COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

APRIL 30, 2008

Appearances:
Bernard Coffey, Q.C. . . . . Commission Co-counsel
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Peter Browne/Jane Hennebury . . . . . Doctors Kara Laing et al

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

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

Mark Pike . . . . . NL Medical Association

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Stacey O'Dea . . . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

LIST OF EXHIBITS

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THE COMMISSIONER:
Q. Good morning. Please be seated.
CHAYTOR, Q.C.:
Q. Good morning, Commissioner.
THE COMMISSIONER:
Q. Ms. Chaytor?
MS. LOUISE JONES, EXAMINATION-IN-CHIEF BY SANDRA CHAYTOR, Q.C.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. Good morning, Ms. Jones.
MS. JONES:
A. Good morning, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. The last thing I want to do, having said that I'd be under an hour, is to start the morning by going backwards. So backwards we shall go. Ms. Jones, if we could have, please, Registrar, Exhibit 0730? This is the letter that we talked about yesterday, Ms. Marion Crowley, addressed to Ms. Marion Crowley, September 19th, 2007 from the physicians. And then 0731, Ms. Crowley's response?
MS. JONES:
A. Yes.

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CHAYTOR, Q.C.:
Q. So you remember our discussion yesterday on this?
MS. JONES:
A. Yes, yeah.
CHAYTOR, Q.C.:
Q. Okay. There was a news story yesterday, and maybe it's not correct, but I thought I should put it to you. I don't know if you heard it, but Carolyn Stokes reported that late yesterday, or late this afternoon, so the same day that you would have given your evidence on this.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. The question of who drafted the letter was answered, the question of who drafted the letter that went to the patients, "Eastern Health informed the media that the letter was written by their lawyers." Are you aware of that, are you aware of the news story?
MS. JONES:
A. No, just I heard the news story this morning at the 8:00 news.

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CHAYTOR, Q.C.:
Q. Okay. Are you aware that Eastern Health informed the media that the letter was written by their lawyers, is that correct?
MS. JONES:
A. There was no--I'm not aware of that, unless they picked it up from the testimony yesterday.
CHAYTOR, Q.C.:
Q. So but you didn't say that in your testimony yesterday.
MS. JONES:
A. No, I didn't.
CHAYTOR, Q.C.:
Q. Okay. So did anyone from your organization tell the media that the letter to the patients was drafted by your lawyers?
MS. JONES:
A. I have no idea. I was here yesterday. I gave testimony yesterday based upon what I knew about the letter and the October the 11th which says that we understood from our lawyers that we could not change the words in the cover letter, and I think we talked to that yesterday. And I've had no contact with

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people inside the organization since I left here 5:00 yesterday afternoon.
CHAYTOR, Q.C.:
Q. So you heard the story for the first time this morning?
MS. JONES:
A. At the 8:00 news.
CHAYTOR, Q.C.:
Q. And did you question that, have you asked anyone in your organization who would have said that?
MS. JONES:
A. I -
CHAYTOR, Q.C.:
Q. Was that said and who said it?
MS. JONES:
A. I have not because I was preparing to come here this morning, so I have not followed up on that.
CHAYTOR, Q.C.:
Q. Okay. You clearly told us yesterday that you didn't know who drafted the letter but that it was not drafted by Eastern Health or on its behalf?
MS. JONES:

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A. It's not drafted by Eastern Health staff.
CHAYTOR, Q.C.:
Q. Or on its behalf?
MS. JONES:
A. On its behalf. It was a court--my understanding is is that because we had the database names, that we had to comply with that in sending information to clients around the class action suit, that's what I understand about that.
CHAYTOR, Q.C.:
Q. Let's go back.
MR. SIMMONS:
Q. Madam Commissioner, if I might, I might be able to shed a little more light on that issue. The question certainly came up yesterday in the course of the evidence about the source of the letter. And I can convey to you my understanding of what I've been informed happened, if that would be helpful.
THE COMMISSIONER:
Q. What you have been informed in respect of the drafting of the letter?
MR. SIMMONS:
Q. Yes, yes.

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THE COMMISSIONER:
Q. Or what you have been informed happened yesterday?
MR. SIMMONS:
Q. Well, what I've been informed happened concerning the drafting of the letter, Madam Commissioner, if that would be helpful at this point, I can certainly do that.
THE COMMISSIONER:
Q. Well, I think that -
MR. SIMMONS:
Q. And I'm happy for Ms. Chaytor continue.
THE COMMISSIONER:
Q. Well, I'd prefer to hear it from the witness who told us a story yesterday to resolve it. Certainly we will have to resolve it in due course and perhaps you could communicate with counsel at the convenient time as to the appropriate witness who may be able to shed the light.
MR. SIMMONS:
Q. Yes.
THE COMMISSIONER:
Q. Assuming this witness can't.
MR. SIMMONS:

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

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

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

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CHAYTOR, Q.C.:
Q. Yes, at the time.
MS. JONES:
A. Yes, when the issue was brought forward, why would we have to have sent out a letter that had incorrect information in it.
CHAYTOR, Q.C.:
Q. Right. And you had that conversation personally with yourself, so this is something that you did have personal knowledge about?
MS. JONES:
A. After the fact.
CHAYTOR, Q.C.:
Q. Yes, after the letter went out?
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. And my line of questioning to you yesterday in terms of your knowledge of who drafted the letter and whether it was drafted on behalf of Eastern Health, that was based on your knowledge of having had discussions with whoever you needed to have discussions with around the time, which included Dan Boone?
MS. JONES:

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A. And that was in relation to we had sent out a letter that was from a court ordered process and that the letter was inaccurate.
CHAYTOR, Q.C.:
Q. Yes, okay. I have a copy of the transcript from yesterday. And at page 162 of the transcript, this is Ms. Jones speaking to the issue, I read the portion of the letter, "What was all that about?" Question. Answer, "That was all about a court ordered letter to be sent out as part of the class action suit and the letter was, we had the names in the database and the court did not have the names in the database, so we were responsible to put a letter that was provided through the solicitors and mail it out to clients, and that would have been somewhere before the 19th of September."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Continuing on at 163. "The other thing is that we were very, very clear and they were very clear in lots of our messages and our communication that this had nothing to do with

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the breast screening. And on a couple of occasions when we were doing media releases and discussions around this particular issue of ER/PR breast screening, we would always say this is not for breast screening. So this, we really were just creating the mailing the lists and addressing the envelopes and putting the information that we had from the courts to move forward."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Coming down to page 164. "What action did you take? Well, I would have spoken to Pat Pilgrim at the time to say what is this issue about. But we had heard that they were going to send a letter and at the end of the day we would respond inside of that." And this point you're talking about the physicians.
MS. JONES:
A. The physicians, yes.
CHAYTOR, Q.C.:
Q. "I understood at that point in time that the information that was in the letter wasn't anything that Eastern Health had generated."

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MS. JONES:
A. Yes. Being our staff, was.
CHAYTOR, Q.C.:
Q. And my question was--sorry?
MS. JONES:
A. Being our staff, Eastern Health didn't generate the letter.
CHAYTOR, Q.C.:
Q. Yes. My next question -
THE COMMISSIONER:
Q. Wait now. But Eastern Health not generating does not include people who might represent you?
MS. JONES:
A. At that time, when I responded to that, it wasn't our--I understand where you're going with that one. But it wasn't like our quality people or whatever who had said, "This is a letter generated by the courts and we have to send it out, so" -
CHAYTOR, Q.C.:
Q. And that's what you understood -
THE COMMISSIONER:
Q. No, no, I'm afraid you don't understand where I'm going with the question, if that's your

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response. When you said yesterday that it, fact, was not generated by Eastern Health -

MS. JONES:

A. Yes, Eastern Health.

THE COMMISSIONER:

Q. - I would have included that people who represent Eastern Health.

MS. JONES:

A. Yeah.

THE COMMISSIONER:

Q. So, for example, if the law firm that was representing Eastern Health in this process had a part to play -

MS. JONES:

A. A part to play, yes.

THE COMMISSIONER:

Q. - in the wording in the letter, then it would seem to me that Eastern Health had an ability to influence what was in the letter.

MS. JONES:

A. Yes, and I -

THE COMMISSIONER:

Q. So your answer would have lead me to believe that that firm had no participation in that. Now, is that right or wrong?

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MS. JONES:

A. I'm not sure when you ask it that way. When I talk about staff, I generally believe internal staff. I do understand that we have people who work as agents for ourselves.

THE COMMISSIONER:

Q. Um-hm.

MS. JONES:

A. When I responded to that, I was responding to staff inside of Eastern Health, okay. Whether, in fact, the lawyer associated with the class action suit, the HIROC lawyer, had any play in what was inside that letter or whether it was generated by the courts or generated by the lawyer for the class action suit, that detail, I would not understand how the actual letter had got generated.

CHAYTOR, Q.C.:

Q. But, let's go on.

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. "So the information in the letter was generated by whom?" Question. "Somebody on" -

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MS. JONES:

A. "Somebody on behalf" -

CHAYTOR, Q.C.:

Q. - "behalf of Eastern Health?" And your answer was, "No, no." "So who drafted the letter? I have no idea who drafted the letter" -

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. - "but I think if you go to the next exhibit you have," and you talk about -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - Marion's answer.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And we go on to that. You talked to Dan Boone, you told us about your conversation with Dan Boone.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And the conversation that you had with Dan

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Boone was about whether you could change anything in the letter. And you clearly told us about that.

MS. JONES:

A. The conversation that I had with Dan Boone was after this, the letter had been sent out.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. And was directly in relation to the physicians who had a major problem with the wording in the letter, and that was the nature of the conversation. Because I think I also said that I asked how we got brought into that particular issue of having to mail out, and it was because we had the names in the database and why wouldn't the courts be able to do that.

CHAYTOR, Q.C.:

Q. Yes. And you clearly indicated -

THE COMMISSIONER:

Q. I'm sorry, sorry.

CHAYTOR, Q.C.:

Q. No, go ahead.

THE COMMISSIONER:

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Q. But things keep running through my mind. Does that mean that Eastern Health would have been willing to give our their patients' names to the court?

MS. JONES:

A. I think that might have been a discussion if we had been asked. In my mind I'm thinking if the court has some kind of a process that, in fact, it has--it can generate or it has to notify people, then they must have confidentiality and all those kinds of things that would be similar to what we would have. And I don't--I'm not aware that that was asked whether, in fact, we would have the list or not, or whether, in fact, it was because we had the list of patients that it was us to generate the list and send out what came as part of the court order. So that was my conversation with Dan was how could we as Eastern Health now with this particular kind of process going on, again, have an issue here with confusion in the public.

CHAYTOR, Q.C.:

Q. And so in your conversation with Dan, you didn't ask him who drafted the letter?

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MS. JONES:

A. No, because I just assumed that it was a court ordered process, we had to put the letters out and it was part of what was happening inside of the class action suit.

CHAYTOR, Q.C.:

Q. And so if the letter was drafted by the lawyers for Eastern Health, you don't know?

MS. JONES:

A. No.

CHAYTOR, Q.C.:

Q. So in saying that it was not drafted on behalf of Eastern Health, and clearly saying, "No, no," to my question yesterday on that, how can you say no to that?

MS. JONES:

A. I think that I put on my lens when I talk about staff, I respect what Madam Justice Cameron has said, that staff includes agents of Eastern Health. I did not ask the question about how that letter was generated. And the wording in the memo that goes back to the physicians, and remember I come in after the fact, because the physicians have identified an issue with the letter in their dealing with

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clients says that the letter which included inaccurate reference to screening was part of that and we couldn't change it.

CHAYTOR, Q.C.:

Q. Ms. Jones, with all due respect, it was two distinct separate questions.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. The first was whether or not the information that was in the letter was anything that Eastern Health had generated. You said that it wasn't. The second was, "So the information in the letter was generated by whom, someone on behalf of Eastern Health?" and that you responded, "No, no." So the answer wasn't, "I don't know," the answer was "No."

MS. JONES:

A. Yeah, I answered that yesterday. And you asked the question, and when you put lawyers in that in terms of, you know, on behalf of Eastern Health, reflecting on that there, I would have to go back and say how did the--my understanding was it was part of a court order

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process. We can go back, as Mr. Simmons has indicated, and give you the exact detail around how that came forward. We also talked about clinically negative to clinically positive yesterday, as well -

CHAYTOR, Q.C.:

Q. Yes, and we do have a question around that, as well.

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. But what I want to get at here and the importance, and I'm sure you appreciate the importance -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - of being able to rely--we've been two long days at this.

MS. JONES:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And we have to be able to rely on the information that's coming from the witnesses.

MS. JONES:

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A. Yes.
CHAYTOR, Q.C.:
Q. To be accurate and complete information. And if we don't know the answers, we don't know the answers, but we have to have complete--so is there anything else in reflection over the past, the evidence of the past couple of days that you've provided to us that you need to go back and check?
MS. JONES:
A. Not that I'm aware of in reflecting on it in the evenings.
THE COMMISSIONER:
Q. You indicated that you did not learn about this until this morning?
MS. JONES:
A. The -
THE COMMISSIONER:
Q. The news report?
MS. JONES:
A. The news report, I heard the news report on the 8:00 news report.
THE COMMISSIONER:
Q. So nobody from communications or anybody else in your organization--well, perhaps you don't

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have a Blackberry. Do you have a Blackberry?
MS. JONES:
A. I have a Blackberry. It's not with me this morning because I was at the office last night. And I wouldn't -
THE COMMISSIONER:
Q. So you were in your office -
MS. JONES:
A. I don't answer my Blackberry in the run of a day unless I happen to have a look.
THE COMMISSIONER:
Q. Okay.
MS. JONES:
A. So I was here all day yesterday.
THE COMMISSIONER:
Q. I appreciate that.
MS. JONES:
A. Yeah.
THE COMMISSIONER:
Q. And I'm sure it was a very long day. But everybody who's come to give evidence in this and a lot of the material, I've been struck by sometimes what strange hours people communicate with each other.
MS. JONES:

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A. Yes.
THE COMMISSIONER:
Q. In your organization.
MS. JONES:
A. Um.
THE COMMISSIONER:
Q. And it just strikes me as being out of the norm for the kind of activity that we have seen that if, indeed--assuming for the moment that the report is accurate, we'll check that out, but assuming for the moment that the report is accurate and that at some point Eastern Health advised the media about the source of the letter indicating that it was something different than you had said, would you not expect that they would -
MS. JONES:
A. Contact me?
THE COMMISSIONER:
Q. - contact you, e-mail you, something?
MS. JONES:
A. They would--they know that I'm not a person who is tied to my Blackberry, okay. They know that after hours they would get me at home. I was with the board chair last night preparing

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for the board meeting today just in case I was not able to be there. So I was with the board chair from 6:30 to 8:00 last night. They would have left a voice message at home if there was anything, if they felt it was important, but there was no communication at all.
CHAYTOR, Q.C.:
Q. So you've checked your e-mails and nobody e-mailed you -
MS. JONES:
A. No, I did not -
CHAYTOR, Q.C.:
Q. You haven't checked your e-mail?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. But nobody from Eastern Health -
MS. JONES:
A. Nobody from Eastern Health.
CHAYTOR, Q.C.:
Q. - has contacted you to say that there's something in the media that either is not correct or it is corrected and we've given information to the media that is not -

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

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communications person -
MS. JONES:
A. Yesterday here at 20 after 5.
CHAYTOR, Q.C.:
Q. And she didn't advise you of this -
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. What Carolyn Stokes is reporting?
MS. JONES:
A. But we have two who report--who deal with external media.
CHAYTOR, Q.C.:
Q. And on top of page 166, "I'm not sure." And I ask, "And would that have been the Eastern Health's lawyers?"
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Because there was reference to the lawyers being notified.
MS. JONES:
A. Um.
CHAYTOR, Q.C.:
Q. "And would that have been Eastern Health's

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

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again. We have the names of the database and we then are perceived, particularly by our physicians, to have actioned a court order that, in fact, is problematic."
MS. JONES:
A. And if I recall, those are the words that were used in the, similar words in the reporting this morning.
CHAYTOR, Q.C.:
Q. Of what you said?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Yes.
MS. JONES:
A. Those words -
CHAYTOR, Q.C.:
Q. Yes, they picked up those words about you saying that Eastern Health has been caught in something that -
MS. JONES:
A. Yes, that's right.
CHAYTOR, Q.C.:
Q. - Eastern Health did not write?
MS. JONES:

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A. Yes.
CHAYTOR, Q.C.:
Q. And was not written on behalf of Eastern Health?
MS. JONES:
A. And that's problematic, yeah.
CHAYTOR, Q.C.:
Q. Right. So like that was the discussion. Here Eastern Health again is caught because of somebody else's action that we had something that we had no action on behalf of somebody else.
MS. JONES:
A. We had to action on behalf.
CHAYTOR, Q.C.:
Q. I'm sorry, "we had to action on behalf of somebody else."
MS. JONES:
A. Yeah, and that seems to be the nature of the reporting, those words.
CHAYTOR, Q.C.:
Q. Yes.
MS. JONES:
A. Would have been the reporting this morning, so -

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CHAYTOR, Q.C.:
Q. And you could see how that is not consistent with Carolyn Stokes' statement that "late this afternoon, the question of who had drafted the letter was answered. Eastern Health informed the media that the letter was written by their lawyers." You didn't tell us that yesterday.
MS. JONES:
A. No, I didn't tell you that yesterday.
CHAYTOR, Q.C.:
Q. And in fact, what the Commissioner was told yesterday would lead us to believe that it wasn't done on behalf of Eastern Health, and you were taking exception with the fact that this had to be done and sent out on Eastern letterhead--Eastern Health letterhead -
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. - with misinformation?
MS. JONES:
A. That's right.
THE COMMISSIONER:
Q. When you finish this line of questioning, Ms. Chaytor.

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CHAYTOR, Q.C.:
Q. Yes, thank you.
THE COMMISSIONER:
Q. While we have this up, there was--it happens to be in an area that I had noted a question for myself. Can we go back to, I think it's page 74, somewhere in there, 74, 75, 76. I think this is from--yes, it is, yesterday's testimony.
MS. JONES:
A. Okay.
THE COMMISSIONER:
Q. And when you were talking about the problems with the content of the letter -
MS. JONES:
A. Yes.
THE COMMISSIONER:
Q. - as I understood that, there were two problems. One was the incorrect reference to screening?
MS. JONES:
A. That's right.
THE COMMISSIONER:
Q. Which this clearly was not.
MS. JONES:

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

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Kara Laings of the world or whatever as around that time, it may have been the pathologists at the time, but this is clinically negative to clinically positive versus an absolute number which is the way the pathologists deal with it."

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. So can you explain a little further what you mean by that?

MS. JONES:

A. From a pathologist's perspective, it is either negative or positive, okay. It is either zero or one percent or more is positive. But from a clinical perspective, when the oncologists are looking at it, they're looking at the percentage, in terms of treatment options. So there's a technical--you know, it's either negative or it is positive versus from a clinical perspective, it depends on, in this instance, you would see over time the percentage of positivity. There were a change in the guidelines over time around whether in fact Tamoxifen should be given. At one point

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in time, it was greater than 30 percent and then as we went to 2001, it dropped down to ten percent. But -

THE COMMISSIONER:

Q. Yes, I understand that there was that progression.

MS. JONES:

A. Yes, yeah, there was that progression.

THE COMMISSIONER:

Q. So is that what you're referring to?

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. Or are you saying that--that was the part that I didn't understand. Were you saying that when you're determining whether someone goes from clinically negative to clinically positive, you have to know what time the test was originally done, so then they can know the standard by which they're operating, or were you saying that the oncologists of the world have indicated to you that in order to do their jobs, they need the percentages?

MS. JONES:

A. I think inside of this letter, it was the

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order had said to identify the clinically negative to the clinically positive.

THE COMMISSIONER:

Q. Yes.

MS. JONES:

A. That is not a way that we would normally reference that. So there was discussion about what does clinically negative to clinically positive mean inside of this order.

THE COMMISSIONER:

Q. Okay.

MS. JONES:

A. And at the end of the day, it went to the panel and the way the decision clinically negative to clinically positive was based upon the oncology because if you do pathology, it's either negative or it's positive. If a pathologist was to read it, anything one percent or over would have been positive.

