 changes.  
 18 MS. JONES:  
 19 A. May have some changes.  
 20 THE COMMISSIONER:  
 21 Q. So if there are changes, you're going under  
 22 the new one?  
 23 MS. JONES:  
 24 A. We'll move to the new one because -  
 25 THE COMMISSIONER:

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1 Q. You will move.  
 2 MS. JONES:  
 3 A. We will move and we've looked at -  
 4 THE COMMISSIONER:  
 5 Q. But have not yet done so.  
 6 MS. JONES:  
 7 A. - we've looked at our document now on  
 8 disclosure and realized that it is consistent  
 9 with this document. We had seen the draft  
 10 documents on this, this has been in works for  
 11 well over a year.  
 12 THE COMMISSIONER:  
 13 Q. Yes, I understand that.  
 14 MS. JONES:  
 15 A. So we were working with that.  
 16 THE COMMISSIONER:  
 17 Q. Okay. I'm still not understanding though if  
 18 I--maybe that won't be a problem, maybe you're  
 19 correct in that everything will line up  
 20 nicely, but if there are any conflicts in  
 21 definitions, I'd presumably go to the old  
 22 definition and not the new one because you as  
 23 yet have not adopted this formally, although  
 24 you may be doing so in the short order.  
 25 MS. JONES:

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1 A. That's right and we would not adopt a document  
 2 like this in its entirety, we would use parts  
 3 of it to form our policy and we'd use it as  
 4 background work, in terms of reference points.  
 5 If you notice our new policies, there is  
 6 reference points on all of it, references for  
 7 where we have taken individual definitions and  
 8 that in our new way that we do policy format  
 9 inside of Eastern Health. So there's always a  
 10 reference point of where we got the definition  
 11 from.  
 12 THE COMMISSIONER:  
 13 Q. Okay, thank you.  
 14 MR. BROWNE:  
 15 Q. Nothing arising, Commissioner, thank you.  
 16 THE COMMISSIONER:  
 17 Q. Thank you, Mr. Browne. I'm sorry, I always  
 18 get the order wrong, Ms. O'Dea?  
 19 MS. O'DEA:  
 20 Q. We have no questions, thank you.  
 21 THE COMMISSIONER:  
 22 Q. Thank you. Ms. Newbury.  
 23 MS. LOUISE JONES, CROSS-EXAMINATION BY MS. JENNIFER  
 24 NEWBURY  
 25 MS. NEWBURY:

1 Q. Good afternoon, Ms. Jones.  
 2 MS. JONES:  
 3 A. Good afternoon.  
 4 MS. NEWBURY:  
 5 Q. Jennifer Newbury, appearing for the Canadian  
 6 Cancer Society, Newfoundland and Labrador  
 7 division. First of all, there's several  
 8 exhibits that I would like to have entered.  
 9 THE COMMISSIONER:  
 10 Q. Yes.  
 11 MS. NEWBURY:  
 12 Q. P-0785 through to P-0789.  
 13 THE COMMISSIONER:  
 14 Q. Okay, P-0785 to P-0789 inclusive entered.  
 15 EXHIBITS ENTERED AND MARKED P-0785 TO P-0789 INCLUSIVE  
 16 MS. NEWBURY:  
 17 Q. Thank you. Ms. Jones, I'd like to ask you  
 18 some questions about, starting with the  
 19 positivity rates that you referred to in your  
 20 evidence. And I think generally, as I  
 21 understood your evidence, that you had  
 22 indicated that there's lots of research going  
 23 on around the issue of positivity rates and  
 24 that you know that we, I take that to mean  
 25 Eastern Health, had called around the country

1 weren't looking at that in the long haul.  
 2 MS. NEWBURY:  
 3 Q. So basically if you look at all ER/PR testing  
 4 for breast cancer without taking, you know, a  
 5 specific type lobular carcinoma or any other  
 6 type of breast cancer, you would look at the  
 7 broad group and on an annual basis see what  
 8 the positivity rate is for that particular  
 9 year?  
 10 MS. JONES:  
 11 A. You really need to talk to the pathologists on  
 12 that because that becomes part of the thing  
 13 that they actually are starting to look at,  
 14 what were our positivity rates over a period  
 15 of time. So they can provide you with much  
 16 more example of how they use those, but what  
 17 we were interested in because there was a  
 18 question, was are you even looking at them.  
 19 MS. NEWBURY:  
 20 Q. Okay.  
 21 MS. JONES:  
 22 A. And then we made those phone calls across the  
 23 country and realized that many people weren't  
 24 looking at them from a trending perspective.  
 25 MS. NEWBURY:

1 and nobody was collecting positivity rates at  
 2 that time. First of all, can you explain what  
 3 that means, you know, the purpose of  
 4 positivity rates and what exactly that  
 5 involves?  
 6 MS. JONES:  
 7 A. Well I think what was being questioned earlier  
 8 on was did we know what percentages of our  
 9 ER/PR tests were positive and there was some  
 10 indication that we should have known that over  
 11 a period of time and looked at the trends over  
 12 time. So there was some work done in the  
 13 summer of 2005 by one of our quality people to  
 14 call across to a number of areas across the  
 15 country to ask labs in fact did they have that  
 16 as part of a quality control or quality  
 17 assurance process inside of their  
 18 organization, and generally there is a  
 19 document that was produced and I don't know if  
 20 it's here in your set of documents at this  
 21 point in time yet, that gave us a listing of  
 22 which ones were actually indicating that they  
 23 were reporting or tending those rates. And it  
 24 wasn't, you know, it wasn't like every or in  
 25 seventy-five percent or whatever, they really

1 Q. And that was, again, I just want to  
 2 understand, I'll obviously ask the pathologist  
 3 or commission counsel will ask the pathologist  
 4 in detail what that means, but your  
 5 understanding of the calls that were made  
 6 across the country, it related to the entire  
 7 testing breast cancer for ER/PR.  
 8 MS. JONES:  
 9 A. Entire group, that's right.  
 10 MS. NEWBURY:  
 11 Q. And all of those calls were completed in the  
 12 summer of 2005?  
 13 MS. JONES:  
 14 A. I think because there was some kind of a  
 15 report, July, August, as they were trying to  
 16 get a handle on this particular issue.  
 17 MS. NEWBURY:  
 18 Q. Okay. And to the best of your knowledge or  
 19 your understanding, other labs were not  
 20 collecting that information.  
 21 MS. JONES:  
 22 A. Were not doing it, yeah.  
 23 MS. NEWBURY:  
 24 Q. Do you know how many labs were contacted or  
 25 what percentage -

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1 MS. JONES:  
 2 A. No, I have no idea, I have no recall. I  
 3 didn't read that report and it's just been,  
 4 you know, I do know that those calls were  
 5 made.  
 6 MS. NEWBURY:  
 7 Q. And do you know at the time that these calls  
 8 were made whether or not the caller requested  
 9 any other information, such as whether they  
 10 had any quality assurance programs, whether  
 11 they had any alternate methods of monitoring  
 12 the results or verifying results or to ask,  
 13 you know, how are you doing your ER/PR  
 14 testing?  
 15 MS. JONES:  
 16 A. You're going to really have to ask somebody  
 17 other in the organization, that would be  
 18 somebody in the quality area because they  
 19 actually did do that piece of work for Dr.  
 20 Williams.  
 21 MS. NEWBURY:  
 22 Q. So you were made aware that there were calls  
 23 about positivity?  
 24 MS. JONES:  
 25 A. Yes.

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1 MS. NEWBURY:  
 2 Q. But you weren't made aware of any other types  
 3 of questions that were made during those  
 4 calls?  
 5 MS. JONES:  
 6 A. I didn't ask about other types of questions.  
 7 MS. NEWBURY:  
 8 Q. And did you ask about positivity? That  
 9 information was relayed to you, you didn't ask  
 10 -  
 11 MS. JONES:  
 12 A. No.  
 13 MS. NEWBURY:  
 14 Q. Okay. So the only information that was  
 15 volunteered to you related to collecting or  
 16 calling around to see if people were  
 17 collecting positivity rates?  
 18 MS. JONES:  
 19 A. I think in terms of what was kind of done in  
 20 terms of this file and when I came into this  
 21 job, that was one of the pieces of information  
 22 we did calls early on, but that was two years  
 23 ago.  
 24 MS. NEWBURY:  
 25 Q. And that's basically a broad statistical tool,

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1 would that be fair to say, from -  
 2 MS. JONES:  
 3 A. I don't know if you'd call it a broad  
 4 statistical tool, to me it's, you know, if you  
 5 did 1000 and you had 70 percent of them that  
 6 were positive or 60 or whatever, what should  
 7 you expect in this lab and is that realistic,  
 8 I don't know if you'd call that stats, but it  
 9 may very well be.  
 10 MS. NEWBURY:  
 11 Q. But if you had, you know, for example, if you  
 12 found out what a positivity rate should be and  
 13 say the positivity rate should be 80 percent,  
 14 but your actual rate for that year, for  
 15 whatever reason, stats are stats.  
 16 MS. JONES:  
 17 A. Yes.  
 18 MS. NEWBURY:  
 19 Q. Your actual rates for that year might be 85  
 20 percent in reality.  
 21 MS. JONES:  
 22 A. Uh-hm.  
 23 MS. NEWBURY:  
 24 Q. And if you looked at your stats for the year,  
 25 you might see 75 percent and think, well 75,

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1 that's pretty close to 80, that's okay.  
 2 MS. JONES:  
 3 A. Uh-hm.  
 4 MS. NEWBURY:  
 5 Q. But you might actually have a 10 percent  
 6 difference.  
 7 MS. JONES:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. So it's a pretty blunt tool, is that fair to  
 11 say?  
 12 MS. JONES:  
 13 A. Yes, but not understanding what this means in  
 14 the context of the work that they do and the  
 15 quality assurance that is asked for.  
 16 MS. NEWBURY:  
 17 Q. So you don't know then why the focus was on  
 18 positivity rates?  
 19 MS. JONES:  
 20 A. No, no, as I said, I just know that they did  
 21 make calls around that because a question was  
 22 asked whether in fact we did monitor them.  
 23 MS. NEWBURY:  
 24 Q. Okay, I'd like to refer to exhibit P-0783,  
 25 please? This is the ethics consultation,

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1 there's several dates, this is the fax that  
 2 was sent to you.  
 3 MS. JONES:  
 4 A. Yes.  
 5 MS. NEWBURY:  
 6 Q. Now, generally in your evidence over the last  
 7 day or so, I understood that in terms of what  
 8 has lead to the problem with ER/PR testing  
 9 between 1997 and 2005, it's your conclusion  
 10 that there are many contributing factors, but  
 11 I think it was your understanding that there's  
 12 never been any conclusion on the particular  
 13 issue and that you can't say yet what the  
 14 actual cause -  
 15 MS. JONES:  
 16 A. On an individual patient basis what that  
 17 particular result, why there was a change in  
 18 that particular result on that particular day.  
 19 MS. NEWBURY:  
 20 Q. On a patient basis.  
 21 MS. JONES:  
 22 A. On a patient basis.  
 23 MS. NEWBURY:  
 24 Q. But can you, looking at the group -  
 25 MS. JONES:

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1 A. I think it's clear to say there's many  
 2 contributing factors, the reports, the  
 3 external review reports identified a number of  
 4 recommendations and when we talk about putting  
 5 all of those recommendations in, it would be  
 6 to make sure that everything that could  
 7 potentially maybe result in an issue has been  
 8 addressed. Okay, so there's no stone left  
 9 unturned and that we try to create a system  
 10 where there would not be any issues.  
 11 MS. NEWBURY:  
 12 Q. So that, as I understood your evidence, that  
 13 takes you forward, okay, we've got a problem,  
 14 we've got a couple of consultants coming into  
 15 the lab, they've give us our list of  
 16 recommendations, we're going to implement  
 17 those. Once we've done that, we're confident  
 18 that we can go ahead with the testing.  
 19 MS. JONES:  
 20 A. Uh-hm.  
 21 MS. NEWBURY:  
 22 Q. But whether five of those recommendations or  
 23 27 of those recommendations or all 52 of those  
 24 recommendations actually caused the problem,  
 25 you can't say -

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1 MS. JONES:  
 2 A. We can't say.  
 3 MS. NEWBURY:  
 4 Q. Okay. Now in the ethics consultation and you  
 5 referred to this yesterday.  
 6 MS. JONES:  
 7 A. Yes.  
 8 MS. NEWBURY:  
 9 Q. Under "Important facts to the history and  
 10 understanding of this case include the  
 11 following: there were no mistakes or  
 12 technical errors at the root of this problem."  
 13 And my question is if you can't say which of  
 14 those recommendations actually was at the root  
 15 of the problem, how can you be confident that  
 16 there were no mistakes or technical errors?  
 17 MS. JONES:  
 18 A. This is a document not written by myself, this  
 19 is one that you really do need to talk to the  
 20 individuals who were there, that was the  
 21 information that was provided. I hadn't seen  
 22 the reports or the technical reports and I  
 23 still don't know if ""A lined up with "B" and  
 24 the swiss cheese analogy that was used last  
 25 week, how that--how the actual issues

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1 happened. I think I clearly said last week or  
 2 in this week that there were issues and I  
 3 think Ms. Chaytor has already alluded to a 42  
 4 percent change in there is a false negative  
 5 rate, so there was something that was going on  
 6 in the lab or in the reading of the results of  
 7 whatever, but as to the exact cause, I don't  
 8 know if we'll ever know and I think I made  
 9 that comment yesterday as well.  
 10 MS. NEWBURY:  
 11 Q. Okay, I realize that you didn't write this  
 12 document and you weren't one of the  
 13 participants there -  
 14 MS. JONES:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. But I understand that based on your recent  
 18 activities regarding retesting of the deceased  
 19 and how you handled that in February of 2008,  
 20 you're still relying on this consultation, is  
 21 that fair to say?  
 22 MS. JONES:  
 23 A. I think that the consultation was, if we go to  
 24 it, what is the--it was around the deceased  
 25 and the families of the deceased. So we