THE COMMISSIONER:

Q. Okay, so that if I really want to know what Kara Laing's problem was, I really should ask Kara Laing you're telling me?

MS. JONES:

A. Yes, and the wording from the Court was

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clinically negative to clinically positive, not--that's not the way we normally would talk about it. It wouldn't have given us a subset to say here is, say, 50 people and these are the results, which does this letter apply to.

THE COMMISSIONER:

Q. Okay, but was your understanding of the problem being conveyed to you by Dr. Laing the problem that arises over the fact that the numbers would have changed over time in respect of what was considered positive or negative by an oncologist?

MS. JONES:

A. I didn't have any discussion with Kara Laing on this. This would have been with Marian Crowley, who was -

THE COMMISSIONER:

Q. Okay. So your understanding of this comes through Marian Crowley?

MS. JONES:

A. Through Marian Crowley and the discussion that they would have had to have, which clients are we talking about that these letters have to go out to. Because we have a database, remember, of all -

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

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

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CHAYTOR, Q.C.:
Q. March '07, yes.
MS. JONES:
A. March '07. At the time we were looking at, we didn't have a crisis communication strategy or plan inside of Eastern Health and that level of experience would not have been inside our current internal communication department. So at this point in time, we were looking for external resources to develop a communication strategy for us around--you have regular media relations and you have a framework really for crisis communication. That was in the winter, but there had been discussion before that.
CHAYTOR, Q.C.:
Q. So has a crisis management strategy been developed?
MS. JONES:
A. We've actually contracted with them, but it would have been--what are we at now? We're -
CHAYTOR, Q.C.:
Q. March 21st, '07.
MS. JONES:
A. No, no, I'm thinking we're in April.
CHAYTOR, Q.C.:

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

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MS. JONES:
A. In 2005, yes, and we've been dealing with the media issues continuing out of that. So it's a very unusual set of circumstances, not your normal media that you're getting on a day-to-day call. So any events like that, that would be considered crisis.
CHAYTOR, Q.C.:
Q. So this is to develop a communication strategy?
MS. JONES:
A. A framework, yes.
CHAYTOR, Q.C.:
Q. For the organization around when a crisis would -
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. - would come up. So this is how Eastern Health would then communicate on the issue, I take it not to patients?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. You have your policies in place for that.

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MS. JONES:
A. We have our policies in that. This would be -
CHAYTOR, Q.C.:
Q. This is intended for external communications to the broader public?
MS. JONES:
A. And stakeholder development and those kinds of things. So it's that kind of thing.
CHAYTOR, Q.C.:
Q. And so has that--so I'm sorry, where are we in that process?
MS. JONES:
A. They came on in December. They did the polling through January or so and then in February, developed a draft and presented that to the Board in February.
CHAYTOR, Q.C.:
Q. So there is a draft?
MS. JONES:
A. Well, it would have been approved at that point in time, after it came out of the Board in February.
CHAYTOR, Q.C.:
Q. Oh, so it's now approved as of February?
MS. JONES:

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A. Yeah, it's a strategy.
CHAYTOR, Q.C.:
Q. February of 2008?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. And that deals with how on a go-forward basis to communicate--in the event of a crisis, how to communicate with stakeholders and how to communicate with the broader public?
MS. JONES:
A. It's a framework and it is components of. So it doesn't actually talk about how do you communicate. It talks about stakeholders and stakeholder alignment and working with individuals, those kinds of things.
CHAYTOR, Q.C.:
Q. And what does it recommend? What does it recommend, for example, in terms of talking or communicating with your stakeholders?
MS. JONES:
A. There's a bunch of principles in there, but it also bounces out of the work that they had done around the polling that they had done in January which talks about Eastern Health and

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you know, from a clinical perspective and that people have trust in Eastern Health, but when you get down to the administrative kinds of things and being open and transparent, they would not be rated as high and that we would have to find vehicles that would allow us to be able to talk and get our messages out into the public. So there's a bunch of principles in there.

There's a bunch of issues with respect to stakeholders and identifying stakeholders who have an interest in a particular issue, and then involving them as we move forward, seeing where they stand on an issue, using individuals who are able to converse with the public in that, like using our physicians as part of communication with the public, those kinds of things.
CHAYTOR, Q.C.:
Q. And does it address communications with other health authorities?
MS. JONES:
A. Not in the sense of other health authorities, only in the sense as they being a stakeholder and if they're important on a particular

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issue. But it's not on an issue by issue basis. So it is really the bigger picture. So depending on what the issue is, the regional health authorities would be a stakeholder. Government would be a stakeholder. Some of the advocacy groups would be a stakeholder. So it depends on the issue and identifying what the issue is and then putting a plan in place to move forward on all aspects, including internal communication around what the issue is and what our internal population need to know as well.

CHAYTOR, Q.C.:

Q. And what about not only what the issue is, but how the issue has been addressed and any key findings from having investigated the issue and getting that information out to the people who need to have the information?

MS. JONES:

A. It wouldn't be specific in those things, other than being transparent and providing as much information as we can inside of whatever the issue was at the time.

CHAYTOR, Q.C.:

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Q. And the people who developed this are Bristol, who are a communications group?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And was there consultation with any people who would have expertise in patient safety issues?

MS. JONES:

A. No. In developing their strategy, they did bring in some people from outside of the province to develop their framework, and there was discussion with them. So I'm not -

CHAYTOR, Q.C.:

Q. So what kind of people were they, what area of expertise?

MS. JONES:

A. They were communications people who had dealt with -

CHAYTOR, Q.C.:

Q. So PR people?

MS. JONES:

A. PR people. I'm not sure where their expertise lay and how much consultation they had done outside, but they had used the polling as part of what they understood and it is a crisis

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communication framework issue.

CHAYTOR, Q.C.:

Q. So I just want to understand. The purpose for this particular exercise or document would be in terms of Eastern Health's PR, Eastern Health's image in going forward and communicating in the event of a crisis?

MS. JONES:

A. In the event of a crisis.

CHAYTOR, Q.C.:

Q. As opposed to any documentation aimed at relaying relevant information to various external bodies?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. That's not the purpose of that?

MS. JONES:

A. That's not the purpose of this.

CHAYTOR, Q.C.:

Q. Has that exercise happened? Has Eastern Health gone through any similar exercises to how on a go-forward basis, in the event of a crisis, how to communicate findings to other people who may need to know?

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MS. JONES:

A. No. No, only in terms of the framework of who needs to be involved or what kind of--on an individual issue, then it would be working with the individual issue and how you would end up communicating. This is not meant to be this. This is meant to have the bigger components of inside of a crisis communication framework, what things you need to keep in your mind as you move forward.

CHAYTOR, Q.C.:

Q. So why hasn't a similar effort been undertaken by Eastern Health in terms of the communication of information which could be germane to patient safety? Why hasn't that piece taken place?

MS. JONES:

A. I think that if you look at that, you would have heard me say in the fall, we have really believed that we are under resourced in communications. We did put some additional resources in communications, to the tune of $200,000 in the fall. This is where, even though there was discussion earlier on about bringing a consultant in to talk about a

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

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was put there.

CHAYTOR, Q.C.:

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

MS. JONES:

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

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CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. That's to come.

CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

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policy within your own organization?

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. If we could have 0773, please?

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THE COMMISSIONER:
Q. Before we move on on this point, it seems to me that that document would be quite valuable.
CHAYTOR, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. Mr. Simmons, can I add that to your list if we do not have it. Perhaps we do, I frankly don't know what's in all of those 5,000 documents.
MR. SIMMONS:
Q. We'll certainly produce it.
CHAYTOR, Q.C.:
Q. I requested that document last week.
THE COMMISSIONER:
Q. Oh, okay.
CHAYTOR, Q.C.:
Q. That's the document that you came back on an e-mail, that was the communication strategy -
MR. SIMMONS:
Q. Yes, but -
CHAYTOR, Q.C.:
Q. And I understood it didn't exist.
MR. SIMMONS:
Q. I understood this to be a different one, but

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

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time as -
THE COMMISSIONER:
Q. So as of yet, the government has not approved?
MS. JONES:
A. Approved inside of the strategic plan, so that would be where those would be, but that's not a problem. They are internal, the board has approved them and the strategic plan has gone forward to government.
THE COMMISSIONER:
Q. Thank you. I appreciate that.
CHAYTOR, Q.C.:
Q. Openness, transparency--I'm sorry, what else did you say were included in the core values?
MS. JONES:
A. Under the connectedness piece.
CHAYTOR, Q.C.:
Q. Yes, the connectedness, we talked about that yesterday.
MS. JONES:
A. Remember I had indicated that we have core values and then we have expected behaviours, what we would expect staff to--how to behave, okay, and that is a piece of work where the value, like respect is expanded to say this is

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what we expect in a respect -
THE COMMISSIONER:
Q. I understood you to say yesterday that in a value such as transparency and accountability would be within what you've described as connectedness.
MS. JONES:
A. There's five or six values and the words "transparency and accountability", you actually would go over to the behaviours that we would expect and you would find them there.
THE COMMISSIONER:
Q. All right, thank you.
CHAYTOR, Q.C.:
Q. Is there a difference, you say openness and transparency, is there a difference?
MS. JONES:
A. Some people would--we've tried to put as many words around it so people understand what we expect them to act like. So openness in terms of open to discuss issues, those kinds of things. Transparency, sometimes people understand it to be more transparency and honesty is another word that you would be used, so they're kind of not interchangeable

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because they all have different elements, but we try to use as many concepts in that so that people will understand how we wish them to act with the public.

CHAYTOR, Q.C.:

Q. I think I was about to go to 0773. Ms. Jones, this is a Confidentiality Acknowledgement Agreement which we understand is a fairly new document at Eastern Health.

MS. JONES:

A. It's new, yes.

CHAYTOR, Q.C.:

Q. Could you tell us about the background to this document?

MS. JONES:

A. The background to this document is is that in the redevelopment of policies inside of Eastern Health, all the legacy boards would have had a confidentiality agreement signed generally by their staff and so over the last couple of years, two years or so, this has come to being to be what we want to move forward inside of Eastern Health with respect to confidentiality agreement and including the signing by physicians, which hasn't always

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been in the legacy organizations.

CHAYTOR, Q.C.:

Q. So physicians hadn't always been asked to sign a confidentiality agreement?

MS. JONES:

A. To physically sign, but as part of their employment or their credentialing, it would have been acknowledged in it, but to physically sign the agreement just like all other staff hadn't been in all of the legacy boards.

CHAYTOR, Q.C.:

Q. And why is that now being of physicians?

MS. JONES:

A. Well this is one way and even though you would understand that signing on the piece of paper was really for them to acknowledge that they had read the policy, were aware of the content of the policy and understand and would abide by the policy. You and I can have a conversation to say have you, do you understand, this is really a documentation of that, that in fact they have seen it, that they have read it, that they are aware of it and that they in fact have documented that

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that is--that has happened.

CHAYTOR, Q.C.:

Q. I'm not sure I got the answer, so in the past, they weren't asked to sign?

MS. JONES:

A. It was part of their credentialing that they would keep information confidential, patient confidentiality was -

CHAYTOR, Q.C.:

Q. I guess part of their code of ethics too in terms of -

MS. JONES:

A. Code of ethics as well.

CHAYTOR, Q.C.:

Q. Is this about patient, personal patient information?

MS. JONES:

A. Yes, personal patient information, anything in terms of their employment, their affiliation, anything that they learn inside of the workplace that is privileged to the workplace, needs to stay in the workplace, and those would be the same things that we would be saying of all of our staff.

CHAYTOR, Q.C.:

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Q. Is this agreement of "Confidentiality Acknowledgment", it's entitled, is this broader than what was in place previously under the Health Care Corporation?

MS. JONES:

A. In terms of the Health Care Corporation, I'd almost have to go back to the original, I don't think the previous Health Care Corporation was all encompassing in the actual paper that we signed. And the reference around business thing is the point that the physicians have picked up in the media this week and it specifically references it in here. I don't believe -

CHAYTOR, Q.C.:

Q. It's right here, we have "this includes confidential and/or private information concerning patient client resident" which of course would be covered in any event, I would think.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. In particular with respect to professionals. "Staff or the business of Eastern Health which

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may come to my knowledge or attention in the course of my employment/affiliation."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. So that's the portion that we've heard publicly that physicians -

MS. JONES:

A. That's the piece that we've heard publicly.

CHAYTOR, Q.C.:

Q. - have an issue with.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And I take it that has been expressed internally to Eastern Health by its physicians?

MS. JONES:

A. By Dr. Howell or John Guy because they have been the ones who had been dealing with the physicians on this. But I do know that they would have, it's a new concept for them and that they would have expressed concern and even with the media on Monday, Dr. Guy has indicated that once it's been talked to with--

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and I wouldn't have that level of detail, but just from hearing him on Monday, it was once it's explained to the clinical chiefs, which are physician leaders, they understand what the concept is all about.

CHAYTOR, Q.C.:

Q. Yes, and if we go to the second page of the document, so this is a policy, I take it, that has been signed off on?

MS. JONES:

A. It's come up through, it's a level one policy which means that it's a regional policy and it has come up through all of the levels and screens inside the organization and it's in the process of being implemented.

CHAYTOR, Q.C.:

Q. Okay, so it's signed off on in terms of you're the issuing authority, Louise Jones -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - is indicated to be the issuing authority.

MS. JONES:

A. All level one policies, which are regional policies in this nature would be signed off by

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the CEO.

CHAYTOR, Q.C.:

Q. Okay, so it is a policy currently in effect at Eastern Health. The issue that's now ongoing is the implementation of having the staff and physicians execute the document.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Is that the issue?

MS. JONES:

A. Yes. Now this one has been in the works for a long time because we had a lot of issues around access to computer information and personal information, the individual's personal information, so there has been a lot of discussion around this.

CHAYTOR, Q.C.:

Q. And so when you say a long time, when did this become an issue?

MS. JONES:

A. We did some discipline of staff around accessing their individual records through a computer system two summer's ago, well it will be two summers this summer, so eighteen months

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or so. And at that point in time, we had--we were using old legacy board policies and so this group has been on the go for at least eighteen months dealing with this issue.

CHAYTOR, Q.C.:

Q. So about eighteen months ago it started?

MS. JONES:

A. This one, yes.

CHAYTOR, Q.C.:

Q. And if we look at the type of confidential information on page two of the document, page three of the exhibit, it includes financial human resources, legal, other administrative information, business initiatives, operational service delivery.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. So I take it, is it the other administrative information business initiatives that are causing concern amongst the physicians? This refers to any information used for administrative purposes, clinic schedules, patient census, employee list, patient list or donor lists, is that contentious?

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MS. JONES:
A. These have patient names and that on it, so I would hope that they are not contentious. What we've heard is the business.
CHAYTOR, Q.C.:
Q. So any information related to the organization's initiatives, example, organizational restructuring, mergers, outsourcing of business units, recruitment--is that recruitment?
MS. JONES:
A. I'm not sure.
CHAYTOR, Q.C.:
Q. Looks to me like it's recruitment. So that's considered a business initiative?
MS. JONES:
A. Yes, restructuring, mergers, outsourcing, business initiatives, they way John Guy explained it was we have physicians who are involved in the assessment of contracts, okay, for the purchase of new equipment and those kinds of things, so there's information that is known through that contract and that selection of preferred vendors and those kinds of things, then that is part of doing the

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

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well.
THE COMMISSIONER:
Q. For example if a physician were to speak about things like overworked because we don't have enough persons of a particular specialty or because they don't have enough people in another department, that kind of thing, would that be contrary to this?
MS. JONES:
A. We have physicians out there who talk to us about that all the time and we, in fact, provide those individuals to the media if in fact those issues come forward.
THE COMMISSIONER:
Q. Yes, but I'm asking whether you anticipate that that would be contrary to that, if what they wanted to say was contrary to what Eastern Health's view of the world?
MS. JONES:
A. We would just want to be able to put our view out there as well.
CHAYTOR, Q.C.:
Q. So would they be prevented from speaking on that if they signed this agreement?
MS. JONES:

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A. We would want to know that they were speaking on that.
CHAYTOR, Q.C.:
Q. So they'd have to have your authorization to be able -
MS. JONES:
A. No, not the authorization because physicians are independent--they are credentialed by us, this here really goes around the initiatives that are inside of Eastern Health that are proprietary to Eastern Health. We have physicians all the time who talk about workload.
CHAYTOR, Q.C.:
Q. Pathologists are employees, aren't they?
MS. JONES:
A. Pathologists are employees, they're still credentialed, but I've been with Nash Denic in the last couple of weeks -
THE COMMISSIONER:
Q. I understand that, Ms. Jones, but what I'm trying to get at is whether, in your view of this document, which I understand you're asking physicians to sign, which they did not have to sign prior to this, that in any way

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prohibits a physician from, who doesn't tell you about it, from deciding to make his or her concerns about the level of staffing in his or her specialty or the level of staffing in another specialty as far as that goes, public?

MS. JONES:

A. No, it doesn't prevent that and they have many vehicles that they use to do that, whether it's a personal vehicle, Newfoundland and Labrador Medical Association and they also have the vehicle to government because they -

THE COMMISSIONER:

Q. Oh I understand you're not preventing the Medical Association from doing it, but my concern for the moment is -

MS. JONES:

A. No, no, for documenting individuals.

THE COMMISSIONER:

Q. - whether--well I guess the real question is whether or not when it says recruitment in business initiatives, how you interpret it.

MS. JONES:

A. That's right.

THE COMMISSIONER:

Q. And as I understand what you're saying to me

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is that interpretation from Eastern Health's perspective is not going to prohibit doctors from--and we're just talking about doctors because I guess they haven't, prior to this, had to deal with it.

MS. JONES:

A. But many of our staff have not had and Ms. Chaytor has already alluded to that, in the old Health Care Corporation business was not part of what they signed as well.

THE COMMISSIONER:

Q. Okay.

MS. JONES:

A. So this is not just a physician issue. This would be an understanding of what would be included in that kind of initiative, things such as information that they've learned as part of their business or inside a contract, negotiations inside of choosing, you know, vendors, those kinds of things. This one here talks about /recruitment and that I would suggest that some of those may very well be individual arrangements that we have made that are part of a personal file at the end of the day.

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THE COMMISSIONER:

Q. Okay, so we should interpret recruitment in this document as being really information regarding contractual arrangements.

MS. JONES:

A. That's personal, right.

THE COMMISSIONER:

Q. It may be, but I'm just trying to figure out what the document means.

CHAYTOR, Q.C.:

Q. This says "any information" it's quite broad, related to the organization's initiatives and then, for example, recruitment is one of those.

MS. JONES:

A. It's one of the points underneath that particular bullet on business -

CHAYTOR, Q.C.:

Q. So any information, so if a physician or a nurse or whoever were to go out and speak as to shortage of staff in their particular profession, you're saying that's not covered by this.

MS. JONES:

A. No.

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CHAYTOR, Q.C.:

Q. But if they know that they have brought forward issues within to say there's been a shortage and they're not happy with the organization's response to that, are they then prevented -

MS. JONES:

A. No.

CHAYTOR, Q.C.:

Q. - from saying that I've brought this forward -

MS. JONES:

A. I brought this forward--we see that all the time--we brought it forward. We brought it through all the channels inside the organization which is generally your manager, your program director.

CHAYTOR, Q.C.:

Q. I know you see it all the time, but this is new.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And in answering my question about is this broader -

MS. JONES:

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A. And the answer is yes.
CHAYTOR, Q.C.:
Q. - you weren't sure, you'd have to go back. But this is broader, business initiatives is new.
MS. JONES:
A. Is broader, it's not in the--usually what we would have seen in the past was more around patient confidentiality and this includes human resources, legal, other administrative -
CHAYTOR, Q.C.:
Q. So, all of that is new?
MS. JONES:
A. All that's new.
CHAYTOR, Q.C.:
Q. So, all that's broader than what they have been traditionally been asked to sign, if they'd been asked to sign anything.
MS. JONES:
A. If they've been asked to sign anything. It's been part of their understanding, like you indicated, their code of ethics as they apply for credentials and in terms of the medical bylaws that they have to abide by. All those issues of confidentiality would be included in

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those kinds of vehicles or medical -
CHAYTOR, Q.C.:
Q. So why, at this point in time, did eastern health, in particular dealing with business initiatives, why is it that that's seen necessary to include under the umbrella of confidentiality?
MS. JONES:
A. Because it's confidential information inside of eastern health. Part of the business, you would not normally be exposed to that or have knowledge of that if you were not part of an employee or some kind of relationship inside of eastern health. This also applies to contractors and that as well. So, it's much broader that just staff. Anybody who comes inside of eastern health, this applies to them as well.
THE COMMISSIONER:
Q. Don't you have a confidentiality arrangement--I mean, wouldn't your normal contracts include confidentiality for everybody who walks through your door -
MS. JONES:
A. Through who -

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

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

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we've done, those kinds of things.
CHAYTOR, Q.C.:
Q. But why wouldn't that also be a policy? If we have a policy here, this is confidentiality. This is how we keep things within ourselves, but here's our parallel policy on if you have concerns, here's how we deal with it.
MS. JONES:
A. The complaints policy would be there and it's -
CHAYTOR, Q.C.:
Q. And what's the complaints policy?
MS. JONES:
A. Well, you've seen it in terms of quality, okay, that would be external complaints.
CHAYTOR, Q.C.:
Q. Yes, that's people coming to complain from outside.
MS. JONES:
A. Coming in--and then we also have, as I just indicated, with our nursing areas, there is an internal process that if they have issues that they've identified from a safety perspective, there's a process, a whole -
CHAYTOR, Q.C.:

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Q. Is that a policy?
MS. JONES:
A. Yes, it would be.
CHAYTOR, Q.C.:
Q. For nurses.
MS. JONES:
A. A whole validated process around how we investigate, how we get back nurses on that. We have professional practice forms inside of the organization where--and that's similar to what I'm talking about for nurses, professional practice forms where issues are identified and there is a process of investigation and getting back to staff. So, those kinds of vehicles do exist, whether they exist in a new regional eastern health format, they all are not transitioned into eastern health, but they're in the process of transitioning.
CHAYTOR, Q.C.:
Q. And this policy pertains to all people -
MS. JONES:
A. All eastern health.
CHAYTOR, Q.C.:
Q. - whether they're employees, independent

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

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

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resource policies, Mr. Dodge would be the lead on human resource policies. Then we have level the policies where they might be programs or might be more than one program. And then we have a level four policy which is a very specific and a very work area that doesn't affect anybody else, maybe how you technically do your task and you're the only one doing your task. So, there's four levels of policies.

CHAYTOR, Q.C.:

Q. And my question to you was, in terms of a policy, similar policy to what you have in your confidentiality privacy policy, something that would be all encompassing, umbrella, standardized for everyone, whether you're a lab technologist or you're a nurse or you're a physician, whatever you are, you have the same policy for reporting -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - any issues that you have or concerns that you might have, in particular with respect to quality control, patient safety.

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MS. JONES:

A. And I would say to you, it wouldn't be specifically quality control patient safety. It would be any complaint that you would have and it could be quality control or patient safety. It could also be working conditions. It could be anything that you have a concern with in your work environment.

CHAYTOR, Q.C.:

Q. A vehicle by which they may speak as -

MS. JONES:

A. A vehicle.

CHAYTOR, Q.C.:

Q. - opposed to a vehicle by which they may not speak. That's what I'm talking about.

MS. JONES:

A. Vehicle which by they speak, lots of vehicles by which they speak.

CHAYTOR, Q.C.:

Q. But no policy.

MS. JONES:

A. I will go back and check, but I'm sure that we will find parts of that, that are in legacy organizations, maybe not redrafted like this one which is a new policy for eastern health

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and we'll bring forward what we've got.

CHAYTOR, Q.C.:

Q. Okay. So, what the answer is right, you don't know.

THE COMMISSIONER:

Q. Did I understand you to say that you believe contracts with CUPE--is CUPE your major -

MS. JONES:

A. NAPE.

THE COMMISSIONER:

Q. NAPE--contracts with NAPE would include provisions that would address patient safety?

MS. JONES:

A. No, they would include provisions that would address, if there were issues in the work place, that the employee could bring forward issues in a certain framework.

THE COMMISSIONER:

Q. Okay. And those issues would not just be employment related issues, but issues related to patient safety?

MS. JONES:

A. Could be any issue.

THE COMMISSIONER:

Q. Okay.

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MS. JONES:

A. Just like we have Occupational Health and Safety, if, in fact, they identify issues of safety in the workplace which sometimes also cross over to issues of patient safety, not just worker safety, there is a whole structure and process around Occupational Health and Safety and reporting in the workplace as well and that would be regional as well.

THE COMMISSIONER:

Q. I understand that there can be occasions when issues relating to occupational safety also relates to patient safety.

MS. JONES:

A. Yes, that's right.

THE COMMISSIONER:

Q. But I'm now, I think, hearing you say that in respect of patient safety issues, you're citing numerous avenues.

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. And those avenues are as broad, you think, as to include the standard NAPE contract.

MS. JONES:

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A. Yes. And I'll use the example that I'm most familiar with and that's professional practice issues inside of nursing. And there is a whole process for issues that are related to safety and that with respect to nursing. There is a whole process inside of the unionized contract in identifying professional practice issues.

CHAYTOR, Q.C.:

Q. And if there is a concern by people within your organization, that they somehow feel that they are going to be constrained from speaking out on certain issues, my question is, an overall umbrella policy signed off at the top by yourself or the person in the position as CEO, reassuring people that there are certain issues which are so fundamental to this organization, such as quality control, such as patient safety, that you can speak out and we want you to speak out and we encourage you to speak out and here's the overall umbrella policy by which you do that. Has eastern health given any consideration to such a policy?

MS. JONES:

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A. I'm sure that they have. Whether it's completed at this point in time, I'm not sure and I will get back to you on that one.

CHAYTOR, Q.C.:

Q. So, it's in the works?

MS. JONES:

A. There is obviously--in the works would be policy in that particular realm. Whether, in fact, it is exactly the way you have or there are multiple parts of that policy like confidentiality is only one part of a policy, I can't speak to what it would be called specifically, but we'll get that for you.

CHAYTOR, Q.C.:

Q. And let's assume the employee or independent contractor signs the confidentiality agreement today.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And you're saying that there is a process in place an there's an issue--there's something of concern to your employee or independent contractor and I take it, they go up the normal chain of reporting to their supervisor.

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MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And it goes on up as far as it has to go up in the chain -

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. - to be addressed. The next day the employee has the concern. What avenue is available to the employee or independent contractor in that situation?

MS. JONES:

A. If it's not resolved, then it generally goes to a level higher, okay. So, if the manager -

CHAYTOR, Q.C.:

Q. But it's gone all the way that it has to go and then from the employee's perspective, the issue continues. What avenue is available to the employee in that situation?

MS. JONES:

A. Then they have exhausted all avenues inside -

CHAYTOR, Q.C.:

Q. Internally, within and they can't say anything.

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MS. JONES:

A. - of it's -

CHAYTOR, Q.C.:

Q. This confidentiality agreement, they can't say anything. What do they do?

MS. JONES:

A. If they've exhausted all avenues inside, then they do have a right to go outside to seek resolution to whatever issue that they have.

CHAYTOR, Q.C.:

Q. And where do they get that right? Where's that?

MS. JONES:

A. It is once it has been addressed internally or identified internally, then that is just the understood that they have used all the vehicles that they have to be able to address an issue and they still have a concern -

CHAYTOR, Q.C.:

Q. And is that in writing, it's understood, but is that reduced to a policy or where -

MS. JONES:

A. That wouldn't be--that's been the general practice, it's always been the practice, if, in fact, something cannot be resolved

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internally, that people have dealt with all of the levels of the organization, then you will generally see it in the external going through to either government or through their different associations or, in fact, them contacting the media or whatever vehicles that they would deem appropriate.

CHAYTOR, Q.C.:

Q. They'd be able to go to the media or to government if they've signed this confidentiality agreement?

MS. JONES:

A. If, in fact, they've exhausted all of the vehicles inside and their issue hasn't been appropriately resolved.

CHAYTOR, Q.C.:

Q. And they risk being in breach of the agreement?

MS. JONES:

A. In this instance once that documentation is there that we have met with them, we've addressed it or not addressed it to their satisfaction, yes.

CHAYTOR, Q.C.:

Q. So this agreement would not prevent them from

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taking the issue wherever they need to go with it?

MS. JONES:

A. Once they have exhausted their internal issue.

CHAYTOR, Q.C.:

Q. And is that in this agreement? Is that written in there anywhere? You can just scroll down.

MS. JONES:

A. If you go through the types of things that are there, at the end of the day when we talk about patient information, really from the new legislation and that, that can't go anywhere, they would be in breach of the law.

CHAYTOR, Q.C.:

Q. Right.

MS. JONES:

A. On that, right.

CHAYTOR, Q.C.:

Q. And we're not talking about that. We're talking about an issue that they may have concern with, for example, what if a lab technologist had concern about what was happening in the lab, what if some concern came to a lab technologist?

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MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And they reported it, did what they thought they should do with it, but then from their point of view that it wasn't resolved and that there was some practice continuing that they had concern with, what avenue is available to that lab technologist as opposed to showing up the next day, doing his or her job, doing it in the same manner, what avenue is available to that lab technologist?

MS. JONES:

A. That lab technologist would have dealt with their manager. If that wasn't acceptable, then they would go to the program director. If that wasn't acceptable, they would have went to the VP. And you would hope along the line that if it was not able to be resolved, that the manager would have gone to the program director to say that "I have an issue here that I can't resolve," because that does happen. Sometimes the individual manager can't resolve it and it may need more resources to be able to address the issue,

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then they have to bring in higher levels of the organization to address a particular issue. And then at the end of the day if we're not able as an organization to address a particular issue for whatever reason, whether it's resourcing or it's education or whatever it is, then we would generally bring that forward to government to say "In this particular area, this is an issue. We're not able to resolve it internally. What is it that we're able to do?" And then we would be moving it through the system.

CHAYTOR, Q.C.:

Q. So the next step above you -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - is government?

MS. JONES:

A. Next step above me, depending on the nature of the issue, it may very well end up having to go to board, if it's something like that, if not, it would end up going to straight through. We have issues, resource issues or whatever that we bring to board and then the

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minister and the board chair will meet on particular issues that we're not able to resolve. But if it's a very operational nature issue, then I would directly go to government and say, "This is an issue inside the organization. We have not been able to resolve it. Where are you on this issue? What can we do with it?"

CHAYTOR, Q.C.:

Q. Yes. And I guess my question is more that you have resolved it, you've made a decision, you've resolved it?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. But the lab technologist is not satisfied, the lab technologist doesn't feel that the issue has been satisfactorily addressed.

MS. JONES:

A. Well, then we haven't resolved it, have we?

CHAYTOR, Q.C.:

Q. Okay. So that person can still then have avenues to go beyond Eastern Health?

MS. JONES:

A. Yes.

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CHAYTOR, Q.C.:

Q. And are not constrained from doing so?

MS. JONES:

A. No. And we've got many, many examples of that and we will have people who will say, "I've been through all parts of the organization," but they may have not completed their journey in the organization. They may have talked to their manager, but clearly--and their manager has not been able to resolve it, but then we would have to say, okay, "Where was the program director in that? Are they aware of it?" And usually it'll come up the line and we will work to resolve whatever issues. We all have many constraints on us about having--but if it's a safety issue, you know, if it's an equipment issue or whatever, those issues come forward and we will go to board and we will go to government and say "This needs to be resolved. We have to take down this service at the end of the day because it's not safe."

CHAYTOR, Q.C.:

Q. And from a practical point of view how comfortable is that, and I'm just using lab

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technologists, but how comfortable is that lab technologist at the end of the day still speaking if it's gone all the way up the chain and the answer has been, "no," how comfortable are they still to speak?

MS. JONES:

A. I think if they, if they really believe in what their issue is and they're an advocate for patient care, irrespective of where they work in the organization, and they really believe that the issue that they want, that they need addressed is affecting safety, then they will carry that forward. They have other vehicles, it's not just them. If, in fact, they haven't been able to address the issue, they have unionized vehicles that usually come in and support them and work their way through the organization in that fashion. So they're generally not alone. And many times they would end up coming collectively versus individually.

CHAYTOR, Q.C.:

Q. There's no, I take it, and I don't necessarily, you know, particularly like the term, but I take it there's no whistle blower

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type policy in place?

MS. JONES:

A. No, not--that term, I've not -

CHAYTOR, Q.C.:

Q. You're familiar with the term?

MS. JONES:

A. I'm familiar with the term. I'm familiar with they're also looking for whistle blower legislation inside of the province or that, but we don't have that. We basically -

CHAYTOR, Q.C.:

Q. All right, so we don't have it legislatively which some provinces do?

MS. JONES:

A. Do, that's right.

CHAYTOR, Q.C.:

Q. And sometimes when it's not mandated through legislation, there are policies within organizations to deal with that issue, but Eastern Health doesn't have that?

MS. JONES:

A. no.

CHAYTOR, Q.C.:

Q. No. And no contemplation to putting such a policy in place?

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

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policies that I wouldn't have seen in this last ten months.
CHAYTOR, Q.C.:
Q. Okay. Thank you. Okay, I'll go back to where I left off yesterday, which is where I intended to start. 0738, please? Okay, you'll remember, Ms. Jones, yesterday we were looking at, this is the document you sent to the board of trustees around the government announcement on November 1st, 2007.
MS. JONES:
A. Um.
CHAYTOR, Q.C.:
Q. And the third page of this document I didn't get to yesterday.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. And this is an Eastern Health statement in response.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. November 2nd, 2007. Did this document go out?
MS. JONES:

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A. Yes, it did.
CHAYTOR, Q.C.:
Q. Okay. And so this would have--this is a press release, I take it?
MS. JONES:
A. This is a press release.
CHAYTOR, Q.C.:
Q. Okay. And this says that "Eastern Health has been working with NLCHI and the department on developing the ER/PR database to prepare for the work of the Commission of Inquiry. Out of respect for that we will address any issues arising from the database through the public process of the Commission."
MS. JONES:
A. Um.
CHAYTOR, Q.C.:
Q. "Right now our primary focus is on insuring that any individuals who need to be notified as a result of the database will be notified. We recognize that effective database management is a key issue for this organization. This is why we have identified information technology investment and decision support systems as two of our top three budget

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requests."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. "For the upcoming year."
MS. JONES:
A. Um.
CHAYTOR, Q.C.:
Q. Ms. Jones--and this is signed off by you, yourself?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Why did you feel it necessary to go out with your own press release on November 2nd?
MS. JONES:
A. We would have been getting many calls from the media in response to the minister's press release that day which talked about the 939 going to nearly 1000, so the media would have been wanting us to explain that, plus the other contents of the press release. And you heard me clearly say yesterday that this was a work in process, that we were not convinced that it was fully done. We were working with

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

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identified that two of the three top priority items were in that area, the first one being human resources, but the second and the third being technology and decision support. So rather than trying to be out there trying to explain why the 939 versus 1000 when we weren't sure that that 1000 was going to hold and it may have gone up or it may have gone down, at that point in time we didn't know, that this was what the Commission of Inquiry was all about, and so that was the reason for that. And this was a Friday afternoon. And so it was really they wanted a response, the media wants a response from us, so this was a written response to them and nobody spoke to it.

CHAYTOR, Q.C.:

Q. This is what the Commission of Inquiry is all about. And not in terms of figuring out if it's 939 or 1013?

MS. JONES:

A. No.

CHAYTOR, Q.C.:

Q. No, okay.

MS. JONES:

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A. It was this one was relating to the database issue and the number of patients and were they actually all identified and were they contacted and all of that. So there's more than just this issue in the Commission of Inquiry.

CHAYTOR, Q.C.:

Q. And so was there something lacking or missing, you felt, or not sufficiently clear in the government's announcement that you felt this would help clarify?

MS. JONES:

A. It was just that we knew absolutely that soon as the minister made that, that they would have been coming to Eastern Health to absolutely clarify. And there was the issue in the press release that talked about the poor data management practices, and we had seen that, and so we wanted to assure the public that we were already, had identified that as one of our key priorities as we move forward.

CHAYTOR, Q.C.:

Q. And there's only really a couple of key points in what you're trying to get out here, one is

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MS. JONES:

A. Absolutely.

CHAYTOR, Q.C.:

Q. - telling people, look, we're going to be contacting the people that this is about -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - we're in the process of notifying. And the second one is, we're dealing with the database management issues?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. Right. That's what you're really telling the public?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. Did you ask the department to include that in its release?

MS. JONES:

A. We didn't see its release, if you remember, we saw a release on the midnight was the redraft

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based upon what we had said. And -

CHAYTOR, Q.C.:

Q. You were seeing drafts back and forth?

MS. JONES:

A. Yeah. We had a first draft, we had offered some comments to it. We got a second draft come close to midnight. We were waiting for the final draft because usually you do get it before the minister goes out. And it was, you know, close to probably 11:00 or so, probably even after that that we had actually got the press release, and inside the press release there were those comments about the database management inside of Eastern Health. We hadn't seen those in earlier drafts. And so we just wanted to assure the public that, in fact, we were looking at that and were aware of it and that we had identified it for information investment.

CHAYTOR, Q.C.:

Q. Okay. 0740, please, Registrar? And this is an e-mail exchange dealing with a, if you want to just scroll down through and see, it's Robert Thompson on November 9th, 2007 contacting you about getting together for a

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meeting?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And "Now that I have almost a week at this work," he writes, "preparing for the Commission (on a sustained basis) I have revamped our work plan and would like to sit down with you to review it. I can also see more clearly that confusion exists around the mandate of this office and how it relates--and how we relate," sorry, "to the department and to the RHAs," the regional health authorities. "Therefore, I would like to meet with you early next week, if possible, to connect these dots and lay the basis for a smooth process as we head towards the Commission." And you're looking at your calendar and you're hoping to come up with a date to meet. Did you actually meet?

MS. JONES:

A. Yes, we did meet.

CHAYTOR, Q.C.:

Q. What did this mean, what's he talking about, what was the purpose of the meeting, to see

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more clearly, what was the confusion around the mandate of his office and how it relates to the department and to Eastern Health is the only one, I guess, you could speak to?

MS. JONES:

A. I think that at that time Robert was working with--he was the acting deputy minister for the--for health at the time until he moved over into doing the task force. So he was carrying two functions, so he was doing the deputy minister function. And when we were interacting with him, we didn't know whether we were interacting with him on behalf of in his deputy minister role or was it his Commission role or was it the task force that we hadn't seen the actual terms of reference for, which we didn't see until much later. So when he's asking for information and those kinds of things, in what role is he asking it for, and so that was the kind of discussion that we had had in terms of -

CHAYTOR, Q.C.:

Q. So is he still deputy minister now in November of '07?

MS. JONES:

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A. He's just, if you said he's almost a week into his new role, so Don Keats has now moved into the deputy minister role. And so all of the issues around the task force and the Commission of Inquiry, Robert is informing me that, in fact, everything around the Commission of Inquiry and the ER/PR is in this particular realm of government and that Don Keats and the department really, any requests around ER/PR are coming from him and not from Don. So that -

CHAYTOR, Q.C.:

Q. But Don Keats would have no involvement with the ER/PR issue?

MS. JONES:

A. That's right, that's right. And that is why as we move forward with the budget submission, remember the decision support thing that I had sent in on the 16th or so of November, it was sent to the department because it was part of a budget. But Robert said any issues arising out of ER/PR, he will be dealing with it, so therefore you would have had, because it was a budget submission, gone to Don Keats and the minister, and then on the other hand because I

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knew he was dealing with the ER/PR issue and budget requests around that, then I also sent a copy to him. So that helped to clarify the issues of ER/PR, the discussion, the preparing for the Commission of Inquiry was going to be out of Robert's new office in the role that he had.

CHAYTOR, Q.C.:

Q. But the preparing of government, I take it?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Not the preparing of Eastern Health?

MS. JONES:

A. Not the preparing of Eastern Health.

CHAYTOR, Q.C.:

Q. Although, Eastern Health had to send all of its documents to Mr. Thompson?

MS. JONES:

A. Which was the discussion that we had had, yesterday about asking that question, why would they need all of that level of detail.