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1 proceeded in a fashion consistent with this,  
 2 which was a notification in terms of a generic  
 3 notification.  
 4 MS. NEWBURY:  
 5 Q. Are you personally comfortable with that  
 6 statement, "there were no mistakes or  
 7 technical errors at the root of this problem"?  
 8 MS. JONES:  
 9 A. I--if you really look at that, I don't know  
 10 what the mistakes are or what the technical  
 11 errors are, I know there were issues in the  
 12 lab and I guess I would still say there were  
 13 issues in the lab or the reading of the tests  
 14 that caused a need for treatment changes for  
 15 clients.  
 16 MS. NEWBURY:  
 17 Q. There's three possibilities as I see it, you  
 18 could say there were mistakes or there were  
 19 technical errors or you could say that there  
 20 weren't mistakes or there weren't technical  
 21 errors, or you could say something in between,  
 22 I don't know which way, one or the other, are  
 23 you in that third category?  
 24 MS. JONES:  
 25 A. I don't know what the mistakes were, I don't

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1 know what the technical errors are, I don't  
 2 work in that lab. If I understood it, I would  
 3 may be able to say A plus B equals that error.  
 4 This particular issue was over a seven-year  
 5 period of time and I would expect that what we  
 6 saw in 2005 or 4, might have been entirely  
 7 different than 1997 or '98. So the whole idea  
 8 is that there was something, I'm not sure  
 9 individually on an actual case by case basis  
 10 what that might have been.  
 11 MS. NEWBURY:  
 12 Q. But can you stand behind that statement and I  
 13 know that you're not a technical person -  
 14 MS. JONES:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. I know that you can't speak to the pathology  
 18 or what have you, but you're the CEO and  
 19 you've been involved in disclosure to deceased  
 20 patients recently based on this consultation  
 21 and this consultation has, as background  
 22 information, there were no mistakes or  
 23 technical errors at the root of this problem.  
 24 And I'm wondering whether you, personally, an  
 25 stand behind that statement.

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1 MS. JONES:  
 2 A. I don't think that any of us can personally  
 3 stand behind this statement, but I would  
 4 suspect that the disclosure that went on with  
 5 the deceased patients, exactly the same  
 6 disclosure that we had with living patients  
 7 when we had to talk to them and when they were  
 8 asking the question what went on, we couldn't  
 9 actually say A, B, C or D, what went on with  
 10 your test because they were individual  
 11 disclosures and what happened on March 31st,  
 12 2007 verses April 1st of 2001 or 1997.  
 13 MS. NEWBURY:  
 14 Q. But that deals with the content of the  
 15 disclosure as opposed to do we disclose and if  
 16 so, how do we disclose, as opposed to what do  
 17 we disclose.  
 18 MS. JONES:  
 19 A. I'm not sure what the--what question you were  
 20 asking.  
 21 MS. NEWBURY:  
 22 Q. This consultation here, as I read it, the fact  
 23 that there were purportedly no mistakes or  
 24 technical errors -  
 25 MS. JONES:

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1 A. Yes.  
 2 MS. NEWBURY:  
 3 Q. - had some bearing on what the consultant said  
 4 at the end of the day.  
 5 MS. JONES:  
 6 A. How the consult played out, yes.  
 7 MS. NEWBURY:  
 8 Q. And my concern is, you know, do you stand  
 9 behind this statement and you've relied upon  
 10 this recently, I guess, do you have any  
 11 concerns, did you have any thoughts about  
 12 going back to do another ethical consultation  
 13 based on, you know, what you understand to be  
 14 the case.  
 15 MS. JONES:  
 16 A. Yeah, that didn't come forward in terms of  
 17 should we do another consultation about how we  
 18 move forward with this. And I didn't ask for  
 19 one.  
 20 MS. NEWBURY:  
 21 Q. And you've indicated a few minutes ago that  
 22 you don't know if anyone will ever be able to  
 23 say specifically which of the recommendations  
 24 or which of the activities in the lab caused  
 25 the problem. Do you know if there's actually

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1        been an effort by anyone at Eastern Health to  
 2        examine that?  
 3 MS. JONES:  
 4        A. I think that the external reviews and  
 5        everything that was commissioned over time to  
 6        ensure that the lab was meeting best standards  
 7        and what recommendations were all focused on  
 8        providing a quality care and a standard of  
 9        service that we could be safe and sure to go  
 10       forward on. When we started this, it was  
 11       what--it was always around was there care  
 12       changes or treatment changes for individual  
 13       clients, so I can't answer that question  
 14       whether in 2005 that that actually went  
 15       retrospective or as part of doing the reviews  
 16       there would be a number of issues that would  
 17       come forward that people would then say, okay,  
 18       because of all of this, this is what happened.  
 19       So individually did they say what happened and  
 20       I don't know whether you could have said  
 21       actually what happened over the seven years.  
 22       But what we've learned through that, through  
 23       the recommendations and that, is that if you  
 24       were to make a fail safe system, this is what  
 25       you need to do.

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1 MS. NEWBURY:  
 2        Q. Right, and that's more to address immediate  
 3        concerns and future concerns, as opposed to  
 4        let's have a look back and see where we went  
 5        wrong.  
 6 MS. JONES:  
 7        A. Yes.  
 8 MS. NEWBURY:  
 9        Q. No one has tried to say these are the  
 10       recommendations that led to this problem.  
 11 MS. JONES:  
 12       A. No.  
 13 MS. NEWBURY:  
 14       Q. They're just saying listen, you need to get  
 15       your lab up to scratch, here's your shopping  
 16       list.  
 17 MS. JONES:  
 18       A. And these are the things that on any one  
 19       individual issue we're not sure, but these are  
 20       the things and we've heard things such as  
 21       fixation and we've heard things such as  
 22       education and all of those things need to be  
 23       in place to assure that you're providing the  
 24       best quality.  
 25 MS. NEWBURY:

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1        Q. And to your knowledge, no one has looked back?  
 2 MS. JONES:  
 3        A. You'll have to ask the questions--nobody has  
 4        provided me with that information.  
 5 MS. NEWBURY:  
 6        Q. Okay. I'd like to refer to exhibit P-0046  
 7        please? So on the review under review of  
 8        cases there, Dr. Banerjee states, he has a few  
 9        comments there about retrospective testing.  
 10 MS. JONES:  
 11       A. Yes.  
 12 MS. NEWBURY:  
 13       Q. And he says, "I've reviewed a number of cases  
 14       from the retrospective testing set with Dr.  
 15       Donald Cook. All of the cases that had  
 16       converted from negative to positive by  
 17       switching platforms had one or more of the  
 18       following characteristics: poor fixation,  
 19       negative internal controls, normal ductal  
 20       epithelium when present was completely  
 21       negative, absent internal controls, no normal  
 22       ductal epithelium present to evaluate. It is  
 23       apparent that too much reliance is being  
 24       placed on external positive controls with no  
 25       attention paid to internal controls". And

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1        then down under conclusions about the reasons  
 2        for test failure which is on the next page,  
 3        page four, it states under Item No. 1, there's  
 4        a question, "is the DAKO system faulty? This  
 5        is unlikely as there are many laboratories  
 6        using the DAKO successfully. The reason for  
 7        test failure was most likely due to lack of  
 8        test optimization including antigen retrieval  
 9        method and antibody detection system titration  
 10       as positive controls showed weak staining in  
 11       general and the internal controls failed on  
 12       all of the negative cases". Down to item No.  
 13       3, there's a question, "is there a problem  
 14       with tissue fixation? There appears to be  
 15       inadequate attention paid by the grossing  
 16       pathologists to the thickness of tissue  
 17       slices, quality and adequacy of fixation and  
 18       there's no standardized fixation protocol that  
 19       everyone adheres to". And item number 4,  
 20       "inadequate or no attention is being paid by  
 21       the reporting pathologist to the status of  
 22       internal controls with inappropriately  
 23       exclusive reliance on external positive  
 24       controls". And he goes on in some detail  
 25       about that.

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1 MS. JONES:  
 2 A. Yes.  
 3 MS. NEWBURY:  
 4 Q. Now, can you say that that is not, in your  
 5 view or your understanding either technical  
 6 error or mistake?  
 7 MS. JONES:  
 8 A. I think that this lists a number of factors  
 9 that on an individual--you talk about the  
 10 negatives to positives. This lists a number  
 11 of things, it takes some things out of the  
 12 system which was, was DAKO or Ventana, which  
 13 was one of the initial questions and there is  
 14 some documentation that one was overpredicting  
 15 and one was underpredicting and you'll  
 16 probably hear that later on. So, it takes  
 17 some of those questions out of. It also adds  
 18 some questions around fixation and positive  
 19 and internal controls. And then if you marry  
 20 that with the technical report, there is a  
 21 whole bunch of issues around standard  
 22 operating procedures and documentation and  
 23 those kinds of things.  
 24 MS. NEWBURY:  
 25 Q. Okay, but do you consider these to be

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1 technical in nature, those items that I've  
 2 just read to you?  
 3 MS. JONES:  
 4 A. I guess if you work in this area, this would  
 5 be technical. I'm not a pathologist. Because  
 6 this references mostly what they do in their  
 7 work, what's an internal control; what's an  
 8 external control. Other than seeing it on a  
 9 slide because I've gone through the lab and  
 10 asked to see it, I guess this is way that they  
 11 do their work and if that's considered the  
 12 technical part, yes.  
 13 MS. NEWBURY:  
 14 Q. Okay. Now you had indicated yesterday that in  
 15 selecting the panel of people to attend at the  
 16 ethics consultation, the view was to having  
 17 the best information or the most accurate  
 18 information around the table.  
 19 MS. JONES:  
 20 A. Yes.  
 21 MS. NEWBURY:  
 22 Q. And I'm just wondering -  
 23 MS. JONES:  
 24 A. That's the standard practice when we put an  
 25 ethics consult together.

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1 MS. NEWBURY:  
 2 Q. I appreciate that but I just wonder if you  
 3 look at just that one small excerpt from Dr.  
 4 Banerjee's report as well as the long list of  
 5 recommendations that you're aware of and  
 6 compare that with that very that very brief  
 7 statement, "there were not mistakes or  
 8 technical errors at the root of this problem".  
 9 Whether you feel now, as CEO, that that was  
 10 really the best information or most accurate  
 11 information to provide to the consultant?  
 12 MS. JONES:  
 13 A. In this instance, the ethics people who were  
 14 there would have been relying on the  
 15 information that they had if that information,  
 16 and this is in 2006, so at least on the  
 17 pathologist side they would have been aware  
 18 and working on some of those things. So, you  
 19 would have to ask them their interpretation.  
 20 But if you talk about what these  
 21 recommendations are, the individuals were  
 22 there, would have known that why they use the  
 23 words, no mistakes or technical errors, I  
 24 don't know.  
 25 MS. NEWBURY:

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1 Q. But if you were to prepare the consultation  
 2 now, you wouldn't use that particular phrase,  
 3 would you, based on what you know?  
 4 MS. JONES:  
 5 A. Based upon this kind of information which I  
 6 would not have been party to and I would have  
 7 been relying on others, I necessarily would  
 8 not have been at that kind of a consultation  
 9 because it wouldn't have been an area unless I  
 10 was intimately involved in the issue that was  
 11 going on.  
 12 MS. NEWBURY:  
 13 Q. During your evidence regarding the general  
 14 framework or guidelines for ethics  
 15 consultation, you referred to a couple of  
 16 examples, food choices and gambling and I  
 17 don't want to go into detail about that, but  
 18 can you say whether or not there were  
 19 representatives of families or patients  
 20 themselves or community groups at either one  
 21 of those consultations?  
 22 MS. JONES:  
 23 A. I can't say specifically on those, the food  
 24 and the gambling. I would think that on the  
 25 more of the clinical consultations depending

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1 on what the issue was. And I'm not sure on  
 2 those.  
 3 MS. NEWBURY:  
 4 Q. Okay. Were those dealing with just one  
 5 specific patient or were they broader -  
 6 MS. JONES:  
 7 A. No, that was policy, direction and issues  
 8 around the old health care corporation of St.  
 9 John's. The gambling was pull tickets in the  
 10 gift shops and whether, in fact, that, from a  
 11 gambling perspective, as a health care  
 12 organization, we should have that activity  
 13 going on. So, that's the nature of that  
 14 particular one. And food choices was, should  
 15 the french fries and all of that kind of stuff  
 16 be sold in our cafeteria, especially with the  
 17 obesity rates.  
 18 MS. NEWBURY:  
 19 Q. Okay. Now, in terms of the testing of samples  
 20 for the deceased patients -  
 21 MS. JONES:  
 22 A. Yes.  
 23 MS. NEWBURY:  
 24 Q. - was it your understanding at the time of the  
 25 ethics consultation that the tested samples of

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1 deceased patients that was in their possession  
 2 had been, by happenstance, hadn't been  
 3 planned, it was just how it ended up.  
 4 MS. JONES:  
 5 A. Hadn't been planned, yes.  
 6 MS. NEWBURY:  
 7 Q. Okay. And are you aware whether prior to that  
 8 ethics consultation there had every been a  
 9 plan to eventually retest the samples of all  
 10 of the deceased patients?  
 11 MS. JONES:  
 12 A. I wouldn't be because at that point in time, I  
 13 wasn't close to the ER/PR file. And I think  
 14 it clearly says we found ourselves with  
 15 results for deceased patients as a result of  
 16 just pulling all of the files from that  
 17 particular point in time and sending them on  
 18 for retesting.  
 19 MS. NEWBURY:  
 20 Q. So, it was never made known to you that there  
 21 might have been, at some point in time, a plan  
 22 to test all of the deceased patient samples,  
 23 one -  
 24 MS. JONES:  
 25 A. No, that was in May of 2007 that Mr. Tilley