CHAYTOR, Q.C.:

Q. Yes. And you didn't get the answer to that?

MS. JONES:

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A. Did never got the answer to that. And we had worked out a process between the lawyers.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. Part of the discussion at the meeting that happened, which was in the early part of the next week, was again around the information that Robert had requested through the summer and where were we and at what point in time could we expect, the department expect to receive all of that information. And on the task force piece here it was we were wondering, because it wasn't--there was very little information out there, we just knew that there was a task force on adverse events. And Robert had indicated that he hadn't gotten his head around exactly what that--where that was going to go, but he had a time line for reporting on it, but it wasn't to get into the specific aspects of adverse events. Because we did talk about was the province, maybe, as he moved forward, going to look at mandatory reporting for adverse events like they have in some of the western provinces and he hadn't

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done the research or got his head around that. But we did talk about events that we could have some learnings from like Burin, like Gander with the radiology, like ER/PR, not the specifics of them, but the learnings from them would be something that as they move forward, so it wasn't a specific event itself. And he wasn't clear at that point in time just where it would go. Sterilization in Labrador had also been one of these events. So whether they would use them kind of as a case study or how they would become involved in the work of the task force. That was just a generic discussion.

CHAYTOR, Q.C.:

Q. And so that was basically what happened at your meeting which took place, I take it, sometime mid November?

MS. JONES:

A. Yeah. And the other discussion that happened would have been me having a discussion around all of the information. And it was the information, it was really how the staff were holding up in terms of there's very little redundancy inside of the organization when you

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

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Commission lawyers, around we had a small cadre of individuals who knew this, there was nobody else who had this information, that you would have in some ways to be patient with us because we could only run so fast as well as keep an organization going.

CHAYTOR, Q.C.:

Q. Did you--so your meeting with Robert Thompson that day was to address him also requesting the information, I take it, from you, the information that you were compelled to have to produce to the Commission?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And the necessity to have to produce it for him, as well?

MS. JONES:

A. That's right. And we had already had a little bit of that discussion when we met on the 1st of November when Robert met with yourself and Mr. Coffey with the database that he was almost ready to pass over.

CHAYTOR, Q.C.:

Q. And if we could move on then. There is a--

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actually 11:00. Did you want to break now?

THE COMMISSIONER:

Q. If this is a convenient place for you.

CHAYTOR, Q.C.:

Q. I'm about to move into--actually, there's a set of minutes from the executive management committee that I need to go back to.

THE COMMISSIONER:

Q. All right. We'll take 15 minutes.

CHAYTOR, Q.C.:

Q. Thank you.

(RECESS)

THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Exhibit P-0488, page 32, please, Registrar? Ms. Jones, this is executive management. And I apologize in going back here to May 30th.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And then we'll skip back to November. But we missed this one, I believe, in going through yesterday. And this is executive management meeting of that date. You are present and Mr.

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Tilley is chairing the meeting?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And Ms. Pilgrim, Ms. Bonnell are in attendance?

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. 2.1.1, "Update on ER/PR Receptor Issue." "The executive reflected on the events of the past week and discussed briefly public confidence in the health system. The board held a special meeting on May 23rd, 2007 and they are sensitive to the tremendous media pressure the organization is currently experiencing and is also concerned that the confidence in the system is being eroded as a result of the misrepresentation of the facts. Strategic communications and external communication specialists will begin to explore other communication strategies to insure the correct messages are communicated to the public." What were the misrepresentation of the facts that was of concern to Eastern Health?

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MS. JONES:

A. I can't speak specifically to what the board and that, but it was potentially more around the issue of why we made--why the CEO made the decision about just releasing part of the information or talking about the deaths because it was around the treatment changes. And in this instance I think at some point there was an apology there. Plus the issue of error rates and the fact that there's been no discussion really about the issue of false negatives and those kinds of things. So other than that, I can't really recall, but it was in, potentially in those particular areas.

CHAYTOR, Q.C.:

Q. So how were the facts misrepresented and who were the facts misrepresented by?

MS. JONES:

A. The media was not reporting the entire story. They had had technical briefings in the past around ER/PR, what the test was, the nature of the test, that there was false positives--false negatives, and that would be part of looking at this entire issue. And those kinds of things were generally never reported in the

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media.
CHAYTOR, Q.C.:
Q. So the fact that the media didn't give information that had been provided to it by Eastern Health as to what -
MS. JONES:
A. The full scope, yeah.
CHAYTOR, Q.C.:
Q. - a, what a range, acceptable range of error would be?
MS. JONES:
A. Yes, part of it.
CHAYTOR, Q.C.:
Q. As opposed to what the range of error was in this particular case -
MS. JONES:
A. And the sensitivity of the test and tests on any one day or so may, you know, may have--the numbers were not an absolute, and understanding what the numbers actually meant.
CHAYTOR, Q.C.:
Q. And that was deemed to be a misrepresentation of the facts as opposed to incomplete -
MS. JONES:
A. Not a full complete picture.

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CHAYTOR, Q.C.:
Q. So that's misrepresentation?
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. So when there's not a full complete picture given, that's misrepresentation?
MS. JONES:
A. In this instance that was the way the secretary captured that in that way.
CHAYTOR, Q.C.:
Q. Well, I guess a word such as "misrepresentation", the secretary wouldn't use that unless the word was being used?
MS. JONES:
A. I'm not sure if those words would have been used, but the whole picture wasn't out there and I guess that's the point that was made.
CHAYTOR, Q.C.:
Q. Continues on the next bullet, "the CEO held a press conference on the ER/PR on Friday, May 18th and media statement and Q and As were provided."
MS. JONES:
A. Um.

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CHAYTOR, Q.C.:
Q. And that's the you just mentioned about Mr. Tilley -
MS. JONES:
A. Tilley's.
CHAYTOR, Q.C.:
Q. - offering an apology?
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. Did you attend that press conference?
MS. JONES:
A. Yes, I did.
CHAYTOR, Q.C.:
Q. And was that the first time that you attended anything in the way of a public event for the ER/PR issue? You weren't at the December, 2006?
MS. JONES:
A. No, I wasn't at the December, 2006. And this was a press conference and we were there to support Mr. Tilley. Pat Pilgrim and myself sat in the audience with the--while the press conference was going on.
CHAYTOR, Q.C.:

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Q. For personal support to Mr. Tilley?
MS. JONES:
A. Personal support to Mr. Tilley.
CHAYTOR, Q.C.:
Q. Because you had not been involved, I understood, in the -
MS. JONES:
A. Absolutely. And the next meeting I also felt it was important to be there for personal -
CHAYTOR, Q.C.:
Q. The meeting with the MHAs?
MS. JONES:
A. MHAs. Pat Pilgrim and myself actually sat in that meeting, as well.
CHAYTOR, Q.C.:
Q. Okay. And why did you go to that meeting with the MHAs?
MS. JONES:
A. Because again, the same thing, for personal support. We had Mr. Tilley and we had Nash Denic, Oscar Howell and that and so it was really to just be there and be a friendly face and to hear the kinds of questions that were being asked by the press and as well as the MHAs.

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CHAYTOR, Q.C.:
Q. Okay. And then there's reference to the judicial inquiry having been -
MS. JONES:
A. Announced.
CHAYTOR, Q.C.:
Q. Announced?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. So I take it in terms of meeting with the MHAs you didn't answer any questions?
MS. JONES:
A. No. We sat at the corner of the table and were just there.
CHAYTOR, Q.C.:
Q. And if you had been called upon, would you have been able to answer any questions on the issue?
MS. JONES:
A. Not particularly. It was a can (phonetic) presentation that they had. Maybe if they had asked specific issue on fixation, I might have been able to answer that, because that was one that I was aware of and had, but that was not

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the nature of it. It was really almost like a technical briefing.
CHAYTOR, Q.C.:
Q. And then there's, under the class action, there's reference to Mr. Tilley having written a letter to the editor of, that should be, "The Globe and Mail" challenging the article printed in relation to ER/PR, and did you know that he was going to be writing a letter to "The Globe and Mail?"
MS. JONES:
A. We wouldn't have known that until probably after the fact.
CHAYTOR, Q.C.:
Q. And do you recall being told why Mr. Tilley felt the need to write a letter to "The Globe and Mail?"
MS. JONES:
A. I have no recall on that, and I'm not sure what the article was.
CHAYTOR, Q.C.:
Q. So you had no involvement -
MS. JONES:
A. There was many articles that were written over the period of time.

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CHAYTOR, Q.C.:
Q. So you had no involvement in drafting the letter?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. And did not have the letter run past you before it was sent?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. And the full letter, it says did not get published. This is another example of the misrepresentation of the message. The Board chair has agreed to bring the full letter and the articles to--what's CHA?
MS. JONES:
A. Canadian Hospital Association.
CHAYTOR, Q.C.:
Q. At their meetings in June. Do you know if that happened?
MS. JONES:
A. If Ms. Dawe would have brought that with her, and had discussion with her counterparts, if that was written there, and Joan was very good

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about doing that, making sure that this issue was understood.
CHAYTOR, Q.C.:
Q. You don't remember any follow up though when Ms. Dawe back?
MS. JONES:
A. I was not at the CHA meetings and I'm not sure on what vehicle she would have done it, but she sits on the board of the CHA.
CHAYTOR, Q.C.:
Q. And the full letter not having been published by "The Globe and Mail" and it's indicated here this is another example of the misrepresentation of the message. Who is saying this at this point in time?
MS. JONES:
A. Well, it's -
CHAYTOR, Q.C.:
Q. The report, update on ER/PR receptor issue, and in brackets is GT, George Tilley.
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. So would that be Mr. Tilley who's saying this?
MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. Yeah, and not understood.

CHAYTOR, Q.C.:

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

MS. JONES:

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A. Needing to know the clinical picture.

CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. - is considered to be a misrepresentation?

MS. JONES:

A. In this instance, yes.

CHAYTOR, Q.C.:

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

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What was that about? What did she have to meet with Mr. Dawe about?

MS. JONES:

A. I have no idea in the context of that. You'll have to ask Ms. Pilgrim what that was about.

CHAYTOR, Q.C.:

Q. You don't recall the discussion around that at the meeting?

MS. JONES:

A. No.

CHAYTOR, Q.C.:

Q. Did that have to do with any concerns that the executive had about any speakings that Mr. Dawe may have had or any discussion Mr. Dawe may have had in the media?

MS. JONES:

A. I can't answer that question.

CHAYTOR, Q.C.:

Q. Do you recall ever being present when Mr. Dawe's involvement on the issue was discussed?

MS. JONES:

A. Only to the extent that people were--the media were going to Mr. Dawe, as part of the Canadian Cancer Society, looking for information or response, probably because we

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weren't as responsive or readily accessible as Peter Dawe, and so in that context, occasionally we would be saying "how come we're not out there as fast as Mr. Dawe is out there?" and so in this instance, that may not have anything to do with the discussion that was had there, but you asked the question was there any discussion about Peter.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. And being out there, and it was the responsiveness of Peter. Sometimes we would--there may have been a phone call from Pat Pilgrim, I would be aware not the exact nature of, saying "Peter, if you want information from us or you want to understand it, give us a call and we'll provide you with whatever resource on a particular issue."

CHAYTOR, Q.C.:

Q. So the question was posed at the executive level as to why Eastern Health wasn't being as responsive on the issue as the Canadian Cancer Society?

MS. JONES:

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A. Or not being able to get the message out to the same--when we respond, it's the executive director who doesn't have the exact knowledge. We would be looking at physicians or some other spokesperson. Those people have full-time work. The oncologists would have been in clinics. They cannot respond when the media are calling at 11:00 in the day and that. So generally we would always be able to provide some kind of a response, but it wouldn't have been in the news cycle that the news media were really wanting us to respond to. We would always get back to them, but by that time, other people who are much more accessible had already spoken.

CHAYTOR, Q.C.:

Q. So if there's any issue in terms of timeliness or lack of response by Eastern Health, it's because there's delay in trying to get the appropriate spokesperson out there? Is that the issue?

MS. JONES:

A. Sometimes, not all the time, but many -

CHAYTOR, Q.C.:

Q. Around this issue?

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MS. JONES:

A. In many instances, it was access to individuals who already have a clinical load and are working, you know, every day, and you know, physicians do lots of work for us before 8:00 in the morning and after 5:00 in the day and that's not kind of a cycle that the media is into.

CHAYTOR, Q.C.:

Q. So was the lack, if any, of responsiveness ever due to Eastern Health making the deliberate decision not to speak to the media?

MS. JONES:

A. I can't respond to that because I wouldn't have been making the decision about whether we were out there or whether we were not out there. If, in fact, we had answered questions in the past and provided information, we may have very well, or not me personally, said "we've answered that yesterday. That's the same question." I'm not--you know, but that would have been in that -

CHAYTOR, Q.C.:

Q. So Ms. Jones, this is where I want to be clear in what the evidence is and the information

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that's going forward to the Commissioner. So if the answer is you don't know, is that the answer? Or is the answer well, it's because of the physicians and having to arrange them and working around their schedule?

MS. JONES:

A. There would be multiple factors, Ms. Chaytor, and it would have depended on the individual, time of the day and the request that was coming forward and what kind of information was being asked about, and therefore, in some instances, it would have been much more appropriate for physicians to respond, because they have that level of detail. In other times, it may very well have been appropriate and we could have had administrative people respond. So depending on the nature of the actual request, who was the most appropriate response person would have been dealt with on that particular issue base.

CHAYTOR, Q.C.:

Q. And my question in terms of whether or not, and at the executive level and you're sitting in on the meetings when the issue is being discussed, at the executive level, was there

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ever any discussion of not responding or not going out to the media on the issue?

MS. JONES:

A. Not to my knowledge, in terms of making a conscious decision. Remember, we, as executive, meet every two weeks. So there's lots of interaction with the media on a daily basis, on an hourly basis.

CHAYTOR, Q.C.:

Q. But on this issue. On this issue, I'm asking you was it discussed at executive that we are getting calls, at any point in time along the way, we're getting calls on the issue, but we are not speaking?

MS. JONES:

A. Not in the way that you would just explain it.

CHAYTOR, Q.C.:

Q. Okay. Well tell me it in the way that you would explain it.

MS. JONES:

A. It would be more in relation to what we knew about the issue. If we could answer the question, we would answer the question. If there was a spokesperson that would be most appropriate and there was trouble accessing

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that particular spokesperson and sometimes we were not in the news cycle and maybe it might have been the next day or sometimes the media are very good in that maybe they don't go with the story that day and they will wait. So those kinds of things happen on a daily basis.

CHAYTOR, Q.C.:

Q. And those things were discussed at executive management level in dealing with the ER/PR issue?

MS. JONES:

A. In a general terms, not in an individual specific issue. We've had a call today and, you know, we can't get a Kara Laing or we can't get a Nash Denic or whatever, so therefore we're not able to respond. That wouldn't have happened.

CHAYTOR, Q.C.:

Q. Was it ever said that "we are getting calls, but we're not speaking?"

MS. JONES:

A. No, it was never--that was never said in that absolute.

CHAYTOR, Q.C.:

Q. I know it wasn't said in those words, but you

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know the message that I'm trying to convey here.

MS. JONES:

A. Yeah, and that was never ever said.

CHAYTOR, Q.C.:

Q. So the only thing you heard at executive was "we're not able to get out there today, or in as timely a manner as we may wish to, because there aren't physicians or appropriate spokespeople available to address the issue?"

MS. JONES:

A. That's right, and we may not be able to answer the question that they're actually asking because we don't have an answer.

CHAYTOR, Q.C.:

Q. Okay, and what questions would they have been?

MS. JONES:

A. The error rate, okay. We had lots of discussion around can we calculate, and you saw that in an ATIPP response from Mark Quinn, and so therefore, there was no--and we talked about that the other day, in being that this was a subset of ER/PR testing and not really looking at an error rate. So you know, there is no answer to that question. There's

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multiple ways of looking at that, but you would have to understand the whole issue around it.

CHAYTOR, Q.C.:

Q. You still think there's no answer to that question?

MS. JONES:

A. I think that there is a--there's no question that there was a change in results from what was happening in our lab to what was happening to the results, results that we've got in Mount Sinai. There's also much documented literature that in fact a percentage of tests will have, if on retest, a change and what the difference was or how many of the tests that were retested would have been naturally changing as part of that false negative, I don't believe that we have sight on that. There's no question that we had changes and we acknowledge those changes and there is change -

CHAYTOR, Q.C.:

Q. To the extent of 42 percent.

MS. JONES:

A. To the extent of 42 percent in this particular

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category that we're looking at.

CHAYTOR, Q.C.:

Q. Is there anything in the literature to suggest that that is up to the range of error being 42 percent?

MS. JONES:

A. No, there is nothing in the literature to suggest that that high.

CHAYTOR, Q.C.:

Q. Right, okay. This also then talks about "a message to all staff from the CEO will be circulated. Executive is fully aware that the events of the past several days are playing heavy on the staff and anxiety has been heightened since the announcement of the Inquiry."

MS. JONES:

A. Of the Inquiry.

CHAYTOR, Q.C.:

Q. And Dr. Howell is to deal with that?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Why would that be, in terms of the message to the staff, Dr. Howell dealing with it, as

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opposed to Mr. Dodge?

MS. JONES:

A. Can you just -

CHAYTOR, Q.C.:

Q. Sure, sorry, yes. You can control the mouse too, if you wish.

MS. JONES:

A. And I'm not sure, but this one here, "it's playing heavily on staff, particularly pathologists and lab technicians," and given that Dr. Howell actually is--the lab reports to him, this may have been a particular message to lab and pathologists, not necessarily to the entire Eastern Health, and it would have been around the Commission of Inquiry and all of those kinds of things. Yes, there it is, okay.

CHAYTOR, Q.C.:

Q. Thank you. Mr. Coffey was telling me to scroll down. "Follow up with the director of laboratory and the staff in this regard." Thank you.

MS. JONES:

A. Thank you.

CHAYTOR, Q.C.:

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Q. If we could have, please, P-0488, page 96? And this, we're back to November now.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. So we'll try and stay a little bit in chronological order here. And this again is executive management meeting, November 14th 2007, and of course, you are interim president and we have Dr. Howell present and Ms. Pilgrim.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And Susan Bonnell is also in attendance. Next page talks about the judicial inquiry, ER/PR. "Executive was provided an update at the regional quality council meeting held 13th November 2007." So the executive was provided an update at the Regional Quality Council meeting on the issue of ER/PR?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Or the judicial inquiry?

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MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Or both?
MS. JONES:
A. It would have been both. It would have been underneath--in Regional Quality Council, we would have had ER/PR been referenced and probably said this is what's going on, the Commission of Inquiry. This is where they are, whatever. And so it would have been an update there.
CHAYTOR, Q.C.:
Q. So does the executive also attend the Regional Quality Council meetings?
MS. JONES:
A. Yes, they do.
CHAYTOR, Q.C.:
Q. Okay, and how often do they meet?
MS. JONES:
A. So there was no need to reiterate it? What?
CHAYTOR, Q.C.:
Q. How often do they meet?
MS. JONES:
A. Regional Quality Council meets about once a

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month or so, so it is executive plus other members. It would have the chair for infection control. There are three physicians who sit with that.
CHAYTOR, Q.C.:
Q. That's fine. I was just wondering how often they meet. So all the executive would attend that, so there's no need to do an update -
MS. JONES:
A. No need to update it there.
CHAYTOR, Q.C.:
Q. - because that was yesterday.
MS. JONES:
A. That was yesterday.
CHAYTOR, Q.C.:
Q. The day before this meeting.
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay, and who would be providing the update at the Regional Quality Council meeting?
MS. JONES:
A. More than likely Mrs. Pilgrim, and she chairs the regional -
CHAYTOR, Q.C.:

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

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

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CHAYTOR, Q.C.:
Q. But Terry Gulliver is still in the picture?
MS. JONES:
A. It's on the database. It's on the numbers and the slides that are gone out and when do they come back and the results and those kinds of things.
CHAYTOR, Q.C.:
Q. So Mr. Gulliver is still actively involved in the issue at that point in time?
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. Next page, 98, 3.6 CEO performance objectives 2007/2008. "Louise Jones advised that the CEO performance objectives were approved by the Board of Trustees at their October 24th 2007 meeting and the areas of focus include formalizing and adopting the medical staff structure in Eastern Health." What does that mean?
MS. JONES:
A. That means the bylaws, as well as the new regionalized structure versus the individual legacy organization structure would be put in

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place in the next year.
CHAYTOR, Q.C.:
Q. Okay, and that's still in progress, I take it?
MS. JONES:
A. That's still in progress, waiting on provincial bylaws.
CHAYTOR, Q.C.:
Q. Initiatives, number two, is "initiatives to develop a safety culture, inclusive of staff and patients."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. What does that mean?
MS. JONES:
A. That means that we have to do work in terms of planning on culture, okay, and that will occur over a period of time. So it's a lot of education. It's a lot of input into how we develop that safety culture so that the staff understand, and you've been at it a number of times, in terms of their role in safety or their advocacy role, those kinds of things, and what role that the patients individually have to play in their own safety. We've had

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things such as, and these would have been in October, the hand hygiene campaign where, you know, we had buttons that say to clients "ask us did I wash my hands," those kinds of things. So there are things that patients can play in ensuring that we have--that we care for them in the best way possible. So that's part of the development of the safety culture.
CHAYTOR, Q.C.:
Q. And these are the five areas of focus given to you to do your job over the next year.
MS. JONES:
A. From the Board.
CHAYTOR, Q.C.:
Q. From the Board.
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. So I take it these are what have been identified as being the key issues overall for the organization to work on?
MS. JONES:
A. These are performance objectives and lining up with these performance objectives would also be the Board's new strategic plan. So some of

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these would be inside of the strategic plan from '08 to '11 and some of those would be not necessarily inside of what they would put in a strategic plan, but medical staff organization and safety culture, although represented in different words, are both inside of the plan for '08 to '11.
CHAYTOR, Q.C.:
Q. And are these in any particular order of priority?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. Okay. So all of them are equally important?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Number three is "formalizing and adopting a health human resources plan, including leadership development."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. What does that mean?
MS. JONES:

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A. That means having an entire plan for the entire organization that looks at everything from physicians all the way to housekeepers, what is the recruitment strategies, what is our attrition, our retirement rates, what is it that we need to move forward in terms of the organization, in terms of initiatives to government that we anticipate shortages in particular areas, all of those kinds of things. Including leadership development, we have a very thin leadership. Recruitment into leadership positions is difficult, so it is how are we going to look at succession planning so that there is a set of leaders that are available to take over and willing to take over as people exit and our leadership group is fairly old, in terms of age range. So this is the whole idea of succession planning.

CHAYTOR, Q.C.:

Q. So succession planning for everyone, including physicians?

MS. JONES:

A. Everyone including physicians and -

CHAYTOR, Q.C.:

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Q. And recruitment of appropriate people.

MS. JONES:

A. And recruitment, retention. What is it that the mandate of the organization is and what is it that we're going to need now and into the future with respect to ensuring that we're able to meet the mandate.

CHAYTOR, Q.C.:

Q. Okay, and number four, "identifying and reporting on performance indicators (outcomes) that are acceptable to the Board." What does that mean?

MS. JONES:

A. That is in terms of the executive limitations, we are reporting on some indicators and we're developing them more. I referenced yesterday that outcome indicators are problematic in health care. We can give you a lot of process, how many of stuff we did, but does it have an ultimate outcome for clients, particularly when you talk about population health. So when you look at this, it is what is it that the Board--what indicators does the Board want to receive on a regular basis and that have meaning for them and so therefore,

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we need to then start putting in processes behind that to produce those for them on a regular basis. We produce things for the Board now, but you know, they're on occupancy and utilization and finance and some of the newer initiatives with the Canadian CIHI, which is the main holder of clinical data information, there are some indicators that are coming out there, hospitalized standardized mortality rate, which is a new one. So it is what is it that the Board wants to receive and are they acceptable to them, and then how do we work them into the monitoring reports.

CHAYTOR, Q.C.:

Q. And the fifth is "initiation of strategies to develop," and I take it that should be "confidence?"

MS. JONES:

A. Confidence, yeah.

CHAYTOR, Q.C.:

Q. "In the services provided by Eastern Health. Strategies will be directed both internally and externally."

MS. JONES:

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A. That's right.

CHAYTOR, Q.C.:

Q. And I take it that has to do with what we were discussing this morning, in terms of any loss of confidence in Eastern Health and the image of Eastern Health?

MS. JONES:

A. As well as stakeholders and partnerships and so, it's a really broad ranging, and it's the initiation of strategies to work in that area.

CHAYTOR, Q.C.:

Q. And that has been worked on as we've discussed.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. If we could have page 99? Page 99 refers to 3.8, CEO meeting with Don Keats, the new deputy minister.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. What does the A in brackets mean?

MS. JONES:

A. Acting.

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CHAYTOR, Q.C.:
Q. Acting, so he's acting deputy minister?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. On November 14th '07. "Louise Jones met with Don Keats to update him on a number of initiatives, issues in Eastern Health. She particularly expressed the concerns of the organization with the request from the department to re-rank capital equipment following our internal process. Louise Jones further emphasized with the deputy minister the 23 items of the operating budget being critical to move forward. Other areas that were discussed included," I don't know what that is, but COI, I guess, is the "Commission of Inquiry, task force on adverse health events, long-term care owner board, cancer control strategy, surgeon recruitment issues, including a number of different types of surgeons, and then the development of space at the cancer bunkers." So was this your first meeting with Mr. Keats?
MS. JONES:

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A. Yes, it was.
CHAYTOR, Q.C.:
Q. And do you meet regularly with Mr. Keats?
MS. JONES:
A. No, but we do have meetings when there are issues and that has not been a practice where the individual CEO meets with the deputy minister on a regular basis. We do meet with the deputy minister through the Newfoundland and Labrador Health Boards Association. The four CEOs, as well as the CEO of the Newfoundland and Labrador Health Board Association, come together every two weeks and the deputy minister or somebody from the department is there.
CHAYTOR, Q.C.:
Q. And so that's done by a conference call, I take it?
MS. JONES:
A. That's done by a conference call, and on a certain number of times a year, there's face-to-face meetings.
CHAYTOR, Q.C.:
Q. And then during those conference calls, has the issue of ER/PR been addressed?

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MS. JONES:
A. In a generic sense, yes. Normally more related to Commission of Inquiry and what is going on, at least since I've been on the system, that it's more Commission of Inquiry Task Force on Adverse Events discussion.
CHAYTOR, Q.C.:
Q. And what would be discussed about the Commission of Inquiry on the conference call?
MS. JONES:
A. Just that it is now up and running, hearings are starting at a particular point in time.
CHAYTOR, Q.C.:
Q. So the logistics?
MS. JONES:
A. Logistics kinds of things.
CHAYTOR, Q.C.:
Q. The issue or the discussion that you had on this date with Mr. Keats, was there anyone else in attendance by the way?
MS. JONES:
A. No, not on this meeting.
CHAYTOR, Q.C.:
Q. Okay, and what was discussed in terms of the ER/PR issue on that date?

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MS. JONES:
A. I don't see that reference there and I probably, just the Commission of Inquiry, that probably would have come up there only in terms of the issues that we may have had with staff burn out and their ability to be able to meeting all of the people who were requiring information from us. So that would have been--the real issue here for us was Don was new back into the system, he had been a previous CEO in the central region. We had a budget process that was going on and we had a major issue with being asked to rank our capital equipment issues, we had a whole process inside of Eastern Health where we had identified a way of categorizing -
CHAYTOR, Q.C.:
Q. Yes, okay, I don't need to go there -
MS. JONES:
A. Yes, anyways, so that was the real issue, but I took that opportunity to talk about budget and being that it was critical for us to have the 23 items and then the other issues that you -
CHAYTOR, Q.C.:

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Q. Yes, I just want to focus in on what we're here to discuss -
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. You might get to your meeting, you might not.
MS. JONES:
A. That's fine.
CHAYTOR, Q.C.:
Q. The issue of ER/PR then, Mr. Keats--did Mr. Keats have any indication or did he ever speak to you about the issue of ER/PR on any occasion?
MS. JONES:
A. No, because if you remember earlier on what we were saying is that Mr. Thompson took that issue with and when he moved over to the--whatever.
CHAYTOR, Q.C.:
Q. Right, so your discussions would be with Mr. Thompson.
MS. JONES:
A. My discussions would be with Mr. Thompson.
CHAYTOR, Q.C.:
Q. Yes, but Mr. Keats would have been in the

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system as a CEO.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. During this and you would have been a COO in the system.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. But you had no occasion on which to speak with Mr. Keats regarding the ER/PR issue?
MS. JONES:
A. No, no, that--and the discussion here would have been, my understanding is that ER/PR would move with Robert to the new job.
CHAYTOR, Q.C.:
Q. So any discussion you're having with Mr. Keats regarding the Commission of Inquiry you're saying would involve workload levels for your staff?
MS. JONES:
A. Absolutely.
CHAYTOR, Q.C.:
Q. Did you include in your budget submission additional staff in that regard, to address

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those issues?
MS. JONES:
A. We did not anticipate, well when we put the budget in, in the fall, the hearings were supposed to have been starting in January, so it would not have been anything that we would have put in as anticipated that the report would have been available in July. This budget submission was for starting April of this year into '08/'09.
CHAYTOR, Q.C.:
Q. And whether the budget or not, though, have you requested any additional funding? You've requested additional funding for other issues, have you requested any additional resources if need be for your staff around those workload issues?
MS. JONES:
A. Around the workload issues, the only individuals who can do the work are the people who are currently doing that work, plus their own jobs.
CHAYTOR, Q.C.:
Q. Right, so what about someone else doing their own jobs?

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

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CHAYTOR, Q.C.:
Q. And so the people in the lab, the IHC lab as you mentioned as your example -
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. I mean, those people, other than come in for an interview, they're not doing work -
MS. JONES:
A. They're doing much work in relation to the class action suit in terms of pulling slides and blocks and sending things to Mount Sinai. With respect to Ms. Pilgrim, I would have said that we rearranged her portfolio to allow her to be able to carry on this role and so other members of the executive team have taken parts of that portfolio.
THE COMMISSIONER:
Q. The people would pull the slides, would they be technicians or are you saying pathologists have to pull slides?
MS. JONES:
A. It would be the people who are working in the immunohistochemistry who know these slides and what it is, so it would have been the

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technologists who were pulling the slides and pulling the blocks, and then the people in the area would be packaging it up and sending it to--so it has to be people who understand this kind of work.
CHAYTOR, Q.C.:
Q. And none of your--well we've met three of your technologists in your IHC and they all still in their positions?
MS. JONES:
A. They're all still in their positions.
CHAYTOR, Q.C.:
Q. Page 100 of the document, 3.13 ER/PR.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. With respect to the retesting of ER/PR, "Eastern Health, St. John's unilaterally decided, i.e. director and manager, to go back to January 1997 when the first testing was carried out. However, in correspondence from the clinical chief (Dr. Don Cook) to the other boards, it referenced May, 1997. Pat Pilgrim and Oscar Howell are following up on the reasons why Eastern Health managers retested

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back to January 1997." Do you recall that discussion at executive management?
MS. JONES:
A. Yes, because that came out of the database.
CHAYTOR, Q.C.:
Q. And what's the concern, what was that about?
MS. JONES:
A. And the concern there is the direction to the other regions was, I'm not sure--well it says May, it was May. We had to make a determination at what point in time in this process did we move from bioassay to immunohistochemistry, so there was a period of time when there was parallel processes going on and so it was ultimately decided that the slides that were going back to the regions, it would have been May--because we didn't have an exact date of moving from the old method to the new method, although we knew that the optimization and that and the work to move us to the DAKO and the work to move us to immunohistochemistry staining verses bioassay was in the winter of 1997, so we had to clarify that because the database, we needed to know if there was anything else that we

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needed to go back to, so that was ultimately clarified with NLCHI and that as to what was the exact date of sending of samples and when did we actually start immunohistochemistry to the best of their ability, going back looking at when the work was being done and that.
CHAYTOR, Q.C.:
Q. And what was the answer?
MS. JONES:
A. The answer--I can't, Ms. Chaytor -
CHAYTOR, Q.C.:
Q. So Ms. Pilgrim will know or Dr. Howell.
MS. JONES:
A. Yeah and they will know exactly, but the discussion was in St. John's, but there was no--I think and you know, but you'll have to clarify, that the slides that were going back to--and it wasn't even slides going back because in '97 we were reading them all.
CHAYTOR, Q.C.:
Q. What did it mean here when it says that "Eastern Health, St. John's unilaterally decided, i.e. director and manager" who is the director and manager?
MS. JONES:

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A. The director and manager would have been Barry Dyer and Terry Gulliver.
CHAYTOR, Q.C.:
Q. So this is saying that Mr. Dyer and Mr. Gulliver unilaterally decided.
MS. JONES:
A. Yeah, they decided, even though what we had seen in correspondence from Don Cook after the fact was, is that they were asked to pull all of the work from May of 1997.
CHAYTOR, Q.C.:
Q. But they actually pulled from January of 1997.
MS. JONES:
A. In St. John's, they did.
CHAYTOR, Q.C.:
Q. So yes, so Dr. Cook asked the other regions from May -
MS. JONES:
A. To pull from May.
CHAYTOR, Q.C.:
Q. Of 1997 and this says that -
MS. JONES:
A. We pulled from January.
CHAYTOR, Q.C.:
Q. But Ms. Pilgrim and Dr. Howell are going to go

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back to find out why Mr. Dyer and Mr. Gulliver went back all the way to January.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. So do I take it there was an understanding that the IHC testing had come in, in fact in May, that the correct date was May and not January?
MS. JONES:
A. There is nowhere in the documentation that says May 1st or whatever. There was parallel processes going on for a period of time through the winter of, so the actual date of move is not documented anywhere that we moved on March 31st or February 28th or whatever, so that was what that was all about.
CHAYTOR, Q.C.:
Q. So it wasn't a bad thing to go back to January because the IHC testing must have been happening back to January.
MS. JONES:
A. In the bioassay.
CHAYTOR, Q.C.:
Q. In bioassay only.

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MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. So what date--but you said it's parallel process, so was IHC testing also going on as of January, 1997?
MS. JONES:
A. Parallel process means that they were getting all of the--they were doing it as a bioassay, but they were preparing themselves and doing testing to validate the way of moving to immunohistochemistry.
CHAYTOR, Q.C.:
Q. But the results were coming out of the bioassay means, as opposed to the IHC?
MS. JONES:
A. Yes, that's right and at what point in time did they totally move over to just doing immunohistochemistry? At that date of transition, stop one, now start the other, that was an open question.
CHAYTOR, Q.C.:
Q. I assume if Mr. Gulliver and Mr. Dyer has records to go back to January of 1997, there must have been reports being generated on

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ER/PR through the IHC method back to January?
MS. JONES:
A. I can't answer that question.
CHAYTOR, Q.C.:
Q. Okay. So whether or not the May date or the January date was the correct date, you don't know?
MS. JONES:
A. And at the end of the day, that was what the--when we talked about all of these questions coming from the database, it was why was--why was the rest of the province said May when there appears to be results in your database from January to May?
CHAYTOR, Q.C.:
Q. I guess in my--my concern would be is there any question that there are other people out there who were tested from other regions, between January and May of 1997 who haven't been -
MS. JONES:
A. And that's what they went to check on.
CHAYTOR, Q.C.:
Q. Just says they're going to check why they went back to January.

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MS. JONES:
A. Yes, and that would have been resolved in that discussion.
CHAYTOR, Q.C.:
Q. So to your knowledge, that has been resolved -
MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And if there were other people from outside the St. John's region between January and May of 1997 who were tested, that issue has been addressed?
MS. JONES:
A. That would have been addressed, yes.
CHAYTOR, Q.C.:
Q. If we could have 0743 please? Okay, now we touched on this yesterday, Ms. Jones. This is your letter of November 16th, 2007.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. To Mr. Thompson and this is the--this is looking for the information management, I believe this is your actual, the presentation would be included here.

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MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. Or your briefing note.
MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And this refers to your meeting earlier this week, was indeed beneficial, and that's the meeting, I take it, that we discussed.
MS. JONES:
A. That we just talked about.
CHAYTOR, Q.C.:
Q. "With respect to Eastern Health's information management and decision support requirements, you may be aware that the board chair has been attempting and is still attempting to get a meeting with the minister in relation to the premier's comments regarding providing resources to Eastern Health to ensure that we are able to address our information management and decision support requirements." So this was your follow up, you indicated yesterday you had heard the premier make comments along those lines.

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

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CHAYTOR, Q.C.:
Q. You don't know!
MS. JONES:
A. I don't know, last night I spent an hour and a half with the board chair, but there was budget letters that had come in at the late day yesterday, 5:00, but you really have to go through the detail of those budget letters to see what's actually in there.
CHAYTOR, Q.C.:
Q. Well in November--or February, sorry, I believe you said there had been a pre-announcement -
MS. JONES:
A. There was a pre-announcement and -
CHAYTOR, Q.C.:
Q. So you assume you got at least was announced at that point in time.
MS. JONES:
A. Absolutely.
CHAYTOR, Q.C.:
Q. But whether or not there was more or less -
MS. JONES:
A. It will be another -
CHAYTOR, Q.C.:

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

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

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

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

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A. The answer on the content management was that there needed to be work done provincially and one of--and if I recall correctly, it was in discussion with the chief information officer for the province, there was a lot of work that needed to be done and therefore, they would want to do it as a province verses moving Eastern Health forward. The 880 that we had or the 800 that we had was the actual cost to implement it inside of Eastern Health, so there was $500,000 there for planning and on the decision support, there really wasn't an answer. They had gone and recognized that we needed to move forward with decision support and Eastern Health would get two out of the five positions. That was the only explanation.

CHAYTOR, Q.C.:

Q. And how confident are you that the resources you've now been provided are adequate to address the concerns that you identified in your information management systems, arising--that you learned about through the ER/PR experience?

MS. JONES:

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A. Well we absolutely need to see if in fact the content management is there, which is the tools to be able to get at some of the information that's inside of databases and we do need resources to be able to work at decision support and decision management. The two recourse, if I was to put them into the IHC lab area, that might very well be fine, but really this particular proposal is for decision support, you know, we've handled the issue--the issue with the IHC lab and where that is, but, you know, if we were to avoid a situation like this in the future for some other issue, then these are the kind of resources that we need.

CHAYTOR, Q.C.:

Q. The issue in terms of the IHC lab itself, wasn't a whole lot of issue around that, I understand, in terms of being under resourced, this issue of information management was more the issue--now whether it's under resourced in other areas, I'm talking information management right now, but this issue of information management was more the, connecting with the patients, wasn't that the

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issue?

MS. JONES:

A. No, the issue of information management is being able to generate that list.

CHAYTOR, Q.C.:

Q. Being able to identify them and connect with that.

MS. JONES:

A. And that's exactly it.

CHAYTOR, Q.C.:

Q. Identifying the patient and connecting with them.

MS. JONES:

A. Yes, and the decision support piece, it is having a set of skills that you could put around the table, clinical epidemiology, you notice in here, as well as bio-statistician, which is a set of skills that we don't have currently inside of a 1 billion dollar organization, you would say why, but -

CHAYTOR, Q.C.:

Q. You don't have an epidemiologist.

MS. JONES:

A. We don't have them, that we would be using in this particular way, they have a set of skills

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that if in fact you have an issue like this, you put a group of individuals, a project team around it to tease out all of the aspects of it. They know the methodology, you may not be able to get at it this way, but because of the way they think and the way that they've been trained, you may be able to get at things in different ways to be able to get you to a point. So there were sets of skills that we have that look at populations and health and factors and research and methodologies that we don't have inside of Eastern Health.