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1 made that determination.  
 2 MS. NEWBURY:  
 3 Q. Okay. And right up until this day, it's still  
 4 up to families of deceased patients to contact  
 5 eastern health -  
 6 MS. JONES:  
 7 A. Yes.  
 8 MS. NEWBURY:  
 9 Q. - for information. And since your press  
 10 release and your conference in February 2008,  
 11 that was February 22 or -  
 12 MS. JONES:  
 13 A. 22nd.  
 14 MS. NEWBURY:  
 15 Q. - and the release went out on the 21st, did  
 16 it?  
 17 MS. JONES:  
 18 A. I'm not sure. That may have been the press  
 19 release that was released on the 22nd when the  
 20 press conference with the minister was. But  
 21 the 22nd stays in my mind, but I was away that  
 22 week, and I think the 22nd is a Friday,  
 23 Thursday or Friday.  
 24 MS. NEWBURY:  
 25 Q. Okay. You indicated that you've received 60

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1 to 80 calls from family members.  
 2 MS. JONES:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. Has that all been since February 2008 or does  
 6 that include calls before that?  
 7 MS. JONES:  
 8 A. I can't--I just ask a question, how many  
 9 families of deceased have called and looking  
 10 for--and that may not be inclusive of the  
 11 people who had asked for the retesting or that  
 12 the oncologist had dealt with earlier on. So  
 13 it was 60 - 80 clients have since this, I had  
 14 understood, but it may very well be 60 - 80  
 15 total.  
 16 MS. NEWBURY:  
 17 Q. Okay.  
 18 MS. JONES:  
 19 A. I didn't ask for that real clarification.  
 20 MS. NEWBURY:  
 21 Q. Okay. And what is the rationale for not  
 22 actually going that extra step and notifying  
 23 the families directly of the retesting  
 24 results?  
 25 MS. JONES:



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1 A. I think it still lies in the consult that was  
 2 done. And you're asking if, in fact, we have  
 3 redone that consult based upon that and we  
 4 haven't. So, we had not gone down that road.  
 5 MS. NEWBURY:  
 6 Q. Okay. Now, is there anything in that  
 7 consultation--and if you want to go back to  
 8 have a look at it, is there anything there  
 9 that suggests that it would inappropriate to  
 10 directly contact the patients?  
 11 MS. JONES:  
 12 A. I don't know.  
 13 MS. NEWBURY:  
 14 Q. Or the patient's families or -  
 15 MS. JONES:  
 16 A. I don't know.  
 17 MS. NEWBURY:  
 18 Q. It's 0783.  
 19 MS. JONES:  
 20 A. It's still there.  
 21 MS. NEWBURY:  
 22 Q. If you want to scroll down and have a look.  
 23 MS. JONES:  
 24 A. There's nothing there that would be contrary  
 25 to it.

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1 MS. NEWBURY:  
 2 Q. Okay. And would you agree that since this  
 3 consultation, June of 2006, there has been  
 4 some other events transpiring? Number one,  
 5 the decision was made to take all of the  
 6 samples and send them off for retesting. So,  
 7 whereas in June of 2006 you had samples that  
 8 had been retested, not by plan, but by  
 9 circumstances.  
 10 MS. JONES:  
 11 A. Yes.  
 12 MS. NEWBURY:  
 13 Q. Whereas in February of 2008 when you did your  
 14 press release, you have now in your possession  
 15 all of the retested samples and that happened  
 16 due to a decision of Mr. Tilley, as we  
 17 understand. So, that's one of the differences  
 18 since June 2006.  
 19 MS. JONES:  
 20 A. Yes, it is.  
 21 MS. NEWBURY:  
 22 Q. And would you also agree that there's been a  
 23 fair amount of criticism, I guess. You've  
 24 mentioned in your May 23, 2007 executive  
 25 management meeting that there was a concern

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1 about public confidence in the system.  
 2 MS. JONES:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. And so there's a certain, I guess, criticism  
 6 by the public, you know, people calling to  
 7 open lines concerned about the transparency  
 8 and openness, I think, underlying that. And  
 9 would you also agree that there's been some  
 10 confusion about some of the issues, you know -  
 11 MS. JONES:  
 12 A. Absolutely, we've said that all along.  
 13 MS. NEWBURY:  
 14 Q. - staining versus ER/PR.  
 15 MS. JONES:  
 16 A. We use the words "misconcepts" today with the  
 17 media.  
 18 MS. NEWBURY:  
 19 Q. And that there have been missed results.  
 20 People have had results retested and have not  
 21 been contacted even recently.  
 22 MS. JONES:  
 23 A. Yes, yes.  
 24 MS. NEWBURY:  
 25 Q. Other people were never retested at all. So,

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1 there's a database issue as well.  
 2 MS. JONES:  
 3 A. And we've been clear to say that, yes.  
 4 MS. NEWBURY:  
 5 Q. And not everyone, even--aside from the  
 6 database issue and your inability to contact  
 7 the living patients directly, a lot of these  
 8 people, even though you've had announcements  
 9 out in the past have not called -  
 10 MS. JONES:  
 11 A. Called or come forward.  
 12 MS. NEWBURY:  
 13 Q. - and found out the results that way. So,  
 14 you've got that certain lack of comfort that  
 15 the family members will indeed get the  
 16 message, that they can contact eastern health.  
 17 That's if they actually understand it.  
 18 MS. JONES:  
 19 A. That's always an issue, yes.  
 20 MS. NEWBURY:  
 21 Q. Okay. So there's been no sort of re-  
 22 evaluation of those factors?  
 23 MS. JONES:  
 24 A. I'm not aware, though, and this is -- you  
 25 know, you asked the question, no, we didn't go

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1 back and go another ethics consult. We relied  
 2 on this and the direction or the suggestion  
 3 that had come out of it, but at the end of the  
 4 day I'm not aware of, and maybe there are  
 5 many, many examples in this country about  
 6 going back and contacting families of deceased  
 7 patients when the event is very far removed  
 8 from on a testing and retest basis, but that  
 9 is no excuse, I know, but I just not -- it  
 10 doesn't come to the top of my mind in thinking  
 11 about retesting or for clients as far back as  
 12 1997.

13 MS. NEWBURY:  
 14 Q. Okay, but even if you, you know, accept the  
 15 ethics consultation as it is, it doesn't  
 16 prevent you from contacting patients directly?

17 MS. JONES:  
 18 A. No, it doesn't prevent us.

19 MS. NEWBURY:  
 20 Q. So you could take that and you can refine it  
 21 and --

22 MS. JONES:  
 23 A. Yeah, and we made a decision in terms of how  
 24 to communicate and that decision I've talked  
 25 about here.

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1 MS. NEWBURY:  
 2 Q. I'd like to refer to Exhibit P-0745, please,  
 3 page 49 of that exhibit. This is the  
 4 accreditation report.

5 THE COMMISSIONER:  
 6 Q. Did you say page 40?

7 MS. NEWBURY:  
 8 Q. Page 49, please. Now goal area, number one,  
 9 culture, item #4, and you were referred to  
 10 this yesterday, so I won't go through that in  
 11 detail, but that deals with the policy  
 12 regarding disclosure of adverse events.

13 MS. JONES:  
 14 A. Yes.

15 MS. NEWBURY:  
 16 Q. And there are particular comments there  
 17 regarding the issue of disclosure to patients  
 18 whose breast cancer status had some changes.

19 MS. JONES:  
 20 A. Uh-hm.

21 MS. NEWBURY:  
 22 Q. And there's a simple statement there that this  
 23 was done as soon as new information was  
 24 available to the team and the patient had been  
 25 traced. Disclosure was conducted in an

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1 ethical and appropriate manner. Do you know  
 2 if the authors of the accreditation report  
 3 were made aware of issues that arose in the  
 4 disclosure process, such as patients who had  
 5 been retested, but not contacted; patients who  
 6 were missed in the initial retesting; the  
 7 repeated assurances of Eastern Health that  
 8 patients have been all contacted were later  
 9 proven to be unreliable, and also the issues  
 10 regarding the testing -- retesting of samples  
 11 deceased patients? Do you know if any of that  
 12 information was --

13 MS. JONES:  
 14 A. I wouldn't be aware because this would have  
 15 been inside. Most of this information  
 16 discussed inside of the cancer team  
 17 interviewer with individual clients that they  
 18 may have picked up information on.

19 MS. NEWBURY:  
 20 Q. Okay, and you had indicated as well that there  
 21 could be a self-assessment report, some  
 22 documentation sent to the accreditors in  
 23 advance?

24 MS. JONES:  
 25 A. Yes.

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1 MS. NEWBURY:  
 2 Q. And who would be the person who could obtain  
 3 any such documentation?

4 MS. JONES:  
 5 A. That documentation would be in our -- in our  
 6 hands in terms of documents that we prepared  
 7 to send to accreditation and then the  
 8 accreditors use them as part of moving forward  
 9 and developing their question lines and what  
 10 they wanted to view when they came inside of  
 11 Eastern Health.

12 MS. NEWBURY:  
 13 Q. Okay. So you would have access to that  
 14 information?

15 MS. JONES:  
 16 A. Yes.

17 MS. NEWBURY:  
 18 Q. Okay, I wonder if it would be possible to get  
 19 that information?

20 MS. JONES:  
 21 A. On which team? We have --

22 MS. NEWBURY:  
 23 Q. That would -- the two areas that are of  
 24 interest would be the one dealing with the  
 25 breast cancer disclosure.

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1 MS. JONES:  
 2 A. The required organizational practises are  
 3 across the entire organization, so there's no  
 4 documentation on this. The answer that I just  
 5 gave you was where did the people get the  
 6 information. It may very well have been in  
 7 discussion with the team, and there is no  
 8 minutes of the team's discussion, but there  
 9 would be a completion of the standards for  
 10 cancer care that would have gone through. So  
 11 that information would be available, and this  
 12 report actually has what council has reported  
 13 back in terms of their assessment. So cancer  
 14 care team, for sure there would be  
 15 documentation around what they answered or how  
 16 they scaled themselves, but there is no  
 17 documentation around -- there is an evidence  
 18 binder, but being that this is a generic  
 19 implement of formal transparent policy and  
 20 process for disclosure of adverse events,  
 21 individual disclosures wouldn't be in it, but  
 22 a policy and the work that we had done around  
 23 the education. So that would be the  
 24 information that would be in that kind of a --  
 25 what we would call an evidence binder. I

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1 would suggest, based upon interviews with the  
 2 cancer care team, that -- I'm not sure what  
 3 the discussion would be, but what the cancer  
 4 care team had sent forward as part of their  
 5 documentation about how they responded to  
 6 particular standards, that is available.  
 7 MS. NEWBURY:  
 8 Q. Okay. So you're confident that there are no  
 9 documents provided to the surveyors --  
 10 MS. JONES:  
 11 A. No.  
 12 MS. NEWBURY:  
 13 Q. That specifically related to the disclosure  
 14 regarding the ER/PR issue.  
 15 MS. JONES:  
 16 A. ER/PR. I wouldn't be as specific as that. It  
 17 would have been in their interview process  
 18 that they would have asked questions.  
 19 MS. NEWBURY:  
 20 Q. And do you know if there were any focus groups  
 21 on this particular issue that would have  
 22 captured either, you know, as a small focus  
 23 group or part of a larger focus group, the  
 24 issue of disclosure on ER/PR?  
 25 MS. JONES:

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1 A. No, not on ER/PR. There were focus groups  
 2 with clients all throughout the organization,  
 3 but I'm -- I can't answer you whether, in  
 4 fact, there was a focus group that had -- I  
 5 would think that inside of the client focus  
 6 group, which is the way we call it inside of  
 7 accreditation, there may have been cancer  
 8 patients. Were they ones that had issues of  
 9 ER/PR, I have no idea at this point.  
 10 MS. NEWBURY:  
 11 Q. Okay, and who selects the participants for  
 12 focus groups?  
 13 MS. JONES:  
 14 A. The participants for focus groups is really --  
 15 sometimes it's a call to patients who are  
 16 known to us, like in our Advisory Committee on  
 17 Mental Health, and we will ask for volunteers  
 18 to come forward, or people who have access to  
 19 multiple parts of our service that are willing  
 20 to come and sit in a group setting.  
 21 MS. NEWBURY:  
 22 Q. Now it's my understanding that the Canadian  
 23 Cancer Society, who is considered to be a  
 24 community partner --  
 25 MS. JONES:

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1 A. Yes.  
 2 MS. NEWBURY:  
 3 Q. Was not invited to participate in any focus  
 4 group as part of this recent accreditation?  
 5 MS. JONES:  
 6 A. A stakeholder, yeah.  
 7 MS. NEWBURY:  
 8 Q. I don't think you knew one way or the other --  
 9 MS. JONES:  
 10 A. No, I didn't know one way or the other.  
 11 MS. NEWBURY:  
 12 Q. There will ultimately be evidence on this.  
 13 MS. JONES:  
 14 A. Um.  
 15 MS. NEWBURY:  
 16 Q. Now this accreditation report, 2007, it  
 17 follows on -- I guess the one prior to that  
 18 would have been 2004.  
 19 MS. JONES:  
 20 A. '04.  
 21 MS. NEWBURY:  
 22 Q. So between 2004 and 2007 you've got three key  
 23 years; 2005, 2006, 2007, where ER/PR issue  
 24 has, I would suggest, remained a top clinical  
 25 issue for Eastern Health.

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1 MS. JONES:  
 2 A. Yes, um.  
 3 MS. NEWBURY:  
 4 Q. And, if anything, the significance of this  
 5 issue or the importance of the issue to  
 6 Eastern Health intensified in 2007.  
 7 MS. JONES:  
 8 A. Um.  
 9 MS. NEWBURY:  
 10 Q. To the point that the inquiry was called.  
 11 MS. JONES:  
 12 A. Yes.  
 13 MS. NEWBURY:  
 14 Q. And throughout this process, the Canadian  
 15 Cancer Society has been probably the primary  
 16 community partner engaged in the ER/PR issue  
 17 throughout each of those years, and would you  
 18 expect in those circumstances that the  
 19 participation of such a community partner in a  
 20 focus group would have added an important  
 21 perspective to the work of the surveyors?  
 22 MS. JONES:  
 23 A. It could very well be that that is a  
 24 particular perspective, but in putting  
 25 together focus groups, and I didn't kind of

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1 have -- you know, say that we had the  
 2 Government and whatever, there are multiple  
 3 stakeholders across the organization, and  
 4 there's a limited number of people who can be  
 5 involved, so --  
 6 MS. NEWBURY:  
 7 Q. I realize that, that there are probably lots  
 8 of people who'd be interested in coming --  
 9 MS. JONES:  
 10 A. Yes.  
 11 MS. NEWBURY:  
 12 Q. And participating in a focus group, but this  
 13 is a key area.  
 14 MS. JONES:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. It's probably your top one, two, three  
 18 clinical issue for each of those years.  
 19 MS. JONES:  
 20 A. Yes.  
 21 MS. NEWBURY:  
 22 Q. Would you not agree that it's probably an  
 23 omission not to have invited someone from the  
 24 Canadian Cancer Society to present?  
 25 MS. JONES:

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1 A. It could very well be. You know, if you were  
 2 to look down that list, and would it have  
 3 jumped out at me on the page if I saw the  
 4 list, probably not as I'm looking across all  
 5 the sectors, but I respect the point that  
 6 you're making.  
 7 MS. NEWBURY:  
 8 Q. Now in some questions earlier this morning,  
 9 you were asked about Peter Dawe and his role  
 10 on behalf of the Canadian Cancer Society in  
 11 dealing with the media.  
 12 MS. JONES:  
 13 A. Um.  
 14 MS. NEWBURY:  
 15 Q. And I understood your evidence that they could  
 16 often get Peter Dawe because he could respond  
 17 quickly.  
 18 MS. JONES:  
 19 A. Right.  
 20 MS. NEWBURY:  
 21 Q. Whereas Eastern Health has, I guess, a more  
 22 cumbersome protocol to follow in terms of  
 23 getting the information and lining someone up  
 24 to do it.  
 25 MS. JONES:

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1 A. Um.  
 2 MS. NEWBURY:  
 3 Q. Do you know for sure whether there were ever  
 4 an occasion that Eastern Health in response to  
 5 a media request pertaining to the ER/PR  
 6 issues, you know, went out, looked for a  
 7 physician who could speak intelligently about  
 8 the issues, but by the time the arrangements  
 9 were made for that physician to be the  
 10 spokesperson, it was too late and the media  
 11 were no longer interested? Did that ever  
 12 happen?  
 13 MS. JONES:  
 14 A. I can't respond because I wasn't there in the  
 15 frontline making the decisions on who at that  
 16 point. No, I can't answer that.  
 17 MS. NEWBURY:  
 18 Q. Okay. Now I understood from your evidence  
 19 earlier this morning that Peter Dawe, Canadian  
 20 Cancer Society, might have beaten Eastern  
 21 Health to it --  
 22 MS. JONES:  
 23 A. The media would be calling many people and  
 24 they would be doing their interviews and  
 25 lining them up.

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1 MS. NEWBURY:  
 2 Q. Sure, and --  
 3 MS. JONES:  
 4 A. Right.  
 5 MS. NEWBURY:  
 6 Q. Would you expect that if Eastern Health, even  
 7 if Peter Dawe did an interview on a Monday --  
 8 MS. JONES:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. That if Eastern Health managed to get a  
 12 physician who was willing and able to talk to  
 13 the issues, that the media would be more than  
 14 willing to speak with that physician Tuesday  
 15 or Wednesday?  
 16 MS. JONES:  
 17 A. It depends on the news cycle because sometimes  
 18 the issue -- they're on to another new issue,  
 19 and sometimes they would and sometimes they  
 20 wouldn't. It depended on what they were  
 21 looking for on that particular day.  
 22 MS. NEWBURY:  
 23 Q. Okay, but this issue has been a fairly  
 24 constant issue throughout 2005 up until 2008?  
 25 MS. JONES:

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1 A. Yes, absolutely.  
 2 MS. NEWBURY:  
 3 Q. Earlier this morning, you mentioned that  
 4 there's a clinical epidemiologist from Health  
 5 Canada now at Eastern Health?  
 6 MS. JONES:  
 7 A. Yes.  
 8 MS. NEWBURY:  
 9 Q. Could you explain what that individual is  
 10 doing?  
 11 MS. JONES:  
 12 A. It is really -- it was some kind of an  
 13 agreement that we made in the fall of the  
 14 year, that it was like a regional position  
 15 looking at surveillance for communicable  
 16 diseases probably just in Newfoundland, but it  
 17 could be Atlantic Canada. I'm not really sure  
 18 of the details, but I do remember it being  
 19 brought to Executive to say that as  
 20 communicable disease and the Public Health  
 21 Agency of Canada were putting resources across  
 22 the country, that Newfoundland was able to  
 23 secure an individual and that individual would  
 24 be housed inside of Eastern Health.  
 25 MS. NEWBURY:

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1 Q. Okay. I don't know that much about medicine,  
 2 but would that not include cancer,  
 3 communicable diseases?  
 4 MS. JONES:  
 5 A. The focus for this individual, it really is  
 6 that that person is just housed inside, but is  
 7 directed by the Public Health Agency of  
 8 Canada.  
 9 MS. NEWBURY:  
 10 Q. So they in all likelihood would have nothing  
 11 to do with cancer, monitoring of cancer?  
 12 MS. JONES:  
 13 A. No, no, no. They're mandate is delivered by a  
 14 different agency.  
 15 MS. NEWBURY:  
 16 Q. Okay, and I want to refer again to Exhibit  
 17 0743, please, and page five of that exhibit.  
 18 There's a referenced there to -- under Item  
 19 #1, under the heading "Moving Forward".  
 20 MS. JONES:  
 21 A. Yes.  
 22 MS. NEWBURY:  
 23 Q. A new team, including a clinical  
 24 epidemiologist and a bio-statistician.  
 25 MS. JONES:

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1 A. Yes.  
 2 MS. NEWBURY:  
 3 Q. And they would work to assist in the  
 4 developing of the framework so that new  
 5 modules are not only user friendly, but are  
 6 maximized with respect to their ability to  
 7 extract data in the future.  
 8 MS. JONES:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. Each team would also educate -- work to  
 12 educate clinicians and to migrate the  
 13 organization to the new system.  
 14 MS. JONES:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. Is that a temporary or permanent position?  
 18 MS. JONES:  
 19 A. In terms of the resources, those people that  
 20 you would see there would be -- would be part  
 21 of number three, which is the decision support  
 22 people, bio-statisticians and --  
 23 MS. NEWBURY:  
 24 Q. Right.  
 25 MS. JONES:

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1 A. So they would be permanent. What we were  
 2 looking for was permanent resources that would  
 3 work on multiple projects and to assist, and  
 4 in this instance if we had those resources and  
 5 those skills, it would absolutely improve our  
 6 ability to make those modules, redevelop them,  
 7 and put them on a single platform the best  
 8 that -- whatever we could get out of them,  
 9 they would have had the skills to be able to  
 10 tease that out. So as we migrated them, we  
 11 had the best that we could.

12 MS. NEWBURY:  
 13 Q. Okay. Now that description there under Item  
 14 #1, it sounds like the start up description of  
 15 that person's job, developing the framework.  
 16 Once the framework has been developed --

17 MS. JONES:  
 18 A. Yes.

19 MS. NEWBURY:  
 20 Q. What role would the epidemiologist or bio-  
 21 statistician have?

22 MS. JONES:  
 23 A. Yes, that would be -- they would be really --  
 24 in terms of the number three item here, which  
 25 is decision support framework, and

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1 consolidating people into a decision support  
 2 department for the entire organization, and in  
 3 that context they would have a framework in  
 4 which they would work, and how they do their  
 5 work, what kind of projects they would be  
 6 involved in, and what kind of skills they  
 7 would bring to projects.

8 MS. NEWBURY:  
 9 Q. And would they have any role in monitoring of  
 10 cancer data, per se?

11 MS. JONES:  
 12 A. Eventually, when you look at the decision  
 13 support in that, those skills could be used  
 14 across multiple parts of the organization.

15 MS. NEWBURY:  
 16 Q. Okay. So not just for cancer, but a number of  
 17 things?

18 MS. JONES:  
 19 A. A number of things.

20 MS. NEWBURY:  
 21 Q. Okay. You've referred a couple of times  
 22 during your evidence to redundancies being  
 23 built into the system and referred to the  
 24 swiss cheese model.

25 MS. JONES:

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1 A. Yes.

2 MS. NEWBURY:  
 3 Q. And would a redundancy include a quality  
 4 assurance person? Is that a type of a  
 5 redundancy built into the system?

6 MS. JONES:  
 7 A. It's some of the processes may in fact be a  
 8 person, okay, and it would be audits kind of  
 9 thing that that person would be involved.

10 MS. NEWBURY:  
 11 Q. Or quality assurance program is what -

12 MS. JONES:  
 13 A. Or quality assurance programs or somebody to  
 14 be able to tease out best evidence and those  
 15 kinds of things.

16 MS. NEWBURY:  
 17 Q. Okay. So redundancy would encompass a quality  
 18 assurance program. Does Eastern Health have a  
 19 pathologist position which includes, as part  
 20 of that person's job, requirements quality  
 21 assurance and monitoring, looking at the  
 22 outcomes of statistics, I guess, or data for  
 23 cancer patients?

24 MS. JONES:  
 25 A. I can't answer that question as specifically

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1 as you might need to ask that to Dr. Nash  
 2 Denic.

3 MS. NEWBURY:  
 4 Q. Dr. Denic, okay.

5 MS. JONES:  
 6 A. With the proficiency testing and the quality  
 7 assurance work that they've done in there, I'm  
 8 not sure what the exact details would be.

9 MS. NEWBURY:  
 10 Q. Are you aware of any discussion though on  
 11 that, either having had one in the past or  
 12 looking to have such a role in the future?

13 MS. JONES:  
 14 A. I can't answer that.

15 MS. NEWBURY:  
 16 Q. Okay. I just wanted to find out from you who  
 17 to ask about the patient navigator type of a  
 18 role. You indicated yesterday that you don't  
 19 have a good understanding of the role -

20 MS. JONES:  
 21 A. Yes.

22 MS. NEWBURY:  
 23 Q. - what would be encompassed in the duties of a  
 24 patient navigator. Is there anyone at Eastern  
 25 Health who would be more familiar with the

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1 concept of a patient navigator?  
 2 MS. JONES:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. Who?  
 6 MS. JONES:  
 7 A. It would be the program director for cancer  
 8 care, as well as Mrs. Pilgrim who sat with the  
 9 cancer control strategy and I know that that  
 10 has been discussed in that forum as well.  
 11 MS. NEWBURY:  
 12 Q. So in terms of names, Pat Pilgrim would be one  
 13 person. Is there any -  
 14 MS. JONES:  
 15 A. And Sharon Smith would be the other.  
 16 MS. NEWBURY:  
 17 Q. Sharon Smith, okay. And can you say whether  
 18 there's been any active consideration given by  
 19 Eastern Health to engaging a patient  
 20 navigator?  
 21 MS. JONES:  
 22 A. I can't say, and I don't remember it being in  
 23 the budget process, at least for this year.  
 24 MS. NEWBURY:  
 25 Q. Okay. Now Exhibit P-0075, please? Now this

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1 is a briefing note that you're probably not  
 2 familiar with, not having generated it.  
 3 MS. JONES:  
 4 A. No.  
 5 MS. NEWBURY:  
 6 Q. But I just wanted to refer you to a comment on  
 7 page three. If you look at the second  
 8 paragraph there. This is a briefing note, I  
 9 should show you from the beginning. It's a  
 10 chronology of events and it was prepared by  
 11 Eastern Health.  
 12 MS. JONES:  
 13 A. Okay, yes.  
 14 MS. NEWBURY:  
 15 Q. And starts at November--May 11th, 2005.  
 16 MS. JONES:  
 17 A. Okay.  
 18 MS. NEWBURY:  
 19 Q. And it was prepared July 20th, 2005.  
 20 MS. JONES:  
 21 A. Okay.  
 22 MS. NEWBURY:  
 23 Q. And on page three, if you look at the second  
 24 paragraph, "extra resources have been  
 25 identified within the Health Care Corporation

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1 of St. John's lab to undertake identification  
 2 and retesting. The list of patients will be  
 3 double checked with the names on the cancer  
 4 registry to ensure none have been missed." So  
 5 I just wanted to bring that to your attention.  
 6 MS. JONES:  
 7 A. Yes.  
 8 MS. NEWBURY:  
 9 Q. And were you aware that this double checking  
 10 of the cancer registry had ever happened?  
 11 MS. JONES:  
 12 A. I have no idea, because this is -  
 13 MS. NEWBURY:  
 14 Q. That's new to you, is it?  
 15 MS. JONES:  
 16 A. - this is two years--this information is two  
 17 years old.  
 18 MS. NEWBURY:  
 19 Q. Sure, okay. If I could refer to Exhibit P-  
 20 0785, please? Now this is another document  
 21 that you may not be familiar with. It's from  
 22 summer of 2005.  
 23 MS. JONES:  
 24 A. Yes.  
 25 MS. NEWBURY:

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1 Q. It's an e-mail from Heather Predham to Pamela  
 2 King Jesso, Deanne Emberly, David McCormick,  
 3 regarding the database.  
 4 MS. JONES:  
 5 A. Okay.  
 6 MS. NEWBURY:  
 7 Q. Now perhaps this came up during your  
 8 discussions with Department of Health and the  
 9 development of the database. You can't recall  
 10 this, can you?  
 11 MS. JONES:  
 12 A. No, this would not--we wouldn't have  
 13 referenced a memo, but is there--there might  
 14 be content in the memo, but I don't know.  
 15 MS. NEWBURY:  
 16 Q. Okay. I just want to refer you to some of the  
 17 comments made there under the heading  
 18 "database."  
 19 MS. JONES:  
 20 A. Yes.  
 21 MS. NEWBURY:  
 22 Q. And the original message here is actually from  
 23 Heather Predham to Dr. Williams, Dr. Cook,  
 24 Terry Gulliver and Patricia Pilgrim.  
 25 MS. JONES:

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1 A. Yeah, okay.  
 2 MS. NEWBURY:  
 3 Q. And under that heading "database" it says  
 4 "I've got the lab database and the NCRTRF  
 5 database combined, but I still have issues to  
 6 clarify. There are data quality issues such  
 7 as people with the same name and address and  
 8 different MCP numbers and people with  
 9 different names and addresses -  
 10 MS. JONES:  
 11 A. But the same MCP.  
 12 MS. NEWBURY:  
 13 Q. - but with the same MCP.  
 14 MS. JONES:  
 15 A. That's right.  
 16 MS. NEWBURY:  
 17 Q. Also, there are a lot of individuals with  
 18 incomplete MCP numbers. I'll work on that  
 19 today."  
 20 MS. JONES:  
 21 A. Yes.  
 22 MS. NEWBURY:  
 23 Q. Down at the next paragraph, "there are a  
 24 couple of issues that came to light through  
 25 during this process," and if you look down to

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1 bullet number three, "rough numbers from the  
 2 combined database show 4,510 people overall.  
 3 The cancer registry does not identify almost  
 4 2100 of individuals who had ER/PR testing.  
 5 Current status, living or deceased, is only  
 6 identified in 1245 of those people. It's  
 7 going to be difficult to determine this for  
 8 the rest of the individuals. ER/PR status is  
 9 indicated in 1230 people with an overall  
 10 positivity rate of 55 percent. Overall  
 11 positivity rate by year, and remember this is  
 12 rough, is 2003 61 percent, 2002 48 percent,  
 13 and 2001 46 percent. (The cancer registry  
 14 only indicates P and N, not percentage)."  
 15 MS. JONES:  
 16 A. I guess that's positive and negative, I'm  
 17 thinking.  
 18 MS. NEWBURY:  
 19 Q. Okay. Are you aware, even if you're not aware  
 20 of this e-mail in particular, are you aware of  
 21 any issues with the cancer registry and the  
 22 fact that here, it didn't identify a number of  
 23 individuals who had ER/PR testing and of the  
 24 individuals that had been identified, they  
 25 didn't indicate the current status, whether

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1 they were living or deceased?  
 2 MS. JONES:  
 3 A. I have no idea about the cancer registry.  
 4 Haven't had any discussion around the cancer  
 5 registry. It hasn't been brought to my  
 6 attention in the time I've been here.  
 7 MS. NEWBURY:  
 8 Q. And who at Eastern Health would be responsible  
 9 for the cancer registry? That is something  
 10 that is under the -  
 11 MS. JONES:  
 12 A. It's housed in Eastern Health and it would  
 13 have been in the old--it's listed here as the  
 14 NCRTRF, so it would have been inside of our  
 15 cancer program.  
 16 MS. NEWBURY:  
 17 Q. Okay.  
 18 MS. JONES:  
 19 A. And I'm not sure how information gets to the  
 20 cancer registry or how it's logged in the  
 21 registry or even if there's mandatory  
 22 registration or mandatory reporting to the  
 23 cancer registry.  
 24 MS. NEWBURY:  
 25 Q. And who at Eastern Health would I ask to get

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1 that information?  
 2 MS. JONES:  
 3 A. Probably Sharon Smith, because the program  
 4 director, the registry would be underneath, in  
 5 that program area.  
 6 MS. NEWBURY:  
 7 Q. Sharon Smith?  
 8 MS. JONES:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. And the people that work at the cancer  
 12 registry, the staff members, would they be  
 13 paid by Eastern Health?  
 14 MS. JONES:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. Employees of Eastern Health?  
 18 MS. JONES:  
 19 A. There is employees of Eastern Health. It was  
 20 one of the legacy boards that came into  
 21 Eastern Health.  
 22 MS. NEWBURY:  
 23 Q. I'd like to refer now to Exhibit P-0786. Now  
 24 this document, Canadian Cancer Statistics  
 25 2005, and if you scroll down to the bottom of



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1 the page there, it's produced by the Canadian  
 2 Cancer Society, the National Cancer Institute  
 3 of Canada, Statistics Canada,  
 4 provincial/territorial cancer registries and  
 5 the Public Health Agency of Canada.  
 6 MS. JONES:  
 7 A. Yes.  
 8 MS. NEWBURY:  
 9 Q. Are you familiar generally with this document?  
 10 MS. JONES:  
 11 A. No.  
 12 MS. NEWBURY:  
 13 Q. Okay. If I can go to page 26, please? On  
 14 page 26, the heading for this particular  
 15 section of the report is "geographic patterns  
 16 of cancer occurrence" and if you look at the  
 17 very first paragraph on that page, it says  
 18 "finally, there are differences in the  
 19 reporting procedures used in cancer  
 20 registration, eg. registration of second  
 21 primary cancers and use of death certificates,  
 22 see appendix 2 regarding cancer registry  
 23 methodology. For example, death certificate  
 24 information has not been available for  
 25 registry purposes in Newfoundland until now,

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1 and this falsely lowers the number of incident  
 2 cases with short life expectancy, such as  
 3 cases of lung and pancreatic cancer."  
 4 I'll refer now to page 98, please? And  
 5 this page states, at the very--this is the  
 6 appendix two that was referred to earlier.  
 7 MS. JONES:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. And it deals with methods, and the very first  
 11 paragraph says "for all cancers, even those  
 12 with poor survival, such as pancreas and lung,  
 13 the annual number of incident cases is  
 14 expected to be similar to or larger than the  
 15 number of deaths. However, there are  
 16 situations in which the number of deaths,  
 17 either observed or projected, is larger than  
 18 the corresponding number of new cases. In the  
 19 case of Newfoundland and Labrador, this is  
 20 caused by the registry not receiving  
 21 information on death certificates that mention  
 22 cancer. This results in an under estimate of  
 23 the number of cases for the years used to  
 24 generate the estimates. Once the Newfoundland  
 25 registry begins receiving information in order

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1 to register these cases, the difference will  
 2 disappear. Deaths may correspond to cases  
 3 diagnosed in previous years so a year-to-year  
 4 variation is also a factor for rare cancer  
 5 sites."  
 6 Now I don't propose to go through these  
 7 other documents, but I can say that the  
 8 information is very similar, even including  
 9 2008, and I'll just, for the benefit of the  
 10 people in the room, the next exhibit is 0787.  
 11 That's the Canadian Cancer Statistics for  
 12 2006, and there are similar references there  
 13 on page 23, the first full paragraph, starting  
 14 with the word "finally" and on page 101, the  
 15 first full paragraph again has a reference.  
 16 And the next exhibit is 0789, or sorry, 0788  
 17 and that's the Cancer Statistics for 2007.  
 18 MS. JONES:  
 19 A. Okay.  
 20 MS. NEWBURY:  
 21 Q. And the two relevant pages are 20 and 98, and  
 22 now if we go to the final of those exhibits,  
 23 0789, P-0789 for 2008, looking at, first of  
 24 all, page 18, under geographic patterns of  
 25 cancer occurrence, about halfway down the

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1 page, it says "issues that should be kept in  
 2 mind when interpreting interprovincial  
 3 variations." Bullet number two, "while the  
 4 completeness of registration of new cancer  
 5 cases is generally very good across the  
 6 country, there are exceptions. For example,  
 7 death certificate information has not been  
 8 available for registry purposes in  
 9 Newfoundland and Labrador and this falsely  
 10 lowers the number of newly diagnosed cases,  
 11 mainly among those cancers with a poor  
 12 prognosis, such as lung and pancreatic  
 13 cancer."  
 14 And on page 89, under the appendix two  
 15 methods, at the very bottom of the page, "for  
 16 all cancers, even those with poor survival,  
 17 such as pancreas and lung, the annual number  
 18 of incident cases is expected to be similar to  
 19 or larger than the number of deaths. However,  
 20 there are a number of--there are situations in  
 21 which the number of deaths, either observed or  
 22 projected, is larger than the corresponding  
 23 number of new cases. In the case of  
 24 Newfoundland and Labrador, this is caused by  
 25 the registry not receiving information on

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1 death certificates that mention cancer. The  
 2 limitation of not having access to death  
 3 certificates is greater for cancers with a  
 4 poor prognosis. This results in an under  
 5 estimate of the number of cases for the years  
 6 used to generate the estimates. Once the  
 7 Newfoundland and Labrador registry begins  
 8 receiving information in order to register  
 9 these cases, the difference will disappear."  
 10 So Ms. Jones, were you aware of these  
 11 apparent, I guess, deficiencies? It seems  
 12 that Newfoundland is the only one pointed out  
 13 to have that particular problem. You're not  
 14 aware of that?  
 15 MS. JONES:  
 16 A. I'm not aware of it, and it talks about here  
 17 in all of those that the registry is not  
 18 receiving death certificates, and I don't know  
 19 what process there is for death certificates,  
 20 what process that happens inside of  
 21 Newfoundland.  
 22 MS. NEWBURY:  
 23 Q. Right, but is that something that Eastern  
 24 Health would think would be important to look  
 25 into?

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1 MS. JONES:  
 2 A. Yes, but not understanding the registry, how  
 3 it's set up, is there mandatory reporting or  
 4 that, then that really needs to--those  
 5 questions need to be asked of who's providing  
 6 the information and why it's not being  
 7 provided.  
 8 MS. NEWBURY:  
 9 Q. It seems that Heather Predham, from her e-mail  
 10 back in August of 2005, had expected to find  
 11 some more information at the cancer registry  
 12 than she was ultimately able to get there.  
 13 MS. JONES:  
 14 A. Able to find.  
 15 MS. NEWBURY:  
 16 Q. And based on your familiarity with the NLCHI  
 17 database project, do you think that the whole  
 18 process of having this NLCHI database process  
 19 could have been simplified or perhaps  
 20 unnecessary if the cancer registry contained  
 21 more information of the type that Ms. Predham  
 22 was looking for?  
 23 MS. JONES:  
 24 A. Yes, or if in fact we had accessed the vital  
 25 stats in Newfoundland to get the information,

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1 because I think that's ultimately where NLCHI  
 2 did get the issue of the deaths, inside that  
 3 database.  
 4 MS. NEWBURY:  
 5 Q. But to have the cancer registry, you would  
 6 identify individuals -  
 7 MS. JONES:  
 8 A. Yes, you would obviously want the cancer  
 9 registry to be as complete as it possibly can  
 10 be.  
 11 MS. NEWBURY:  
 12 Q. Yes, okay, and that's not something that  
 13 you're aware of has been on the radar for  
 14 Eastern Health?  
 15 MS. JONES:  
 16 A. No. Well, it's not on--hasn't been on my  
 17 radar, but it may very well be on other  
 18 people's radar.  
 19 MS. NEWBURY:  
 20 Q. There have been some recent media reports, I  
 21 guess, about the concern about retention of  
 22 pathologists triggered by a recent  
 23 resignation, as I understand it, by a  
 24 pathologist here and the possibility of other  
 25 pathologists who may resign in the future, I

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1 think, was the tenor of the report.  
 2 MS. JONES:  
 3 A. That's right.  
 4 MS. NEWBURY:  
 5 Q. I'm not sure how accurate that all is. But  
 6 can you speak generally about the reasons for  
 7 any resignations or any concerns that Eastern  
 8 Health has?  
 9 MS. JONES:  
 10 A. I think that Dr. Denic has been clear. We are  
 11 very concerned about the number of  
 12 resignations that we've had. We have had  
 13 turnover in pathology for a number of years  
 14 and I think there's some exhibits here that  
 15 will show the rate of turn over and the length  
 16 of stay. There has always been issues in the  
 17 last couple of years about compensation and we  
 18 continue to talk about issues with  
 19 compensation and whether, in fact, we're  
 20 appropriately compensated. And there has been  
 21 work done with respect to identifying  
 22 workloads and to see if, in fact, we need more  
 23 pathologists. So all of those issues have  
 24 been and continue to be discussed and are a  
 25 problem inside of Eastern Health right now.