CHAYTOR, Q.C.:

Q. So being able to track trends and for example, how many lobular invasive breast cancers had ER negatives, ER positive -

MS. JONES:

A. What's the outcome, yes.

CHAYTOR, Q.C.:

Q. Being able to track those kinds of trends.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. So the money that you're seeking would be to put someone in place who would be able to do

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

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

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no standardized reporting on the pathology reports.
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. And that's something that, that had that been occuring perhaps in terms of the system that you have in place right now, it may have been easier then to retrieve the information -
MS. JONES:
A. They have been easier to retrieve the information and those systems that we have have evolved over time. And they really need to, as you move towards to a single consolidated system, they need to be set up in a fashion os that you're going to be able to get out, not individual patient pieces of information that there is a database that is able to be generated and to be used for things like we're talking about, positivity rates or any of those kinds of things.
CHAYTOR, Q.C.:
Q. Okay. If we could just move on then to page 2 of your proposal, there's just a couple of points I'd like to address with you here. And

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

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

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. "During the creation of eastern health, it was noted that none of the other six boards possessed decision support tools similar to those that were available in the health care corporation and there were limited resources associated with financial and/or health record analysis". So, since 2005, eastern health has attempted to use the tools and/or expertise that was available inside health care

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

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Outside of St. John's?

MS. JONES:

A. Yes, but eastern--old health care corporations still had a lot of work to do, even though we had made investments, there was still a lot more work to do. We did--if you go back to your first--we had decision support tools which was a cognizant (phonetic) tool that we had that we were working on and developing over time. And these were all related to making efficiencies in the system. They were

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

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or limited computerization.

CHAYTOR, Q.C.:

Q. The identification and the notification of the patients -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - for eastern health, the eastern health's portion anyhow, that happened with St. John's resources.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. That was done in St. John's, not--in terms of identifying who needed to be retested. So, that was done within St. John's. So, was any of the information management deficiencies that you had identified and that you go forward in your proposal on here, did any of those deficiencies contribute to the problems encountered in identifying and/or notifying the patients?

MS. JONES:

A. We didn't have the sophistication, we had to use a manual process. So, if we had had some

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of the tools that are referenced in here like the content management kind of tool that could sit on top of our existing hardware like Meditec and CRMS, but it's meditec in this instance. There may very well have been a more in-depth way to be able to get at the information that we were looking for. It still would have been not, from '97 to 2005, would not have been in a format, you know, a standard format, wasn't keyed in a field. But the other thing that you have to remember is a lot of the information wasn't inside of eastern health. We were relying on--you referenced -

CHAYTOR, Q.C.:

Q. Yes, that's -

MS. JONES:

A. - and as well as Gander and Grand Falls and Corner Brook and those kinds of things.

CHAYTOR, Q.C.:

Q. Yes, I just spoke to you about the area within your jurisdiction and what other areas did how they identified. But in terms of within eastern health, did Carbonear then identify their own patients or -

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MS. JONES:

A. Carbonear identified their own patients, the same as we did in St. John's going through the pathology reports.

CHAYTOR, Q.C.:

Q. And did that, to your knowledge, because we know there were, I think, some 14 patients were listed in Carbonear.

MS. JONES:

A. More than that.

CHAYTOR, Q.C.:

Q. More than that.

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. Did that have anything to do with lack of or deficiencies in information management?

MS. JONES:

A. Well, they couldn't have gone into their meditec system and found it any better than we could. So, they had to go to a manual based process to identify.

THE COMMISSIONER:

Q. Sorry, but I'm not understanding the answer to the question here. In respect of those--

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let's, for the moment, forget Carbonear and Burin.

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. But otherwise the groups that you would have been identifying would have been within what is the old St. John's Health Care Corp.

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. And can we come back to the original question which was, whether any of those deficiencies that had been identified in the communications here, contributed to the difficulties in respect of ER/PR. And what I heard you to say was maybe it took us longer to do it.

MS. JONES:

A. There would be no way that we could have fully identified because the meditec system is based upon an individual order. It's not a database management system. So, unless we had an individual field inside of meditec that was set up initially, what were looking at was pathology reports of which in the text of the

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report, ER/PR was within the text of a pathology report. So, the becomes your problem. And so therefore, every pathology report would have to come out and there's no way inside of a computerized system that we have, that you could say, ER/PR--spit out every ER/PR test that was done.

CHAYTOR, Q.C.:

Q. So, what happened instead?

MS. JONES:

A. That's where the manual process came in. Every pathology report associated with breast -

CHAYTOR, Q.C.:

Q. In that time period from 1997, whether it's January in St. John's to 2005 were pulled.

MS. JONES:

A. Were pulled.

CHAYTOR, Q.C.:

Q. And manually looked at.

MS. JONES:

A. And manually looked at.

THE COMMISSIONER:

Q. So, the answer really is what technology you had was of no assistance at all in the process

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that you had to go through for the purpose of identifying patients?

MS. JONES:

A. For the specific ER/PR.

THE COMMISSIONER:

Q. Yes.

MS. JONES:

A. That's right.

THE COMMISSIONER:

Q. That's what I'm interested in in the sense of--at least that's what I understood the question which was being proposed to you, was that how did the deficiency in your operation contribute, as it were, to the problems that have been identified over the period of time with ER/PR. Any my understanding of the response is the technology which you used within your operation--leaving aside for the moment, Carbonear and Burin, which I'm sure came with their own individual problems--did not permit you to search for particularly identifiable, in fields which had been set up for the purposed of identifying path report or whatever.

MS. JONES:

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A. That's right.

THE COMMISSIONER:

Q. And therefore, the only way of getting at the information was the old fashion manual, pull the files and look at it system.

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. Okay.

MS. JONES:

A. And there's nuances in there because you can order an ER/PR test, but not always was an ER/PR test ordered. So, you could line that particular piece up, but it wouldn't--we knew from the way our database worked and from the pathology reports that that wouldn't give you a complete listing.

CHAYTOR, Q.C.:

Q. So you couldn't search under ER/PR?

MS. JONES:

A. We could search under ER/PR, but that would give you a limited search. It wouldn't be a complete search. And so that -

CHAYTOR, Q.C.:

Q. And why was that?

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MS. JONES:

A. Because in order to--you had to enter the order in, but you didn't necessarily need an order to do the tests because if the pathologist was looking at, they would have said, do ER/PR on this particular test, not always entered into the computer system. So, there's not a system -

CHAYTOR, Q.C.:

Q. So it wasn't that the system couldn't find. It's that it may not have been recorded in a standardized format on the pathology report.

MS. JONES:

A. And that was only the order, there was no results in--because you also know that from, after a period of time the slides went back to be reread. So, we did the technical piece. And we didn't know the actual result for Gander, you know, for all of the other pathologists who read the reports. Our pathology reports inside St. John's would have only had the ER/PR numbers that were read inside of St. John's. So, we had a potentially had an order that says, do ER/PR, but not all of the specimens would have had

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that order on it and the tests would have been done.

CHAYTOR, Q.C.:

Q. Right, and so what I'm trying to ascertain here is whether or not the system you had in place was, in fact, adequate, but -

MS. JONES:

A. It wasn't.

CHAYTOR, Q.C.:

Q. - the information hadn't been put in in a format which would enable retrieval from the system.

MS. JONES:

A. It is set up as an individual patient basis. It's not set up on a database basis. And therefore you have to overlay different tools on it to be able to extract it from meditec to be able to get at it. So, it was not set up. Meditec is not set up in that fashion, to be able to drill down that far. We had not set it up inside of our system. It had not been set up. And therefore we were not able to get it out in that fashion.

CHAYTOR, Q.C.:

Q. So, it was done manually.

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MS. JONES:
A. It was done manually.
CHAYTOR, Q.C.:
Q. And do you know if any of the people that were not identified were missed manually? Was that the problem?
MS. JONES:
A. Obviously that was part of the problem because you're doing a manual search of all of the--Carbonear is a good example, where there was a manual search of pathology records for the ER/PR. And as late as the fall of 2007 there were other people who were identified.
CHAYTOR, Q.C.:
Q. Right, but you don't know the reason for that.
MS. JONES:
A. No, I don't know the reason.
CHAYTOR, Q.C.:
Q. Whether or not it had anything to do with cut offs or years or timing, you don't know.
MS. JONES:
A. Don't know.
CHAYTOR, Q.C.:
Q. All right. The bottom paragraph says that the--actually, before we skip to that I did

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

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

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As well as moving managers out of the system because they believe that there could be collapsing of some of the programs. There was issues that we didn't agree with which was a single emergency in St. John's and the closing of our acute care beds on Bell Island. So, there were some issues that, at the end of the day, the organization didn't agree with and went forward to government and said, this is things we can't agree with.
CHAYTOR, Q.C.:
Q. Maybe we can focus in on some that may or may not be relevant to this issue, but what about the decrease. Were there any decreases in managers in the quality department?
MS. JONES:
A. In this area they wouldn't have been looking at it in Hay.
CHAYTOR, Q.C.:
Q. Okay. What about in terms of in the lab? Were there -
MS. JONES:
A. There was workload decreases in the lab that would have looked decreasing the number of FTEs, but they were related to workload.

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Automation that would allow more tests to be done in that particular area.

CHAYTOR, Q.C.:

Q. So, was there anything in, with your knowledge and background of this exercise through the Hay Group, was there anything that could have contributed to the problems that ultimately come out of the lab in terms of the ER/PR issue?

MS. JONES:

A. At the end of the day there was very little that was referenced and I don't see it here, there was very little reference with respect to the lab. There was some cuts and there was some efficiencies and that kind of thing. They referenced in the lab that we were well automated, one of the better labs across the country from an automation perspective. So, from a clinical efficiency perspective, there wasn't very much there. And what they really pushed was to get support tools, utilization and decision support tools in for the entire organization that would then allow us to move forward. A lot of the focus was on in-patient beds. We were 25 - 30 percent above the

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national average for length of stay in a bed. So, if somebody -

CHAYTOR, Q.C.:

Q. Okay.

MS. JONES:

A. - came in, and that is where -

CHAYTOR, Q.C.:

Q. That's fine.

MS. JONES:

A. - the savings were mostly attributed to.

CHAYTOR, Q.C.:

Q. Okay, all right. So, nothing that would really jump out, in your mind, in terms of what could be relevant to this issue?

MS. JONES:

A. No.

CHAYTOR, Q.C.:

Q. Okay. So, during the creation (unintelligible - coughing) eastern health, it was noted that none of the six boards and I think I took you through that.

MS. JONES:

A. Um-hm.

CHAYTOR, Q.C.:

Q. I'm sorry, it's the next paragraph, "with the

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creation of Eastern Health in 2005, government identified 98" -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - "positions". And I take it that's an additional 98 on top of, we had 220 before.

MS. JONES:

A. Well, the Hay implementation was done by 2004. So, Hay was long, but this was really just to give a history of what we had been doing.

CHAYTOR, Q.C.:

Q. Okay. So, the accomplishment of 220 full time equivalents had already taken place.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And now government has identified an additional--this is new people.

MS. JONES:

A. New people.

CHAYTOR, Q.C.:

Q. Ninety-eight positions.

MS. JONES:

A. That's right.

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CHAYTOR, Q.C.:

Q. With an associated savings of 5.7 million to be achieved as a result of regionalization.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And of the 98 positions, 13.5 were to be reduced in information management. Sixteen positions in human resources and two in quality and approximately 15 related to financial and accounting.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. The organization did reduce approximately 37 positions with the savings of 1.6 million. Were any of those 37 positions in information management or quality?

MS. JONES:

A. They would have been from a directorship perspective in that area.

CHAYTOR, Q.C.:

Q. In information management?

MS. JONES:

A. That's right. And we've actually put more

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people in quality versus taking them out. And on the financial management there would have been some losses there. So, they would have been in the 37--most of the 37 would have been in higher level management positions, but I would say to you in that, then you're taking out a condry (sic.) of support that was inside the organization. So, the CEOs, you know there were seven CEOs, now we have one. There were management teams in all of the seven. So, a lot of them were at the senior executive management, but there were individuals, but they weren't in quality, we added in quality. Human resources would have been at that executive level and there was a couple of financial -

CHAYTOR, Q.C.:

Q. And information management, there was a director that came out.

MS. JONES:

A. The director, they ended up staying inside the organization, but not at the director level.

CHAYTOR, Q.C.:

Q. Okay. So, in terms of where the plan is to go from here on, is there still any plan to

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reduce in the areas of information management or quality?

MS. JONES:

A. We have said now. We accomplished 1.6. We have no direction been given to us that we have to go to the 5.7. We ask every year about that particular issue.

CHAYTOR, Q.C.:

Q. Okay. And then you have a graph that you present. And what you indicate here is that this graph has been utilized by eastern health in presentations over the past two years to point out the fact the organization is underinvested and you reference a database there, in the area of administration, support and information management.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And so in the past two years, who had this presentation been made to?

MS. JONES:

A. It had been made to the department. If you reference some of the budget submissions. We started it in 2005. As we came out of the old

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health care corporation of St. John's, there were different graphs that we were using, but we were having--even though we had put a major investment in terms of information technology, we were still way under what the Canadian average would have been in information technology. So, yes, we've come a long way, but we had a long way to go. So, we were using and trying to use the Canadian benchmarks and we know that Canada is well under the rest of the world with respect to investment and health information technology. And that's why we have Canada Infoway and that moving forward. So these graphs that you see attached here were used in 2005 and in 2006 and again in 2007, so at times there would have been where ministers were in place, with the minister of health at a particular time and we've also utilized them for the minister of treasury board in the past, in terms of presentations.

CHAYTOR, Q.C.:

Q. So this is not the first time, my point being that Eastern Health has gone to the department and said we need this money for this purpose.

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MS. JONES:

A. Absolutely, information management has been on the agenda for awhile and I would, you will look there and you say, we've also, just in the Eastern Health point there around bring out 98 positions, we have many times when people talk about us being over invested in management and support systems and in fact, we are way under invested and if in fact we had the management and the support systems, then we may very well be able to have avoided some of these things because we would have had supports, we would have had managers who would have been able to really get to the meat of some of the work that you expect managers to get to.

CHAYTOR, Q.C.:

Q. Okay, thank you. P-0488 please? Page 106, okay, just bear with me because this is a situation where our page numbers have changed so, here we go, December 12th, 2007.

MS. JONES:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And this again is the executive management

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committee meeting and you are chairing the meeting.
MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Judicial Inquiry, ER/PR and there's under the Inquires Act, the NLHBA, Newfoundland and Labrador Hospital Board Association.
MS. JONES:
A. Health Boards Association.
CHAYTOR, Q.C.:
Q. "Health Boards Association will be pursuing the minister of health and the minister of justice as it relates to the Inquiries Act and the implications for the health care system." What is that all about?
MS. JONES:
A. This was in December?
CHAYTOR, Q.C.:
Q. December 12th.
MS. JONES:
A. Yeah, this was in reference to the decision that we had made to go to court around the Evidence Act and the Inquiries Act with respect to the peer reviews and looking for

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clarification.
CHAYTOR, Q.C.:
Q. And the NLHBA, who would sit on that from Eastern Health?
MS. JONES:
A. The NLHBA, their board chairs and CEOs, so the CEOs meet with the deputy every two weeks and then the board chairs meet on every couple of months to talk about, you know, the entire system.
CHAYTOR, Q.C.:
Q. So you and Mrs. Dawe would sit on that?
MS. JONES:
A. Mrs. Dawe, that's right.
CHAYTOR, Q.C.:
Q. And did you do that? Did the NLHBA pursue the minister of health and justice on the issue?
MS. JONES:
A. I'm not sure about the minister of justice, but we did have discussion with the minister of health around the Inquiries Act and more specifically around the Evidence Act and the Inquiries Act that provision around the information.
CHAYTOR, Q.C.:

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Q. So you did do that?
MS. JONES:
A. Yes, we did.
CHAYTOR, Q.C.:
Q. And were you involved in those discussions?
MS. JONES:
A. There was a meeting, probably the latter part of November where the minister came in, usually comes in for supper and along with a number of issues that we would have had on the agenda that night, we did talk about the peer review and the need to protect peer review, so that was really in the context of the discussion, that I was with where the minister was.
CHAYTOR, Q.C.:
Q. And the implication for the health care system being the need to protect peer review.
MS. JONES:
A. Peer review.
CHAYTOR, Q.C.:
Q. And without going down that long road again because I know the Commissioner had some questions with you around that a couple of days ago, but what are the implications for

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the health care system? What exactly are they?
MS. JONES:
A. We've not had a discussion around peer review, I don't believe here.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. I think I raised peer review in the context of -
CHAYTOR, Q.C.:
Q. Patient safety.
MS. JONES:
A. Okay.
CHAYTOR, Q.C.:
Q. Remember the Commissioner put to you about the issues of about, you know, the whole original--the whole intent for peer review was patient safety.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. So in today's modern world and the issue of patient safety seemingly to be first and foremost in people's minds.

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

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in the 80s, there's always been a discussion about what it is, where it is, the need for that protection so that that open and honest discussion actually happens. And that has been a way that the health professions have evolved, it is something that for them, allows them in some way to feel as if, that they have that safety to be able to have that discussion and to have experts to be able to talk to them that they may not have had an ability to be able to talk to in the past.

So it's just been one of those things that has been there. It's the way we operate. We do our work inside of it. The discussions stay inside of there. There's learnings. There's education that comes out of it and that's essentially the ethos of how health care has operated.

CHAYTOR, Q.C.:
Q. Yes, to date.
MS. JONES:
A. To date.
CHAYTOR, Q.C.:
Q. And the discussion with the minister around that, did you speak?

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MS. JONES:
A. All of the CEOs would have had something to say in terms of -
CHAYTOR, Q.C.:
Q. So did you?
MS. JONES:
A. Yes, yeah.
CHAYTOR, Q.C.:
Q. And what position did you advocate?
MS. JONES:
A. In terms of our physicians, as well as our staff inside, had said to us that really on peer review, that that was a critical component of the way that the health system works and that we needed to move forward with that particular approach.
CHAYTOR, Q.C.:
Q. And had you read the reports at that point in time?
MS. JONES:
A. I had.
CHAYTOR, Q.C.:
Q. Okay, and so you were still advocating that those reports should be protected under the legislation?

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MS. JONES:
A. These reports were done underneath the auspices of peer review and our physicians were very clear with this, as well as our staff, that that was the way that they were set up, and if, in fact, these particular reviews were opened in any single way, that the protection of the principle of peer review under the Evidence Act would have been damaged in some way.
CHAYTOR, Q.C.:
Q. And did you have any concerns about the protection of patients if that information was not forthcoming?
MS. JONES:
A. At that point in time, when I read those reviews, we were back redoing IHC testing. The issues that were identified in those reviews, the recommendations that were in those reviews were already actioned. So from the perspective of patients on the go-forward basis, there was not an issue.
CHAYTOR, Q.C.:
Q. And they had been actioned where? The information in those reports had been actioned

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where?
MS. JONES:
A. The recommendations in those reports had been actioned.
CHAYTOR, Q.C.:
Q. Within Eastern Health?
MS. JONES:
A. Within Eastern Health.
CHAYTOR, Q.C.:
Q. Had there been disclosure to the other health authorities? This is December 2007.
MS. JONES:
A. Yeah, the IHC lab is the--the working of that lab, the producing of the slides is internal to Eastern Health. There would have--you're probably going to suggest the fixation issue and I'm not sure how much of that had been actioned outside of. There had already been discussion by Mr. Tilley in terms of raising the issue nationally to look at best practices or benchmarks or standards or whatever, because there was nothing in the Canadian system. So there was a move to--there was an attempt by Eastern Health to raise that profile of an issue to try to, at least,

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develop standards, benchmarks and that so that it was well aware across the country that we had experienced issues inside our lab, and that the Canadian Pathology Association, through Don Cook, in their meetings early, along after we had identified this issue, had discussions to say "look, there are no standards here. This is what we're dealing with, in terms of the results that we were getting."
CHAYTOR, Q.C.:
Q. And at this point in time, December of 2007, when you're advocating that position that the recommendations and whether or not the recommendations had all been implemented, are you saying that all the recommendations were implemented?
MS. JONES:
A. The recommendation that's not implemented is the system that has nothing to do with the quality. It's the processing, the quickness of the processing.
CHAYTOR, Q.C.:
Q. In December of 2007?
MS. JONES:

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A. In December of 2007.
CHAYTOR, Q.C.:
Q. And in terms of what had happened, in terms of education or any education that may have been required for the individuals involved, what had happened along those lines?
MS. JONES:
A. You'll have to talk to Dr. Howell or Dr. Williams specifically about that, but I do know that there was pathologists that availed of additional education in the way of workshops through that outside of the province and that we had also sent technologists to other labs. So the actual detail of that, you'll have to find from them, but the education of the technologists and the pathologists in this particular area is more best suited for those individuals to talk to you about.
CHAYTOR, Q.C.:
Q. Ms. Jones, the idea that all but one of the recommendations have been implemented, is that in writing anywhere?
MS. JONES:
A. No. There's a spreadsheet of recommendations

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that says ongoing for education and those kinds of things, a compiling of them, but that one around--and I can't even pronounce it, but the machine. I've seen the machine in there.
CHAYTOR, Q.C.:
Q. Yes, we've seen the spreadsheets and I assume we have the latest spreadsheet, and I would suggest to you that that spreadsheet, if that's what you're talking about, has other things ongoing or in the process besides education pieces.
MS. JONES:
A. The ongoing ones, education will never be completed.
CHAYTOR, Q.C.:
Q. No, and I'm not talking about those.
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. Have you seen any documentation that says all but one of the recommendations has been implemented?
MS. JONES:
A. That's been--I've seen documentation. Now whether it says ongoing or whatever, but in

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discussion with Dr. Howell, and that is the only recommendation that remains outstanding.