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1 MS. NEWBURY:  
 2 Q. Thank you, Ms. Jones. Those are all the  
 3 questions that I have for you.  
 4 THE COMMISSIONER:  
 5 Q. Thank you. Do you have any questions?  
 6 MS. LOUISE JONES, CROSS-EXAMINATION BY MS. DARLENE  
 7 RUSSELL  
 8 MS. RUSSELL:  
 9 Q. Good afternoon, Ms. Jones, I'm Darlene Russell  
 10 on behalf of the class action for breast  
 11 cancer testing.  
 12 MS. JONES:  
 13 A. Okay.  
 14 MS. RUSSELL:  
 15 Q. I just have a few questions.  
 16 MS. JONES:  
 17 A. Yes.  
 18 MS. RUSSELL:  
 19 Q. Could I please have Exhibit 0488? Excuse me,  
 20 0488, page 40. Got the wrong page. Okay.  
 21 Could I try 0287?  
 22 THE COMMISSIONER:  
 23 Q. Exhibit 0287 or page 287?  
 24 MS. RUSSELL:  
 25 Q. Exhibit 0287. Yes, this is it. These are

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1 minutes of an executive management meeting  
 2 held June 13th, 2007.  
 3 MS. JONES:  
 4 A. Yes.  
 5 MS. RUSSELL:  
 6 Q. And I believe you were present at this  
 7 meeting?  
 8 MS. JONES:  
 9 A. Yes.  
 10 MS. RUSSELL:  
 11 Q. And if I could go down to bullet 1.6 on page  
 12 2? And it says here that, "The CEO is  
 13 scheduled to meet with the deputy minister of  
 14 health and community services on June 14th and  
 15 requested input on these key messages."  
 16 MS. JONES:  
 17 A. Um-hm.  
 18 MS. RUSSELL:  
 19 Q. Do you recall this discussion?  
 20 MS. JONES:  
 21 A. No, and this says deputy minister, the board  
 22 chairs and the CEO. No.  
 23 MS. RUSSELL:  
 24 Q. You would have been the COO at the time?  
 25 MS. JONES:

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1 A. I would have been the COO at that time, but--  
 2 can you just go down to the bottom of this to  
 3 see if there's any other context around that?  
 4 Location of services. So this would have been  
 5 a meeting, by the looks of it, and board  
 6 chairs and CEOs. Really that normally would  
 7 happen inside of the Newfoundland and Labrador  
 8 Health Boards Association with respect to  
 9 issues that they wanted to talk about when the  
 10 minister and the deputy minister would have  
 11 been there, because there would be no reason  
 12 for the board chairs and the CEOs other than  
 13 that. So there probably is a meeting on the  
 14 14th of June where these issues are going to  
 15 be discussed.  
 16 MS. RUSSELL:  
 17 Q. Okay. So you're present at this meeting?  
 18 MS. JONES:  
 19 A. Yes.  
 20 MS. RUSSELL:  
 21 Q. And my understanding is is that Mr. Tilley is  
 22 the CEO at that time?  
 23 MS. JONES:  
 24 A. Yes, he is.  
 25 MS. RUSSELL:

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1 Q. And he's looking for some input on these key  
 2 messages?  
 3 MS. JONES:  
 4 A. Um.  
 5 MS. RUSSELL:  
 6 Q. And one of the messages is HIROC's concern  
 7 with full disclosure and the impact on  
 8 insurability. What can you tell me about  
 9 that?  
 10 MS. JONES:  
 11 A. I can't tell you anything around that at all.  
 12 MS. RUSSELL:  
 13 Q. You have no recollection?  
 14 MS. JONES:  
 15 A. I have no recollection on that. This is in  
 16 June of 2007.  
 17 MS. RUSSELL:  
 18 Q. Yes. This would have been your last meeting,  
 19 I think, before you were appointed?  
 20 MS. JONES:  
 21 A. Yeah, we would have been having some  
 22 discussion around--not we, but there would  
 23 have been some discussion around insurance  
 24 premiums or whatever or liability coverage or  
 25 whatever, but I don't know what that is. You

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1 really do have to ask him. It didn't resonate  
 2 even when I looked at this list of things.  
 3 Usually I remember something very, you know,  
 4 poignant about something, but that doesn't  
 5 resonate with me at all.  
 6 MS. RUSSELL:  
 7 Q. Okay. And you wouldn't have kept any notes?  
 8 MS. JONES:  
 9 A. No.  
 10 MS. RUSSELL:  
 11 Q. With respect to that?  
 12 MS. JONES:  
 13 A. No. I just keep minutes of meetings, right.  
 14 Location of services, that, you know, like I  
 15 would understand what that one was. Again,  
 16 the need for highly skilled human resources  
 17 and the capital equipment because we'd been  
 18 talking about capital equipment for a long  
 19 time. But in the context of this meeting in  
 20 June, I have no recall on that.  
 21 MS. RUSSELL:  
 22 Q. Difference between patient disclosure and  
 23 public disclosure, do you recall anything  
 24 about that?  
 25 MS. JONES:

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1 A. No, only probably the same as we've been  
 2 discussing now, individual patient disclosure  
 3 and at what point in time to go to the public  
 4 with that. And just culture along falling in  
 5 the same way.  
 6 MS. RUSSELL:  
 7 Q. Okay. So what you're saying is we would have  
 8 to ask Mr. Tilley about HIROC's concern?  
 9 MS. JONES:  
 10 A. Absolutely, that's right.  
 11 MS. RUSSELL:  
 12 Q. You don't have a recollection?  
 13 MS. JONES:  
 14 A. No.  
 15 MS. RUSSELL:  
 16 Q. Okay. Thank you. Could I also refer to  
 17 Exhibit 0125, please? I don't know if you're  
 18 familiar with this document?  
 19 MS. JONES:  
 20 A. I wouldn't, not briefing notes.  
 21 MS. RUSSELL:  
 22 Q. These are briefing notes.  
 23 MS. JONES:  
 24 A. Yeah.  
 25 MS. RUSSELL:

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1 Q. Okay. Could I go to page 19? These are  
 2 briefing notes prepared by Health Predham.  
 3 MS. JONES:  
 4 A. Um.  
 5 MS. RUSSELL:  
 6 Q. July 31st, 2006. If I could scroll down to  
 7 the bottom? Okay, that's good. Are you  
 8 familiar with the term "retro converters"?  
 9 MS. JONES:  
 10 A. I've heard it. I hardly understand what it  
 11 means, though. I do understand it is positive  
 12 -  
 13 MS. RUSSELL:  
 14 Q. What's your understanding of what it means?  
 15 MS. JONES:  
 16 A. It's the reverse of going from negative to  
 17 positive, from positive to negative.  
 18 MS. RUSSELL:  
 19 Q. So would it be like a false positive, maybe?  
 20 MS. JONES:  
 21 A. I'm not sure that you would even put that kind  
 22 of context on it.  
 23 MS. RUSSELL:  
 24 Q. Okay. Well, maybe I'll just read through what  
 25 it says here.

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1 MS. JONES:  
 2 A. Yeah.  
 3 MS. RUSSELL:  
 4 Q. For retro converters. "All patients who are  
 5 negative for ER were included in the retesting  
 6 process."  
 7 MS. JONES:  
 8 A. Yes.  
 9 MS. RUSSELL:  
 10 Q. "As the clinical definition of negative  
 11 changed over the years all patients with an ER  
 12 of 30 percent or less were retested. That  
 13 means that in the group retested there are  
 14 women who, although their ER level met this  
 15 definition of negative, they were considered  
 16 positive at the time and received hormonal  
 17 treatment." So some people who were actually,  
 18 I guess you can use the term clinically  
 19 positive were retested?  
 20 MS. JONES:  
 21 A. Yes.  
 22 MS. RUSSELL:  
 23 Q. "In four cases retesting by Mount Sinai  
 24 identified that women in this category now  
 25 have an ER/PR status of zero percent, which

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1 has been confirmed by subsequent retesting at  
 2 Mount Sinai."  
 3 MS. JONES:  
 4 A. Yes.  
 5 MS. RUSSELL:  
 6 Q. Did you know that?  
 7 MS. JONES:  
 8 A. I've heard the use retro converters and I've  
 9 heard the number four in terms of four  
 10 patients.  
 11 MS. RUSSELL:  
 12 Q. Okay. And then it says, "Representatives of  
 13 Eastern Health and the clinical chiefs of  
 14 pathology in cancer care will meet with them  
 15 in the near future to disclose this  
 16 information."  
 17 MS. JONES:  
 18 A. Yes.  
 19 MS. RUSSELL:  
 20 Q. Are you aware of whether that happened?  
 21 MS. JONES:  
 22 A. If that's said there, then I'm anticipating it  
 23 did, but I -  
 24 MS. RUSSELL:  
 25 Q. You have no personal knowledge?

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1 MS. JONES:  
 2 A. I have no personal knowledge on that.  
 3 MS. RUSSELL:  
 4 Q. Okay. But you know that there were four  
 5 people that tested zero percent?  
 6 MS. JONES:  
 7 A. I've heard this, I've heard this and I've  
 8 heard exactly what's said here, that it's been  
 9 disclosed. But, you know, I haven't gone  
 10 asking "Can you confirm to me that that has  
 11 been disclosed? What does it mean?"  
 12 MS. RUSSELL:  
 13 Q. Okay. Are you curious as to what it means?  
 14 MS. JONES:  
 15 A. Most of this file has been around the ER  
 16 negative going to positive. There are other  
 17 aspects of this file that this is one of and  
 18 that I haven't delved into to wonder if, in  
 19 fact, there are other issues that need to be  
 20 there.  
 21 MS. RUSSELL:  
 22 Q. Okay.  
 23 MS. JONES:  
 24 A. This is, I think you showed me that this is a  
 25 2006 document.

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1 MS. RUSSELL:  
 2 Q. Okay. Could I go over to page 25, please?  
 3 Okay. The impacts of treatment with  
 4 Tamoxifen.  
 5 MS. JONES:  
 6 A. Um-hm.  
 7 MS. RUSSELL:  
 8 Q. "The drug Tamoxifen is believed to prevent the  
 9 growth of cancer in ER/PR positive patients.  
 10 It does have possible side effects, which  
 11 includes endometrial cancer, blood clot to the  
 12 legs, stroke, abnormal growth of uterine  
 13 tissue, hair and nail thinning and fertility  
 14 problems." So these are some of the side  
 15 effects.  
 16 MS. JONES:  
 17 A. Yes, I understand those.  
 18 MS. RUSSELL:  
 19 Q. That are associated.  
 20 MS. JONES:  
 21 A. That's right.  
 22 MS. RUSSELL:  
 23 Q. So the four people who were receiving hormonal  
 24 treatment.  
 25 MS. JONES:

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1 A. Yes.  
 2 MS. RUSSELL:  
 3 Q. Could have suffered these side effects  
 4 needlessly?  
 5 MS. JONES:  
 6 A. Yes.  
 7 MS. RUSSELL:  
 8 Q. Okay. My question, I guess, is are there  
 9 others? Like, did you retest any of the other  
 10 positives besides the ones that were just  
 11 incidentally retested?  
 12 MS. JONES:  
 13 A. No, we haven't. Unless there's been  
 14 individual patients, we have had many  
 15 individual patients who have been positive who  
 16 have come forward and asked to be retested and  
 17 we have not denied retesting. If an  
 18 individual has concerns, we will--if they are  
 19 still connected with an oncologist, we will  
 20 ask them do they want to talk to their  
 21 oncologist to see, and sometimes they talk to  
 22 their oncologists. If they don't have an  
 23 oncologist, we just send them off for  
 24 retesting.  
 25 MS. RUSSELL:

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1 Q. So that is happening, so people who are  
 2 approaching Eastern Health -  
 3 MS. JONES:  
 4 A. Yes.  
 5 MS. RUSSELL:  
 6 Q. - and saying that they are positive and they  
 7 weren't retested in the initial group -  
 8 MS. JONES:  
 9 A. In the original, because they weren't in the  
 10 negative -  
 11 MS. RUSSELL:  
 12 Q. - you are prepared to retest those people?  
 13 MS. JONES:  
 14 A. We have been retesting as they have come  
 15 forward. We have not denied anybody the  
 16 testing.  
 17 MS. RUSSELL:  
 18 Q. And people are being told this? People who  
 19 are calling in to Eastern Health?  
 20 MS. JONES:  
 21 A. People are calling in, and what we normally  
 22 will do is ask them if, in fact, they have an  
 23 oncologist.  
 24 MS. RUSSELL:  
 25 Q. Um-hm.

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1 MS. JONES:  
 2 A. And then we sort of say, "Well, do you want to  
 3 talk to your oncologist?" And the oncologist  
 4 will talk to them to talk about their result,  
 5 what it means, that kind of thing. If they  
 6 want testing, they are sent off for testing.  
 7 If they don't have an oncologist, we just  
 8 automatically test for them.  
 9 MS. RUSSELL:  
 10 Q. Okay. Is that written anywhere, is that on  
 11 your web site or, you know, how has this been  
 12 made known to the public that they can be  
 13 retested?  
 14 MS. JONES:  
 15 A. We haven't done any public announcements.  
 16 We've responded to the public who have come  
 17 forward. We've got lots of clients who keep  
 18 coming forward asking questions, we provide  
 19 them with whatever information. And we've not  
 20 made a decision to go out, but if clients are  
 21 asking, then we have moved forward and  
 22 respected their wish. This is such a public  
 23 issue and for them there is obviously a need  
 24 for them individually to reaffirm whatever  
 25 ER/PR result that they have.

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1 MS. RUSSELL:  
 2 Q. Do you have a plan to go forward with that  
 3 information publicly?  
 4 MS. JONES:  
 5 A. We haven't discussed a plan to go forward with  
 6 that one.  
 7 MS. RUSSELL:  
 8 Q. Do you know whether there's any confusion out  
 9 there among people?  
 10 MS. JONES:  
 11 A. We've always talked about this as being an  
 12 ER/PR.  
 13 MS. RUSSELL:  
 14 Q. Um-hm.  
 15 MS. JONES:  
 16 A. Negative issue. Anybody who's -  
 17 MS. RUSSELL:  
 18 Q. Yes, that's the confusion.  
 19 MS. JONES:  
 20 A. Yeah. Anybody who has called in and asked for  
 21 their ER/PR results, if we have them inside of  
 22 our database, we will give them their results  
 23 or we will connect or find the results from  
 24 the other parts of the region that we don't  
 25 have.