CHAYTOR, Q.C.:

Q. So that's what Dr. Howell tells you?

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. Have you seen anything in writing?

MS. JONES:

A. No. I've probably seen early versions of the 52 on the page with the spreadsheet, just like you have.

CHAYTOR, Q.C.:

Q. Which would clearly have ongoing on it.

MS. JONES:

A. On many of those, yeah.

CHAYTOR, Q.C.:

Q. On many of those.

MS. JONES:

A. And many of those would be always continued to be ongoing.

CHAYTOR, Q.C.:

Q. Well, some of them, I'd suggest to you. I think I went through that process with the minister and was able to identify, at that

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point in time, the latest spreadsheet we have, 12 or 13 that weren't complete, and weren't necessarily things that -

MS. JONES:

A. Would have been that they would never be completed.

CHAYTOR, Q.C.:

Q. No, it was dated, but if there's something more--you know, I think it was back, but it's in 2007, but if there's something more recent, I'm wondering if you've seen it.

MS. JONES:

A. I can't attest to seeing that.

CHAYTOR, Q.C.:

Q. I think it was June 2007.

MS. JONES:

A. I've seen a spreadsheet, yeah.

CHAYTOR, Q.C.:

Q. June 2007, I think, is the most recent one we have and what you're saying here is in December.

MS. JONES:

A. And I'm thinking we'll check to see if there is an updated--because that spreadsheet does get updated. I'm not sure what date I would

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have seen.

CHAYTOR, Q.C.:

Q. But as of December 2007, there was only one recommendation that hadn't been implemented?

MS. JONES:

A. To my knowledge, that would have been, and that was around the efficiency versus the quality piece.

THE COMMISSIONER:

Q. Ms. Chaytor, it's five to one.

CHAYTOR, Q.C.:

Q. Oh.

THE COMMISSIONER:

Q. Do you want to take the luncheon break?

CHAYTOR, Q.C.:

Q. Yes, thank you.

THE COMMISSIONER:

Q. 2:10, thank you.

(LUNCH BREAK)

CHAYTOR, Q.C.:

Q. I think, Registrar, we're at 0488, page 106. Good afternoon, Ms. Jones.

MS. JONES:

A. Good afternoon.

CHAYTOR, Q.C.:

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Q. Sorry, Commissioner, just trying to find where were left off. We were with the December 12th, 2007 minutes.

THE COMMISSIONER:

Q. Yes. And Dr. Howell and Dr. Williams were going to speak to the education element.

CHAYTOR, Q.C.:

Q. Um-hm. Here we are, okay. Back before this. Here we go, yes. That's right. Yes, it was the meeting with oncologists and pathologists under 2.1. "Dr. Howell, Pat Pilgrim, Stephen Dodge and Heather Predham meet with several of the oncologists and pathologists on Monday, 10th of December, 2007. The physicians have requested that Eastern Health go public with a statement of support for its physicians. Bristol Communication will be engaged to develop both internal and external communication strategies that will guide the organization in the coming weeks as the organization moves through the COO." What was the purpose of the meeting with Dr. Howell and the others with the oncologists and the pathologists?

MS. JONES:

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A. Exactly as it's listed there in that they wanted Eastern Health to publicly make a statement about support for the work that they do.

CHAYTOR, Q.C.:

Q. Okay. And in terms of--and has that happened or is that happening?

MS. JONES:

A. We did not do that. We basically had discussions with them about what really was their intent of that and that as we go through the Commission of Inquiry that they had to go through the Commission of Inquiry and those things would come out during that particular point in time. We weren't sure what that would actually do, like, what would a support or a communication of a support for pathologists and oncologists do in the public realm. We were trying to support them internally in the best way we could with looking at their workload and what we could do to allow them to continue on and do the best work that they could.

CHAYTOR, Q.C.:

Q. What did it mean they were looking for Eastern

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Health's support or to go public with a statement of support, a statement of support for physicians in what respect?

MS. JONES:

A. Well, that was what we wanted clarified from them. And that's when Dr. Howell and Pat and Steve actually did go and talk to them and say, "What is it that you're looking to in that particular realm, what is the outcome that you actually want? You know that we support you, you know that we value the work that you're doing." So those were the discussions. "So what is it that you want out there in the public forum?" And I wasn't at that meeting so I'm not sure what the individual input, but they were feeling fairly demoralized as a result of all of the exposure and that that was going in.

CHAYTOR, Q.C.:

Q. Did they report back to you, Dr. Howell and the others, did they report back to you and/or the executive as to the outcome of that meeting?

MS. JONES:

A. Only to the point that we had indicated that

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really, you know, going out with a paid ad or whatever really wouldn't achieve what it is that they were looking for.

CHAYTOR, Q.C.:

Q. Did any of your other staff or personnel or professional groups have a similar request of Eastern Health?

MS. JONES:

A. The lab has also had--you know, they've been in the media with the same pictures of the pathology immunohistochemistry lab being photographed and showed all along. And we had actually run new footage ourselves in the fall and shared that with the media so that, you know, really to show the full breadth of the lab and not every time they talked to show the pathology lab. So, you know, we've been working with them, as well.

CHAYTOR, Q.C.:

Q. That was the footage that I guess the media took when the media was invited in in December -

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

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Q. - or 2006?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. Yes. But have the technicians or the technologists, have they asked that Eastern Health go public with a statement of support for them?

MS. JONES:

A. Not particularly in the way that the physicians would have asked.

CHAYTOR, Q.C.:

Q. And then, "Bristol Communication will be engaged to develop both internal and external communication strategies to guide Eastern Health" or "the organization in the coming weeks as we move through the Commission of Inquiry." What's that all about?

MS. JONES:

A. That is using an external lens to help us with a communication strategy around a little bit like what we were talking about this morning, the crisis communication, what is it, what would need to be part of it. And I think this is early in December, so at that point in time

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they had not done the public poling to see where Eastern Health was and what the public felt about Eastern Health. So it wasn't on ER/PR poling, it was just an overall image of Eastern Health based upon the clients in our region.

CHAYTOR, Q.C.:

Q. Yes. And so what strategy has been developed to guide the organization through the Inquiry?

MS. JONES:

A. It is a, it's a document only to the--of what we should be doing in the short term and in the longer term. And then we talked about elements of that, about stakeholder engagement, partnerships, about interacting with the media, to have stories other than ER/PR out there, this issue that we talked about earlier on this morning about public confidence because Eastern Health is a very large organization with large parts of our organization that are not involved in this, but--so those kinds of things, we have -

CHAYTOR, Q.C.:

Q. So putting good news stories out there about good things that are happening -

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MS. JONES:

A. As well as -

CHAYTOR, Q.C.:

Q. - while the Inquiry is going on?

MS. JONES:

A. As well as managing -

CHAYTOR, Q.C.:

Q. That kind of thing?

MS. JONES:

A. - as well as internal communications, keeping our own staff up to scratch on what was going on both inside the organization -

CHAYTOR, Q.C.:

Q. That's internal, yes.

MS. JONES:

A. That's all internal.

CHAYTOR, Q.C.:

Q. Yes, okay. And so the external piece would be in terms of getting out that there's some good things happening while this process is going on -

MS. JONES:

A. And the messages and what--that kind of thing.

CHAYTOR, Q.C.:

Q. To help with the issue of the image of Eastern Health and the public's confidence?

MS. JONES:

A. Not just--the public's confidence, yeah.

CHAYTOR, Q.C.:

Q. Public's confidence in the -

MS. JONES:

A. Not image of Eastern Health, that's not really the way we would talk about it. It's confidence in the system.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. In the entire system.

CHAYTOR, Q.C.:

Q. Okay. All right. If we continue on then, there's the class action suit is referenced. The statement of defence is anticipated to be filed in December. And a meeting with a case management judge. "Where HIROC will be discussing the process of requirement with respect to the potential naming of the third party in the class action suit." Who is the third party?

MS. JONES:

A. Well, I do believe that in terms of that, if

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there's anything other than Eastern Health named or that has to be done within a particular period of time.

CHAYTOR, Q.C.:

Q. Did you understand, though, was there discussion around the potential of who that third party would be?

MS. JONES:

A. There's always the discussion of whether physicians would be named as a group.

CHAYTOR, Q.C.:

Q. Okay. So that would be referencing the physicians?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. The laboratory workload?

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. "The services of DynaCare, a private pathology lab in Ontario, will continue to be utilized in the short term for non-complex pathology. This is due in part to the impact of the preparatory," I'm not sure if that word is

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right, "phase for the COI and subsequent demands on the pathologists and staff in preparing for same."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And how long have--the services of DynaCare, I understand, is something that's been in place for awhile in your organization?

MS. JONES:

A. Been in place for awhile. Off and on we had taken back some of the work that we were sending out to DynaCare and it really depend on the number of pathologists. But in more recently, especially with the resignations that we've got and people off, we have increased our service contract with DynaCare, as well.

CHAYTOR, Q.C.:

Q. And the resignation that you've got from the pathology lab, Dr. Carter, I take it, you're referring to?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

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Q. But Dr. Carter is still in her position?

MS. JONES:

A. She's still in her position, but we do have our other person who is in our breast group who is off on stress leave.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. And we've also had a resignation in there that, an exit earlier on since this winter. So we have been increasing our reliance on external resources to do the pathology work and our pathologists in preparation for being here at the Commission of Inquiry and that also will require time. The other thing is that we're still dealing with some of the database and having to rely on pathologists for samples that are coming back and rereads and those kinds of things, so it's a significant demand.

CHAYTOR, Q.C.:

Q. Yes. And is ER/PR still being done in St. John's?

MS. JONES:

A. Yes, it is.

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CHAYTOR, Q.C.:

Q. Okay. ER/PR database. "The results of the ER/PR database are in the process of being finalized. The focus now is on the communications, in particular, communications with families of the deceased. Consideration will be given to engaging an oncologist from outside the province to meet with the families of the deceased, however a process has not yet been defined." And we spoke about this issue yesterday about the deceased.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And I take it that there was not an oncologist engaged from outside the province?

MS. JONES:

A. No, there wasn't.

CHAYTOR, Q.C.:

Q. And that is no longer the plan to do that?

MS. JONES:

A. That's no longer the plan. We've made the announcement and we will, if we have families who call, we will talk to our local oncologists. If, in fact, they have--there is

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a relationship with that family, they will deal with it and then on an individual basis we'll see how we manage it.

CHAYTOR, Q.C.:

Q. Okay. "The organization has panelled the sick living patients. Of the two, there are two patients that will," "Of the six," I'm sorry, it's a mistake there in the minutes, but "Of the six there are two patients that will have their treatment changed."

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. And so I take it that the same panel came together to panel those six patients. But was there an issue that the oncologists weren't prepared to meet with those people or why would you have -

MS. JONES:

A. No, this -

CHAYTOR, Q.C.:

Q. - been looking at this point in time in having someone outside the province -

MS. JONES:

A. This has nothing to do with the discussion

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that's above that, which is on the deceased. This -

CHAYTOR, Q.C.:

Q. Oh, I'm sorry, yes, this is six living patients.

MS. JONES:

A. Yeah, six living patients -

CHAYTOR, Q.C.:

Q. These were the six that were missed?

MS. JONES:

A. These were missed.

CHAYTOR, Q.C.:

Q. Right, okay.

MS. JONES:

A. And results back from Mount Sinai -

CHAYTOR, Q.C.:

Q. Okay, yes.

MS. JONES:

A. - so they have to be panelled and -

CHAYTOR, Q.C.:

Q. Okay. Yes, okay. And those, I take it, the communication to those two, the living patients, those were done in the usual manner?

MS. JONES:

A. In the usual manner.

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CHAYTOR, Q.C.:

Q. And the strategic planning for a three-year term, 2008 to 2005?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And I think most of these points we've talked about in one way or another. There's, for example, under "Safety" "Required to list out the measures and indicators for the first year." And I believe you mentioned that to us in the goals that have been set or objectives that have been set for you, as well, as the CEO?

MS. JONES:

A. There's a template that the strategic plan under the transparency and accountability has to look for, so it's goals that have to be identified over first year, second year and third year. So this was we had come out of the strategic planning session with the board in November and this was completing the document and getting it ready to go back to board.

CHAYTOR, Q.C.:

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Q. Okay. And that then goes on to government, I take it?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And accountability, "The need to identify more concrete indicators. Suggestion that there be quarterly or semi-annual meetings with the department and the Eastern Health board."

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. Has that been happening?

MS. JONES:

A. There hasn't been on a formal basis, but this is something that the board has listed as one of the areas that it wants to have more formalized relations with the minister and the department.

CHAYTOR, Q.C.:

Q. Okay. If we could have 0752, please? This is a series of e-mails, Ms. Jones, which are in January of 2008?

MS. JONES:

A. Yes.

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CHAYTOR, Q.C.:

Q. January 23rd, 2008?

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. And it seems to involve meeting or trying to schedule a meeting with Mr. Thompson, which would include oncologists Dr. Kara Laing and Dr. McCarthy?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. What--did that meeting ever take place?

MS. JONES:

A. That meeting did take place, but Dr. McCarthy wasn't there, Dr. Kara Laing was there.

CHAYTOR, Q.C.:

Q. And what was the purpose of that meeting? Who attended, first of all?

MS. JONES:

A. It would have been Pat Pilgrim, myself, Robert Thompson, Dr. Laing and Dr. Howell. I'm thinking -

CHAYTOR, Q.C.:

Q. And what was the purpose?

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MS. JONES:
A. I'm thinking Dr. Howell was there. I would be 95 percent sure of that.
CHAYTOR, Q.C.:
Q. And I take it this meeting took place sometime late January or -
MS. JONES:
A. It took place on a Friday afternoon, I think maybe the following--maybe the Friday of that week, the 25th or later on.
CHAYTOR, Q.C.:
Q. Okay. And what was the purpose of that meeting?
MS. JONES:
A. The purpose of the meeting was to look at how we were going to handle the notification of families of the deceased.
CHAYTOR, Q.C.:
Q. And at whose request was this meeting?
MS. JONES:
A. That was at our request.
CHAYTOR, Q.C.:
Q. At your request.
MS. JONES:
A. So that because if you remember earlier on

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

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-
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. - if that person's physician was no longer around?
MS. JONES:
A. And didn't know what -
CHAYTOR, Q.C.:
Q. The next best thing would be another oncologist?
MS. JONES:
A. That's right, you know. And at the end of the day, but would not have been known the background behind the treatment protocols that were used on that particular patient and why the decisions were made.
CHAYTOR, Q.C.:
Q. Right. And so what happened then at this meeting, what was discussed?
MS. JONES:
A. It was--so there was really just an understanding there at the end of the day that we would move forward with a public notification, which is where we had thought we

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were going to go, and that in what vehicle we would move forward with that public notification.
CHAYTOR, Q.C.:
Q. And what was Dr. Laing's position expressed at the meeting?
MS. JONES:
A. The only position that Dr. Laing had, which was the same as what the oncologists had had, was the decision to retest all of the deceased was an administrative decision, because it was made by Mr. Tilley in May of 2005. So that was the only--it was an administrative decision. They would deal with -
CHAYTOR, Q.C.:
Q. May 2007.
MS. JONES:
A. In 2007, sorry about that, and as they moved forward, they had been dealing with individual families of the deceased because they had been getting calls and they had been retesting results, so they were dealing with them as it went through, but there could not be an expectation that they would deal with all of the calls that would come in because of just

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what we talked about, they didn't have a relationship. There was already a work load issue and they really wouldn't have answers, but you know, they would do what they could for us.

CHAYTOR, Q.C.:

Q. And that decision you say was made by Mr. Tilley in May of 2007, because originally, and we looked a day or two ago at the ethics consult, the original decision was that Eastern Health was not going to retest all of the deceased?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. Only if the families of the deceased came forward requesting that?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. Mr. Tilley, in making--coming to a different decision then about a year after the ethics consult, was the executive part of that decision?

MS. JONES:

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A. No.

CHAYTOR, Q.C.:

Q. Did he consult with anyone? Did he consult with you on it?

MS. JONES:

A. No, he didn't consult with me.

CHAYTOR, Q.C.:

Q. And do you know whether or not--who he may have consulted or whether or not he took direction from anyone else on that?

MS. JONES:

A. No, you're going to have to ask Mr. Tilley on that, but I do know that he did announce it when he did the press conference in the May time frame.

CHAYTOR, Q.C.:

Q. So there was no discussion at executive about now testing all of the deceased?

MS. JONES:

A. No, not that I recall.

CHAYTOR, Q.C.:

Q. And if we could have, please, 0758? And this, I think, Ms. Jones, is the copy of the press release that goes out regarding the deceased patients.

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MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. February 21st, 2008.

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay, and I understand that you were out of town, you said, when this happened?

MS. JONES:

A. That's right. I was out of town that entire week.

CHAYTOR, Q.C.:

Q. Okay. It talks about "Eastern Health has followed through on its commitment to retest ER/PR results of all our deceased patients and will provide these retest results to the next of kin who would like to have them."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And this is Mrs. Pilgrim speaking, and "everyone at Eastern Health is very concerned about the patients and their families that have been impacted by the ER/PR testing

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issues. We understand that this has been a long process for families of our deceased patients and we believe it is important to provide an opportunity for those next of kin to contact us for the results," and then we've talked about that process and the phone number -

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. - and so if anyone asks for a consult, oncologists within Eastern Health, I believe you told us, will meet with them?

MS. JONES:

A. I said that we would--if it was their own patients, they would meet with their own patients, and on an individual patient basis, we would go to the clinical chief, Kara Laing, and ask if there was an individual oncologist who was willing to meet with this family, based upon the questions.

CHAYTOR, Q.C.:

Q. And that hasn't come up yet?

MS. JONES:

A. Not that I'm aware of.

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CHAYTOR, Q.C.:
Q. You haven't had that issue yet?
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay. But Kara Laing, as clinical chief, has agreed to that process?
MS. JONES:
A. We would go and ask Kara Laing.
CHAYTOR, Q.C.:
Q. Okay, so -
MS. JONES:
A. Okay, so we went -
CHAYTOR, Q.C.:
Q. - Kara Laing hasn't necessarily agreed to the process?
MS. JONES:
A. Kara Laing has not necessarily agreed to that process, but they said they would help us out in whatever way.
CHAYTOR, Q.C.:
Q. Yes, okay. So right now, the oncologists have agreed that they will meet with their own--the families of their own patients?
MS. JONES:

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A. Absolutely, yes.
CHAYTOR, Q.C.:
Q. And if and when the situation arises that it's somebody -
MS. JONES:
A. They will look at the individual case.
CHAYTOR, Q.C.:
Q. - other than one of the current oncologists, you're hoping you'll be able to go to the clinical chief and arrangements will be made?
MS. JONES:
A. Absolutely, and they have, as I said to you yesterday, they have been very accommodating when requests have come forward to us.
CHAYTOR, Q.C.:
Q. If we could have 0754, please? I think the issue around this e-mail, this is an e-mail February 5th 2008 and we discussed yesterday this e-mail. It's to Robert Thompson from yourself, and it says from Joyce Penney, but it's forwarded on your behalf?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. And this was the 175 that was put forward?