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1 MS. RUSSELL:  
 2 Q. Okay.  
 3 MS. JONES:  
 4 A. So we've always done that.  
 5 MS. RUSSELL:  
 6 Q. So you're not aware of any phone calls to  
 7 Eastern Health whereby people have been told  
 8 that they won't be retested?  
 9 MS. JONES:  
 10 A. I'm not aware of that because the only  
 11 question that has been asked is if, in fact,  
 12 people have called in, and I know they are  
 13 calling in because I've heard, you know,  
 14 they've been referred to oncologists and, in  
 15 fact, you know, that we just send it out.  
 16 MS. RUSSELL:  
 17 Q. Okay. So I just want to clarify one final  
 18 point. You're prepared to retest anybody  
 19 who's looking to be retested in that period of  
 20 time, from 1997 to 2005?  
 21 MS. JONES:  
 22 A. If that is their wish.  
 23 MS. RUSSELL:  
 24 Q. If that's their wish?  
 25 MS. JONES:

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1 A. That's right.

2 MS. RUSSELL:

3 Q. Thank you. I have no further questions.

4 THE COMMISSIONER:

5 Q. Mr. Pike?

6 MR. PIKE:

7 Q. I had a couple of points that I intended to

8 cover, but they've been covered by Ms. Chaytor

9 and Ms. Newbury. Thank you.

10 THE COMMISSIONER:

11 Q. Thank you. Mr. Simmons.

12 MS. LOUISE JONES, CROSS-EXAMINATION BY MR. DANIEL SIMMONS

13 MR. SIMMONS:

14 Q. Ms. Jones, I expect you're glad to finally see

15 me, and you'll be even gladder to see Ms.

16 Chaytor again when I'm done. So I'll -

17 MS. JONES:

18 A. Go on.

19 MR. SIMMONS:

20 Q. I'll try and give Ms. Chaytor the chance to

21 get back here as quickly as I can. Can I have

22 P-0773, please? Ms. Jones, this is the

23 confidentiality acknowledgement document that

24 you were questioned on earlier today.

25 MS. JONES:

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1 A. Yes.

2 MR. SIMMONS:

3 Q. And I want to bring you down here to the third

4 page of it, which you've been asked questions

5 about already.

6 MS. JONES:

7 A. Yes.

8 MR. SIMMONS:

9 Q. Which describe types of confidential

10 information. And my question to you rises out

11 of some questions you were asked earlier about

12 people who might have, within the organization

13 of Eastern Health who might have concerns

14 about patient safety.

15 MS. JONES:

16 A. Yes.

17 MR. SIMMONS:

18 Q. And whether they're able to bring those

19 concerns forward and make sure that they are

20 dealt with.

21 MS. JONES:

22 A. Um.

23 MR. SIMMONS:

24 Q. And my question is, are you aware of anything

25 in this confidentiality acknowledgement or

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1 this policy or what you see here that would in

2 any way prevent anyone from within Eastern

3 Health bringing forward, either within the

4 organization or outside of it a patient safety

5 concern?

6 MS. JONES:

7 A. No.

8 MR. SIMMONS:

9 Q. There's a portion here that's marked "Business

10 initiatives" there near the bottom.

11 MS. JONES:

12 A. Yes.

13 MR. SIMMONS:

14 Q. And that's the description on the left in the

15 box on the left is business initiatives and

16 then it's further described as "Any

17 information related to the organization's

18 initiatives, example, organizational

19 restructuring, mergers, outsourcing of

20 business units" and also says, "recruitment".

21 And when you read those examples there, would

22 you read those in the context of any type of

23 initiative the organization would take about

24 recruitment or in the context of business

25 initiatives related to -

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1 MS. JONES:

2 A. It talks about on the top of that, types of

3 confidential information and that clearly is

4 tied to the box that talks about business

5 initiatives.

6 MR. SIMMONS:

7 Q. Right. Now you told us earlier in relation to

8 recruitment that there could be arrangements

9 made with particular staff of physicians,

10 financial compensation arrangements,

11 arrangements dealing with their personal

12 benefits.

13 MS. JONES:

14 A. Yes, moving expenses, any of those things.

15 MR. SIMMONS:

16 Q. That would relate to recruitment, right. Is

17 that what this restriction on disclosure of

18 confidential information is intended to apply

19 to?

20 MS. JONES:

21 A. I would expect because when you talk about

22 recruitment things, such as moving expenses,

23 personal expenses that we cover and those are

24 part of individual staff or physician's

25 information.

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1 MR. SIMMONS:  
 2 Q. Right, okay. So although there may not be an  
 3 organization wide overarching policy which  
 4 explicitly says anyone who has a patient  
 5 safety concern can bring it forward in this  
 6 way and there is no restriction -  
 7 MS. JONES:  
 8 A. Yes.  
 9 MR. SIMMONS:  
 10 Q. Though that may not exist and you've told us  
 11 that there are other policies in legacy  
 12 organizations that may in other ways address  
 13 some of those issues.  
 14 MS. JONES:  
 15 A. Uh-hm.  
 16 MR. SIMMONS:  
 17 Q. There is nothing in this acknowledgement that  
 18 stands in the way of anyone doing that?  
 19 MS. JONES:  
 20 A. No.  
 21 MR. SIMMONS:  
 22 Q. You were referred to P-0743 which was the  
 23 submission made for funding for a number of  
 24 things.  
 25 MS. JONES:

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1 A. Yes.  
 2 MR. SIMMONS:  
 3 Q. And it's been described in some of the  
 4 questioning as information technology  
 5 requests.  
 6 MS. JONES:  
 7 A. Yes.  
 8 MR. SIMMONS:  
 9 Q. And if we run down, here beginning on the  
 10 fifth page, there's three areas of funding  
 11 requests listed.  
 12 MS. JONES:  
 13 A. Yes.  
 14 MR. SIMMONS:  
 15 Q. And you've been asked a number of questions  
 16 about these already, I just wanted to ask you  
 17 a bit more about the decision support, that's  
 18 the third one.  
 19 MS. JONES:  
 20 A. Uh-hm.  
 21 MR. SIMMONS:  
 22 Q. Is decision support really an information  
 23 technology thing or is it something really  
 24 different from information technology.  
 25 MS. JONES:

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1 A. It's really different, the two other things  
 2 that are in there are actually information  
 3 technology, whether it's consolidation on  
 4 databases or another tool to be able to use,  
 5 decision support would be used throughout the  
 6 entire organization to look at trends and  
 7 analysis and I talked earlier on about tying  
 8 clinical information through to financial  
 9 information and to outcome data, so that is  
 10 not--that is information, I guess, at the end  
 11 of the day, but these individuals would work  
 12 in various capacities and I do believe we've  
 13 heard from Ms. Newbury when she asked about  
 14 clinical epidemiologists being available in  
 15 the cancer care program and that--and this is  
 16 the whole idea of decision support and  
 17 supporting the organization in making  
 18 decisions and is not tied specifically to  
 19 information.  
 20 MR. SIMMONS:  
 21 Q. And how was it envisaged that decision support  
 22 would fit into the organizational structure?  
 23 Where would the people be?  
 24 MS. JONES:  
 25 A. People would be--basically now we have a

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1 number of some of these kinds of skills in  
 2 various departments. The whole idea with this  
 3 decision support is to consolidate all of  
 4 those people into a single department and I  
 5 think I used the word "virtual" in some sense  
 6 as to be going out on individual projects or  
 7 whatever, so that we would have a staff of  
 8 around 30 individuals that would support the  
 9 entire organization and gather the  
 10 information, the evidence based kinds of  
 11 things, helping the organization move forward  
 12 with, articulating methodology in terms of  
 13 looking at issues and the reference to it in  
 14 the first bullet there was using clinical  
 15 epidemiology and bio-statisticians to help us  
 16 organize and move forward on the IT side in  
 17 terms of just the architecture, the  
 18 methodology. So this would be a single unit  
 19 inside of Eastern Health that would serve all  
 20 parts of Eastern Health, which would be  
 21 community, long-term care, acute care, any of  
 22 the program areas.  
 23 MR. SIMMONS:  
 24 Q. Okay, Health Care Corporation brought into  
 25 Eastern Health, I believe, some decision



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1 support capacity, is that correct?  
 2 MS. JONES:  
 3 A. Yes.  
 4 MR. SIMMONS:  
 5 Q. And was that primarily limited to areas of  
 6 finance and efficiencies?  
 7 MS. JONES:  
 8 A. Absolutely.  
 9 MR. SIMMONS:  
 10 Q. And would I be correct to assume that that  
 11 probably grew out of the circumstances that  
 12 lead to the Hay review and the results of the  
 13 Hay review and the focus on finding financial  
 14 savings within the Health Care Corporation?  
 15 MS. JONES:  
 16 A. Yes, it did.  
 17 MR. SIMMONS:  
 18 Q. Among the 30 people that you contemplate  
 19 forming the decision support group, what kind  
 20 of professions--you spoken of a clinical  
 21 epidemiologist, who else would comprise those  
 22 30 people?  
 23 MS. JONES:  
 24 A. Well you see some of them here, you've got  
 25 budget analysts that we would bring in, health

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1 records analysts who would be able to get at  
 2 our clinical data, you got the clinical epi,  
 3 the bio-statistician, you would have people  
 4 who would understand information technology,  
 5 how to develop new applications or the  
 6 databases that we might need on an individual  
 7 basis, like in this particular area or the  
 8 Burin radiology, how can you pull those  
 9 together to develop a database and also in  
 10 this particular, we do have a lot of external  
 11 reporting just to make sure that our data is  
 12 clean and that there are no issues in our data  
 13 submissions, either to the Department of  
 14 Health or to external bodies. So it would be  
 15 a housing area for all of the data and then  
 16 trending on the data, as well as a  
 17 understanding of how it should be structured,  
 18 what we should be collecting on, it would  
 19 assist the board in identifying and bringing  
 20 forward the indicators on a region-wide basis  
 21 so that they understand what's going on, so  
 22 making sure that the data collection and input  
 23 supports the work that the board needs to do.  
 24 MR. SIMMONS:  
 25 Q. And what is a bio-statistician?

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1 MS. JONES:  
 2 A. It's a statistician, but somebody in our neck  
 3 of the woods.  
 4 MR. SIMMONS:  
 5 Q. Okay. And can you give me maybe some concrete  
 6 example of what kind of decisions would be  
 7 supported in a clinical area?  
 8 MS. JONES:  
 9 A. In this area it may very well be from a  
 10 program perspective, how efficient and how  
 11 effective it is, where we might be able to  
 12 look at flow analysis and how we can better  
 13 utilize. You really absolutely want to get to  
 14 what is the impact that this particular area  
 15 has on the population, so that's where your  
 16 clinical epidemiology would play, just to make  
 17 sure that you're getting the best outcome for  
 18 the resources that you're putting in. Are  
 19 there other ways of achieving that? So that's  
 20 where the evidence and the researched base  
 21 kind of thought process comes in from the  
 22 clinical epidemiology, their skills.  
 23 MR. SIMMONS:  
 24 Q. And would this decision support function  
 25 provide any benefits in promoting patient

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1 safety?  
 2 MS. JONES:  
 3 A. Yes, it would because at the end of the day  
 4 you would have things, such as your fall rates  
 5 or your infection control rates and those  
 6 kinds of things, so it may highlight trends  
 7 over time. It may pinpoint areas which in  
 8 fact you may have a need to focus on and so  
 9 those are the ways that you would do it  
 10 because it's a trending that you need to look  
 11 at, so if you're going up, why are you going  
 12 up? That's the analysis piece of it.  
 13 MR. SIMMONS:  
 14 Q. You were asked some questions a moment ago  
 15 about positivity rates and tracking positivity  
 16 rates.  
 17 MS. JONES:  
 18 A. Yes.  
 19 MR. SIMMONS:  
 20 Q. Would there be any role for this decision  
 21 support function in areas like that?  
 22 MS. JONES:  
 23 A. It, as I have said to Ms. Newbury, depending  
 24 on the projects I had and what we were  
 25 actually doing, we have a lot of registries

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1 that we have developed and a lot of areas that  
 2 want to develop registries that at the end of  
 3 the day, can provide valuable information, so  
 4 yes, that could be part of this work as well.  
 5 MR. SIMMONS:  
 6 Q. Okay, and the budget request was \$880,000 for  
 7 to implement decision support. How far would  
 8 that have brought you towards putting in place  
 9 your 30 staff that you contemplate?  
 10 MS. JONES:  
 11 A. We figure at this point in time if you were to  
 12 take the budget analyst of the people that are  
 13 already out in those functional departments,  
 14 we probably got about 12 to 15 people. If you  
 15 were to bring them, you needed to marry them  
 16 with another 10 or 15 people, so this would be  
 17 well on our way to developing a solid core of  
 18 individuals, develop the expertise and then  
 19 see where we needed to go because you couldn't  
 20 do it altogether.  
 21 MR. SIMMONS:  
 22 Q. Based on the announcements that were made  
 23 before the budget yesterday, and I understand  
 24 you're not completely conversant with what  
 25 yesterday's budget gave you.

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1 MS. JONES:  
 2 A. Budget was, yes.  
 3 MR. SIMMONS:  
 4 Q. Based on those announcements, how much of  
 5 those requirements had you been told that you  
 6 were getting?  
 7 MS. JONES:  
 8 A. Two and that would not have been enough to  
 9 consolidate with two extra individuals.  
 10 MR. SIMMONS:  
 11 Q. Are, do other--are you aware whether other  
 12 health care organizations in the country have  
 13 this type of decision support capability?  
 14 MS. JONES:  
 15 A. In the way that we're looking at setting it  
 16 up, yes, absolutely and the reference here is  
 17 to Hamilton Health Sciences because that was  
 18 one of the areas that was almost like the gold  
 19 star when we were looking in 2001, 2001, so  
 20 all large health care organizations would have  
 21 departments pull together in this fashion.  
 22 MR. SIMMONS:  
 23 Q. Okay. Just a couple of questions about the  
 24 issue of the method to use to disclose  
 25 retesting results to families of deceased

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1 patients.  
 2 MS. JONES:  
 3 A. Yes.  
 4 MR. SIMMONS:  
 5 Q. Would I be correct in suggesting that there  
 6 are a couple other factors to be taken into  
 7 account when comparing the method for  
 8 disclosing to families of deceased to  
 9 disclosures to living patients and that one of  
 10 those would be that for living patients, quite  
 11 obviously there is the potential to give them  
 12 an option for change in treatment and that  
 13 that would drive the need to disclose directly  
 14 to them.  
 15 MS. JONES:  
 16 A. Yes.  
 17 MR. SIMMONS:  
 18 Q. And another factor, would I be correct in  
 19 suggesting that with disclosures to the  
 20 families of deceased, there's an added  
 21 complication in that it's not always possible  
 22 to readily determine who is the appropriate  
 23 family member of next of kin to make the  
 24 disclosure to, if you're going out and  
 25 actively looking to make those disclosures.

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1 MS. JONES:  
 2 A. We would end up having to use the current  
 3 databases and we wouldn't know whether they  
 4 were accurate or not and lots of times in  
 5 terms of the next of kin that we would list in  
 6 terms of our databases on registration, would  
 7 be contact individuals verses next of kin, so  
 8 it maybe, if we were to disclose to next of  
 9 kin, you would be going down almost like the  
 10 advanced health care director route, which  
 11 would be in that hierarchy and lots of times  
 12 what we have in our current databases is who  
 13 to notify, not necessarily next of kin.  
 14 MR. SIMMONS:  
 15 Q. Okay, and the final question that I will ask  
 16 you is that Ms. Newbury asked you some  
 17 questions about related to trying to identify  
 18 the cause of changed results for people who  
 19 had an original test and then a retest result  
 20 that was different.  
 21 MS. JONES:  
 22 A. Yes.  
 23 MR. SIMMONS:  
 24 Q. And in your answer, you said, if I understand  
 25 correctly, that there were a range of

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1 potential causes identified and the  
 2 recommendations were put in, were acted on to  
 3 address those range of potential causes, but  
 4 that for any particular test at any particular  
 5 time, it would be very difficult to identify  
 6 which of those causes were in play for that  
 7 particular -  
 8 MS. JONES:  
 9 A. Yes.  
 10 MR. SIMMONS:  
 11 Q. - that particular test.  
 12 MS. JONES:  
 13 A. That's what I believe.  
 14 MR. SIMMONS:  
 15 Q. And let me ask you this, if you had taken the  
 16 approach of saying there's 50 potential causes  
 17 that we've identified, and we do the work or  
 18 find a way to identify--to determine that only  
 19 half of those actually caused changes in  
 20 results here and the other 25 hadn't been  
 21 actual causes of these change in results.  
 22 MS. JONES:  
 23 A. Uh-hm.  
 24 MR. SIMMONS:  
 25 Q. Would you have been able to just fix the 25

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1 that had been actual causes or would you have  
 2 had to deal with them all?  
 3 MS. JONES:  
 4 A. I would have to deal with them because the  
 5 whole idea is to put as much of assurance in  
 6 the system, to plug as many holes there  
 7 possibly could be there, so that redundancy  
 8 that I talk about is absolutely there, it's  
 9 not one, it's two, it's three, it's four  
 10 different ways.  
 11 MR. SIMMONS:  
 12 Q. Right, and by dealing with all the potential  
 13 causes, do you then feel reasonably assured  
 14 that you will deal with the ones that were the  
 15 actual causes at any particular time?  
 16 MS. JONES:  
 17 A. At any particular time.  
 18 MR. SIMMONS:  
 19 Q. Okay, fine. Thank you very much.  
 20 MS. JONES:  
 21 A. Thank you.  
 22 THE COMMISSIONER:  
 23 Q. Thank you, Mr. Simmons. Ms. Chaytor?  
 24 MS. LOUISE DAWE, RE-EXAMINATION BY MS. SANDRA CHAYTOR  
 25 CHAYTOR, Q.C.:

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1 Q. I know it's late, just three very quick  
 2 questions.  
 3 MS. JONES:  
 4 A. Okay.  
 5 CHAYTOR, Q.C.:  
 6 Q. If I could have P-0069 please? And this picks  
 7 up on the last question of Mr. Simmons on  
 8 potential causes and as well, I think Ms.  
 9 Newbury asked you about individual causes.  
 10 MS. JONES:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. You may not be aware of this document -  
 14 MS. JONES:  
 15 A. This is 2005, yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. 2005 and it's a letter actually by Dr. Carter  
 18 to Dr. Cook.  
 19 MS. JONES:  
 20 A. Dr. Cook, okay.  
 21 CHAYTOR, Q.C.:  
 22 Q. And it concerns efforts that she was going to  
 23 undertake at the time to review individual  
 24 slides.  
 25 MS. JONES:

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1 A. Okay.  
 2 CHAYTOR, Q.C.:  
 3 Q. Was the executive ever made aware of Dr.  
 4 Carter's proposed efforts in this regard?  
 5 MS. JONES:  
 6 A. No, not as executive and this is July, so we  
 7 wouldn't have been meeting through the summer  
 8 too much, so -  
 9 CHAYTOR, Q.C.:  
 10 Q. So have you ever been made aware, up to now in  
 11 your current role as CEO that Dr. Carter had  
 12 undertaken a review of individual slides back  
 13 in July of 2005?  
 14 MS. JONES:  
 15 A. Only in reviewing this file for the  
 16 Commission.  
 17 CHAYTOR, Q.C.:  
 18 Q. Pardon me?  
 19 MS. JONES:  
 20 A. Only in reviewing the file for the Commission,  
 21 I didn't talk to Dr. Carter herself.  
 22 CHAYTOR, Q.C.:  
 23 Q. So you only learned about that in, when? The  
 24 last couple of months?  
 25 MS. JONES:

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1 A. The last couple of months.  
 2 CHAYTOR, Q.C.:  
 3 Q. That Dr. Carter had set out in reviewing the  
 4 slides on an individual basis?  
 5 MS. JONES:  
 6 A. I had asked the question because Dr. Carter  
 7 was a breast pathologist, as we were going  
 8 through this, what role did she take on and  
 9 did she make herself available to assist with  
 10 this, because she was a breast pathologist and  
 11 the answer was yes, and that she did start in  
 12 very early on to work through this.  
 13 CHAYTOR, Q.C.:  
 14 Q. And the fact that she was going to need  
 15 resources for that, that was never brought to  
 16 the executive's attention by Dr. Williams?  
 17 MS. JONES:  
 18 A. No.  
 19 CHAYTOR, Q.C.:  
 20 Q. So Dr. Williams never told the executive that  
 21 Dr. Carter had set out on this initiative?  
 22 MS. JONES:  
 23 A. No.  
 24 CHAYTOR, Q.C.:  
 25 Q. And recently having become aware of that, did

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1 you ask any questions as to why Dr. Carter  
 2 didn't continue on?  
 3 MS. JONES:  
 4 A. I think there may have been some  
 5 correspondence later on and I think maybe Mr.  
 6 Tilley talked about a meeting that they had  
 7 had in August with pathologists and  
 8 oncologists and I'm not sure what was the  
 9 outcue (phonetic), but at the end of the day,  
 10 Dr. Carter had indicated that she wasn't going  
 11 to make herself available to do this work.  
 12 CHAYTOR, Q.C.:  
 13 Q. On the issue, again I think this was questions  
 14 by Ms. Newbury about the contact with the  
 15 media or the lack of contact with the media  
 16 and she was asking you about, arising out of  
 17 my question on, you had indicated Peter Dawe's  
 18 responsiveness.  
 19 MS. JONES:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. On issues and how Eastern Health has  
 23 encountered difficulties lining up individuals  
 24 to speak in a timely fashion. Are you aware  
 25 of any occasion on the ER/PR issue where

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1 Eastern Health offered themselves or any  
 2 individual up to the media and the media  
 3 declined the opportunity because the news  
 4 cycle, as you had phrased it, had passed?  
 5 MS. JONES:  
 6 A. I'm not aware, I couldn't say on September  
 7 whatever that that actually happened. I  
 8 wasn't part of, you know -  
 9 CHAYTOR, Q.C.:  
 10 Q. But on any occasion, have -  
 11 MS. JONES:  
 12 A. On any occasion?  
 13 CHAYTOR, Q.C.:  
 14 Q. Yes, have you ever heard of that, that the  
 15 Eastern Health -  
 16 MS. JONES:  
 17 A. Yes, yeah, not on ER/PR.  
 18 CHAYTOR, Q.C.:  
 19 Q. - went forward to the media and the media  
 20 declined on ER/PR?  
 21 MS. JONES:  
 22 A. Not on the ER/PR, but yes, there have been  
 23 times when that particular issue was out of  
 24 the news cycle and that they don't doctor such  
 25 and such to speak or whoever it is today.

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1 I've been caught in that myself, you know, and  
 2 not -  
 3 CHAYTOR, Q.C.:  
 4 Q. But not on the ER/PR issue?  
 5 MS. JONES:  
 6 A. But not on ER/PR. I've been caught in that  
 7 myself, not available until the next day and  
 8 the issue was -  
 9 CHAYTOR, Q.C.:  
 10 Q. But not on ER/PR, I just want to be clear.  
 11 MS. JONES:  
 12 A. Not--I can't--yeah.  
 13 CHAYTOR, Q.C.:  
 14 Q. And would it be fair to say or would it be  
 15 fair to say that there were probably numerous  
 16 occasions on which the media sought Eastern  
 17 Health's position or to comment on it, but  
 18 there are no occasions in which the media  
 19 declined Eastern Health in coming forward to  
 20 speak on the issue?  
 21 MS. JONES:  
 22 A. I can't really answer that question.  
 23 CHAYTOR, Q.C.:  
 24 Q. You don't know. Would you be surprised if  
 25 that were to be the case?

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1 MS. JONES:  
 2 A. I probably would be surprised, Ms. Chaytor.  
 3 CHAYTOR, Q.C.:  
 4 Q. That there were times when Eastern Health -  
 5 MS. JONES:  
 6 A. Offered our self -  
 7 CHAYTOR, Q.C.:  
 8 Q. - declined--oh, you'd be surprised just that  
 9 they offered themselves.  
 10 MS. JONES:  
 11 A. That's right.  
 12 CHAYTOR, Q.C.:  
 13 Q. Yes, I'm suggesting to you that would be a  
 14 surprise.  
 15 MS. JONES:  
 16 A. Because you had two parts to that question.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, the first part--I'm trying to hurry.  
 19 MS. JONES:  
 20 A. That's okay.  
 21 CHAYTOR, Q.C.:  
 22 Q. The first part is that there may have been  
 23 occasions and perhaps numerous occasions in  
 24 which the news media came looking to Eastern  
 25 Health for information and -

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1 MS. JONES:  
 2 A. And we weren't able to respond.  
 3 CHAYTOR, Q.C.:  
 4 Q. - and it was declined, the interview, for  
 5 whatever the reason was declined.  
 6 MS. JONES:  
 7 A. Was declined, yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. But not the other way around, that Eastern  
 10 Health made itself available and that the  
 11 media declined Eastern Health?  
 12 MS. JONES:  
 13 A. We tended not to be out there making ourselves  
 14 available. If we made ourselves available, it  
 15 would be through press conferences or  
 16 technical briefings or whatever and generally,  
 17 the media would come to us, because that was--  
 18 at that point in time, they wouldn't have  
 19 known what we were going to say. So it would  
 20 have been a story.  
 21 CHAYTOR, Q.C.:  
 22 Q. On the confidentiality agreement -  
 23 MS. JONES:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. - and I just want to be clear, because I know  
 2 I've gone down that road with you already, but  
 3 I want to be clear out of answering questions  
 4 that Mr. Simmons put to you on that. Are you  
 5 saying that if it's an issue of patient  
 6 safety, that employees and independent  
 7 contractors of Eastern Health are free to go  
 8 outside the organization and discuss that  
 9 issue?  
 10 MS. JONES:  
 11 A. Yes, and all I would say to you in that  
 12 respect is that I would hope, from out of a  
 13 respectful relationship, that they would have  
 14 talked to us.  
 15 CHAYTOR, Q.C.:  
 16 Q. First?  
 17 MS. JONES:  
 18 A. First, and we would have attempted to resolve,  
 19 because we can't fix an issue if we don't  
 20 understand the issue. So that would be in any  
 21 respectful relationship.  
 22 CHAYTOR, Q.C.:  
 23 Q. Can you point to me anywhere in that document  
 24 where patient safety is listed as an  
 25 exception?

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1 MS. JONES:  
 2 A. No, there--but it doesn't say patient safety  
 3 anywhere in that document. It talks about  
 4 confidentiality.  
 5 CHAYTOR, Q.C.:  
 6 Q. Thank you, Commissioner. Those are my  
 7 questions.  
 8 THE COMMISSIONER:  
 9 Q. Thank you. Well, it's been a long three days.  
 10 MS. JONES:  
 11 A. I'm still going to a board meeting.  
 12 THE COMMISSIONER:  
 13 Q. Well, your stamina is to be admired. We thank  
 14 you very much.  
 15 MS. JONES:  
 16 A. Thank you.  
 17 CHAYTOR, Q.C.:  
 18 Q. Thank you.  
 19 THE COMMISSIONER:  
 20 Q. 9:30 in the morning.  
 21 (UPON CONCLUSION AT 5:42 P.M.)

CERTIFICATE

1  
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 30th day of April, 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 30th day of April, A.D., 2008  
13 Judy Moss

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**Inquiry on Hormone Receptor Testing**

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Inquiry on Hormone Receptor Testing

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