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MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. I believe at one point, we had looked at 178, but in your e-mail here, it's actually 175.
MS. JONES:
A. 175, yeah.
CHAYTOR, Q.C.:
Q. For the additional funding, and just a couple of questions about this. "Eastern Health has allocated a full-time quality leader to the regional lab who is spending a significant amount of time working with staff on the development of policies, procedures and establishment of a QA program."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. I take it, is that Lynn Wade's position?
MS. JONES:
A. That's Lynn Wade.
CHAYTOR, Q.C.:
Q. Okay, and "we have done a significant amount of work to educate staff and pathologists, but this work needs to be ongoing if we are to

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ensure continued competence of staff and pathologists."
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. What exactly has been done in terms of "a significant amount of work to educate the staff and pathologists?"
MS. JONES:
A. I think we already answered that this morning, that you would have to ask Dr. Williams and Dr. Howell, but I referenced this morning that our pathologists have been sent out to conferences and our pathologists have actually gone to labs, but I do know that the staff have actually gone on site visits in other IHC laboratories.
CHAYTOR, Q.C.:
Q. And I know I did ask you this morning, but I know you also referred me to the others, but you're writing this yourself.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. So I thought perhaps maybe this would jog your

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memory.
MS. JONES:
A. And that's the same as I gave you this morning.
CHAYTOR, Q.C.:
Q. Yes, so have the staff, the technologists and pathologists, received further education on ER/PR specifically?
MS. JONES:
A. Yes, and the staff as well, the pathologists continue to do work with the technologists because we're looking to increase the scope of the work that they do, about reading their own internal--the controls on the slides and that, so that work is ongoing.
CHAYTOR, Q.C.:
Q. And in terms of the work that Lynn Wade is doing, the new quality leader, in the development of policies and procedures, are you aware of any difficulties that Ms. Wade has encountered?
MS. JONES:
A. I wouldn't know that on a personal note with Lynn.
CHAYTOR, Q.C.:

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Q. So you don't know that?
MS. JONES:
A. I don't know that.
CHAYTOR, Q.C.:
Q. So that hasn't made its way up to the executive?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. And if we could have then, please, P-0755? This is an e-mail from Pam Bennett to yourself, along with the CEOs of the other three regions, Susan Gillam, Boyd Rowe, Karen McGrath.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. And it's dated February 6th 2008, and it's with respect to a noon conference call, and it's called "early lessons learned." Who's Pam Bennett?
MS. JONES:
A. I have no idea. Must be somebody in Robert's office, but I don't know.
CHAYTOR, Q.C.:

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Q. So this, you understood, is coming from Robert's office or is it coming from Don Keats? The next, if we look down, the original meeting, Don Keats.
MS. JONES:
A. Yeah, but the original is from--my understanding was it was Robert.
CHAYTOR, Q.C.:
Q. Robert Thompson to Don Keats and then on?
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay, and so who was on the conference call on February 6th?
MS. JONES:
A. We would have had the four people that were listed here. We also had--I know that Oscar Howell was with me. I know that Ken, the VP for medicine in Western, Ken, and I don't remember his last name, was there with Susan Gillam.
CHAYTOR, Q.C.:
Q. Jenkins?
MS. JONES:
A. Ken Jenkins. Karen McGrath doesn't have a VP

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for medicine, so I'm not sure if there was anybody with Karen. Boyd was on and I'm not sure whether, in fact, his VP for medicine was on or not.
CHAYTOR, Q.C.:
Q. Okay, and -
MS. JONES:
A. And Mr. Thompson.
CHAYTOR, Q.C.:
Q. - and what was the purpose of this call?
MS. JONES:
A. If you go to the -
CHAYTOR, Q.C.:
Q. Next page?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. There you go.
MS. JONES:
A. Robert wanted to have discussion about this particular document because they were getting ready for to do the release of the database or to talk about the database. The minister was going to go out and he felt that he may very well be able to announce some monies for some

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aspects of that. So they wanted to marry it with if in fact they could make some announcements, but there was no commitment that they would be able to make any announcements. And he wanted to talk about the components that were in here.

CHAYTOR, Q.C.:

Q. And the early lessons learned and preliminary responses, are they early lessons learned from the ER/PR issue? Is that what this is about?

MS. JONES:

A. You'll have--this is Robert's document.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. So I'm assuming that he is talking about that. He also had the task force on adverse events at the same time. But our understanding was it was around ER/PR.

CHAYTOR, Q.C.:

Q. Yes, and you would have read the document, I take it? It's not--it's only less than a two-page document.

MS. JONES:

A. That's right.

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CHAYTOR, Q.C.:

Q. And you participated in the conference call.

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. So you understood it was around the ER/PR issue?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And the data management and tracking says "better data management and tracking could have provided greater certainty that all negative ER/PR cases were identified and sent to Mount Sinai on a timely basis and would have aided the patient communication process."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Do you agree with that statement?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And the preliminary response indicated, so this is Robert's team drafting this?

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MS. JONES:

A. This is Robert's team drafting what potentially may be recommendations from him as they move forward.

CHAYTOR, Q.C.:

Q. "establish a new policy for the department and the regional health authorities that whenever there is an adverse event that requires contact, testing or treatment for a group of patients, a single official is to be charged with clear, organization wide responsibility for directing patient contact and data management and that person must have access to an appropriately skilled data manager, trained to use or design an information system which can require comprehensive data for all events in the response process, provide timely reports and can be audited."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And did you and the other CEOs agree with that?

MS. JONES:

A. Absolutely, because there is nobody tasked

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with that right now inside the organizations. There was some question about whether we had the skills to be able to do that.

CHAYTOR, Q.C.:

Q. So is this a situation where--and I think there are three different lessons learned with preliminary responses. Was this a situation where this was being suggested by Robert or Robert and his team, and he was seeking feedback from you?

MS. JONES:

A. He was seeking feedback.

CHAYTOR, Q.C.:

Q. And do you recall, were any of these issues contentious?

MS. JONES:

A. Only the third one. This first one was not contentious and as Robert had said to me, if you look at the three bullets that were underneath here, they are very similar to the ones that we had sent in the November document.

CHAYTOR, Q.C.:

Q. Okay, and which includes approving of budget allocation. The second one then is the

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quality assurance and monitoring the immunohistochemistry laboratory.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And I take it this would predominantly pertain to Eastern Health?

MS. JONES:

A. Yes, but if you look down further, there is a discussion that there is--what would the system believe--was the system supportive if we moved to laboratory accreditation for the entire province, and everyone on the system said absolutely a must.

CHAYTOR, Q.C.:

Q. Okay. Everybody wanted that?

MS. JONES:

A. Everybody wanted it.

CHAYTOR, Q.C.:

Q. Not only did they agree with it, they would insist upon it?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. Okay. "Since 2005, the recommendations of the

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peer review have been implemented, including the adoption of external review procedures. Two external reviews were completed in 2007," and I take it that refers to the accreditation?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And the QMPLS in December 2007?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And the preliminary response, "the recommendations of these reviews should be implemented with budgetary appropriations." The next one is "government should commit to legislation that would make laboratory accreditation a mandatory requirement as is currently the case in Ontario."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And is that what everybody was unanimous in supporting?

MS. JONES:

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A. They were.

CHAYTOR, Q.C.:

Q. In seeking a change to the legislation?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. "And adopting a policy which clarifies where the authority resides for quality control for tests for which there is a single testing site in the province." So adopt a policy which clarifies where the authority resides for quality control for tests for which there is a single testing site in the province. So that would be the ER/PR tests obviously -

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. If it's to happen in St. John's or with Eastern Health again. "A mechanism for the testing site to specify standards, QA and monitoring for all steps in the test should be established."

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

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Q. Did the other three health care authorities agree with that?

MS. JONES:

A. Yes, because they also have some provincial program areas that they have responsibility for.

CHAYTOR, Q.C.:

Q. And has such a policy been adopted?

MS. JONES:

A. No, these were recommendations that Robert asked our input into and haven't gone anywhere. Some of them ended up in terms of announcements, but it hasn't happened.

CHAYTOR, Q.C.:

Q. And is anybody working on such a policy?

MS. JONES:

A. Not that I'm aware of right now. The discussion around this was for all of those areas where we have provincial programs that really we needed to formalize the provincial programs in a memorandum of understanding about the entire program and the roles and responsibilities of each one of the partners in. So what was sent back to Robert was a bigger issue around provincial programs.

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CHAYTOR, Q.C.:
Q. Okay. The government committing to legislation to make laboratory accreditation a mandatory requirement, if all of the four health care authorities in the province are in agreement and feel strongly about that, that can happen without any change obviously in the legislation.
MS. JONES:
A. It can happen without any change, but there was also just a discussion to say that if in fact we're to move that way, we need to know exactly what those standards would be, where are the standards, those kinds of things. So rather than individually--really, it needed to be a provincial system. So Western Health could go find somebody, a consultant to come in. Eastern Health might have a different consultant, and there really wouldn't be a provincial standard. So it had to be a provincial wide, but individually, we could. There was nothing holding us individually back.
CHAYTOR, Q.C.:
Q. And until such legislation, if it were to come

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to pass, until that happens, there could be collaboration between the four authorities to make sure you are using either the same organization or at least the same standards?
MS. JONES:
A. Or at least the same standards.
CHAYTOR, Q.C.:
Q. And the communications protocols, you indicated this was a little more contentious.
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. "Communication protocols are needed for adverse events that have an impact on large groups of people. The principles to be observed include a patient's right to know and a patient's right to participate in the management of their own care. Other important principles of large group events include, as appropriate, advising the media early to avoid the anxiety and uncertainty associated with uncoordinated information going to the media, and allowing for effective patients to self identify to the RHA when there is uncertainty over whether internal databases will identify

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all patients in a timely manner. These principles must respect the priority of the patient-doctor relationship, the protection of personal privacy and the urgency and significance of the adverse event." Was there anything contentious in that?
MS. JONES:
A. Not in the way that these are articulated, but we were very clear to say that it was patients first. That we wanted the opportunity to be able to identify and to notify patients, and then you have the other parts of this that come into play, essentially after that, and key to that, as well, is the one principle that I don't think we've talked about in this room, at least while I've been here, is the priority of the doctor-patient relationship being critical to--because that's where the relationship and that's where the trust comes. So this was the first time we had seen that particularly articulated. So in terms of the principles that are here, absolutely that the patients are first, that the doctor-patient relationship needs to be maintained and protected. You have the issues of personal

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privacy, and then we get into the public disclosure and the confidence in the system.
CHAYTOR, Q.C.:
Q. What did that mean in this context? What is being talked about the priority of the patient-doctor relationship?
MS. JONES:
A. Many times that if we use the example of tests, the test is ordered by a physician. The physician really needs to know that there's a change in the test so that they can appropriately inform their patients or whatever about the change and understand that. So -
CHAYTOR, Q.C.:
Q. And had that not happened?
MS. JONES:
A. And that's where the relationship actually happens. It's not the health authority to the patient in lots of way. It's the patient is accessing services because a physician as referred them on and they need to be critical as we move forward on any issue.
CHAYTOR, Q.C.:
Q. And so what was the issue? How had that not

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happened, this is dealing with the ER/PR issue, what was the concern? How had that not happened?

MS. JONES:

A. I think the discussion that we had is that you have to keep this in the broadest context, that you cannot take the physician out of this relationship when there are issues that the patient and the physician have to be priority and then we have the public disclosure and those kinds of things. So the principles, all of the points that were here were well supported.

CHAYTOR, Q.C.:

Q. Yes, okay. So I just want to be clear whether or not that was an issue in the handling of the ER/PR issue. Was it, for example, was it because of the panelling, that patients who were patients of physicians other than those on the panel, were put through the panelling process, is that what the issue was?

MS. JONES:

A. It had nothing to do with the ER/PR or the panelling issue.

CHAYTOR, Q.C.:

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Q. So that wasn't seen as being something that wasn't respectful of the patient/doctor relationship?

MS. JONES:

A. No, no.

CHAYTOR, Q.C.:

Q. That's not what is being discussed.

MS. JONES:

A. As we are going to move forward, this talked about early lessons, but as a province and as moving forward on this issue, you saw database there being the first end and then you happened to see lab accreditation and then there was an issue around communication and communication protocols. So it was more than just -

CHAYTOR, Q.C.:

Q. So there was no issue on the ER/PR -

MS. JONES:

A. No.

CHAYTOR, Q.C.:

Q. - as to priority not being given to the patient/doctor relationship?

MS. JONES:

A. No, no, it was just that that was an important

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one to maintain as we move forward.

THE COMMISSIONER:

Q. So there was really no controversy about communication protocol?

MS. JONES:

A. Not in this, only make sure that the patients are, the patient, the individual patient contact happens first.

CHAYTOR, Q.C.:

Q. And in terms of the priority of the patient/doctor relationship, the majority of the patients in the ER/PR situation were in fact not contacted by their doctor, is that the issue?

MS. JONES:

A. That's right. No, I don't think you can't tie the two of them together, there was no discussion around how we hand handled that, it was more in terms of communication protocols and if you go to the bottom when we talk about what the controversy was, it's more in what is written in the bottom, not what's written in the bullets on top.

CHAYTOR, Q.C.:

Q. Okay, well let's read that because perhaps

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then I will understand.

MS. JONES:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. "Preliminary response. The Department of Health and the RHAs to adopt a communication policy which recognize these principles."

MS. JONES:

A. Not a problem.

CHAYTOR, Q.C.:

Q. And I take it there was no problem.

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. "Through performance contracts, place an obligation on the CEO to advise the department about group adverse events so that communications can be co-ordinated as necessary and appropriate." And then the issue becomes how to define the group, was that controversial?

MS. JONES:

A. That was a huge issue in terms of what is the group, is the group in some instances two patients or three patients or is a group like

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

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

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MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. One of those issues.

CHAYTOR, Q.C.:

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

MS. JONES:

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

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CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

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

CHAYTOR, Q.C.:

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

MS. JONES:

A. And that that discussion needs to -

CHAYTOR, Q.C.:

Q. And you have no problem with that principle?

MS. JONES:

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

CHAYTOR, Q.C.:

Q. I'm sorry?

MS. JONES:

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

CHAYTOR, Q.C.:

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

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

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

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MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. What did you do when you received this from Mr. Thompson? What did you do with his request?
MS. JONES:
A. This immediate request, as soon as it came in, there's a couple of faxes over a period of days, they immediately went to Pat Pilgrim and Pat followed up directly with letters back to Robert on each one of the questions that were asked inside of the fax that had actually come in.
CHAYTOR, Q.C.:
Q. So what you would do is pass it on to Pat Pilgrim who has been tasked with it?
MS. JONES:
A. Has been tasked to do it and then there would also be, Pat, when you've got this completed, let me know.
CHAYTOR, Q.C.:
Q. Okay, and did Pat do that? Did she get back to you and tell you it had been completed?
MS. JONES:

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A. I think that you have e-mails that will follow up on these that says yes, all signed off, all letters have gone forward.

CHAYTOR, Q.C.:

Q. Okay, and then if we have P-0763 please? So this is Pat's letter, I take it.

MS. JONES:

A. This is the letter, that's right.

CHAYTOR, Q.C.:

Q. March 7th, 2008 back to Mr. Thompson.

MS. JONES:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. So this was, he had written to you March 6th?

MS. JONES:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. So she's promptly getting back, March 7th, 2008 and we have eight people.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And Janet Andrews name is left there as well. And she writes, "The following table of information is in response to correspondence

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of March 6th, 2008 and please note patients 1, 4, 5, 6 and 7"--so that doesn't pertain to Ms. Andrews, she's No. 3, and "four of them had their specimens tested and Mount Sinai's testing was not being conducted at Eastern Health. The disclosure of these results was handled as per any test results ordered by a physician." Okay, the No. 3, Janet Andrews, it says, "She was never tested for ER/PR as she was diagnosed with DCIS. This specimen was tested on her request and was disclosed to the patient in September, 2005."

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And what would the source of that information be? Where would Ms. Pilgrim get that information?

MS. JONES:

A. She would have gotten them out of chart review.

CHAYTOR, Q.C.:

Q. Chart review.

MS. JONES:

A. Or if in fact maybe the communication logs

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because we're seeing stuff back as far as September 2005, so if they weren't on the communication logs that NLCHI already had, they went back into chart reviews.

CHAYTOR, Q.C.:

Q. Okay, so this is saying that she was never tested for ER/PR, she was diagnosed with DCIS, so I take it that means originally she wasn't tested -

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. And then her specimen was tested on her request and was disclosed to the patient September 2005.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. So her results of her retest.

MS. JONES:

A. No, results of a test because she was never tested.

CHAYTOR, Q.C.:

Q. So results of her test.

MS. JONES:

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A. Yes.

CHAYTOR, Q.C.:

Q. So she was then tested, the specimen was tested on her request.

MS. JONES:

A. On her request.

CHAYTOR, Q.C.:

Q. And disclosed to her in September 2005?

MS. JONES:

A. Yes, that's what Pat replied to Robert on the 7th, yes.

CHAYTOR, Q.C.:

Q. Okay, if we could have C-0150 please? And do you recognize this document? We understand this comes from Nancy Parsons?

MS. JONES:

A. I don't recognize it, but -

CHAYTOR, Q.C.:

Q. Okay, and it pertains to Ms. Henley-Andrews.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And November 7th, 2005, we understand these are Nancy's notes of conversations with people who are calling in.

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MS. JONES:
A. Okay.
CHAYTOR, Q.C.:
Q. "This patient had DCIS but has requested that she be retestd. I asked Dr. Cook, he will send her sample for retesting."
MS. JONES:
A. Yes, okay.
CHAYTOR, Q.C.:
Q. And if we could see the date here, it's November 7th, 2005.
MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. So Ms. Henley-Andrews didn't request her test to be done until November 7th, 2005.
MS. JONES:
A. Until November and this is September -
CHAYTOR, Q.C.:
Q. The document sent to Mr. Thompson says that she was informed of her result -
MS. JONES:
A. In September.
CHAYTOR, Q.C.:
Q. - in September '05. If we could look at C-0151 please? And this, we understand to be the test Mount Sinai conducted?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. On Ms. Henley-Andrews, her name is over here.
MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And if you can see the date of the procedure was November 16th, 2005. Date and time of report is November 22nd, 2005.
MS. JONES:
A. 22nd, uh-hm.
CHAYTOR, Q.C.:
Q. So Ms. Henley-Andrews could not have been told the result of her test in September of 2005. If we could have C-0152 please? And this is again a document from Eastern Health charts for review. Actually, this may be from Dr. Cook, physician review panel. And I don't know if we can read that. It says with Janet Henley-Andrews anyhow here.
MS. JONES:
A. Yes.

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CHAYTOR, Q.C.:
Q. And the results are indicated to be over here.
MS. JONES:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And you can see that this is going to the review panel on -
MS. JONES:
A. 1st of December.
CHAYTOR, Q.C.:
Q. - December 1st. And, of course, Ms. Henley-Andrews has stated that she was not told her results by Eastern Health and in fact, only learned of it through the process of the inquiry. I'm not sure if you were present that day when she gave her evidence.
MS. JONES:
A. No, I wasn't.
CHAYTOR, Q.C.:
Q. So on March 7th, 2008, you're saying the information on which Ms. Pilgrim would have based -
MS. JONES:
A. For my understanding would have been a chart review -

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CHAYTOR, Q.C.:
Q. - would have been from her chart.
MS. JONES:
A. - or a contact log. And it wouldn't have been Ms. Pilgrim who would have done it, it would have been people who work with her, doing the chart reviews.
CHAYTOR, Q.C.:
Q. And who would that be?
MS. JONES:
A. What?
CHAYTOR, Q.C.:
Q. And who would that be?
MS. JONES:
A. I don't know on this particular issue. There were a number of individuals who were working on it because there was at least three faxes in that week.
CHAYTOR, Q.C.:
Q. And I'd like to finish up then with a discussion that I was going to start with yesterday which was about the quality and risk management framework, so I hope it's still fresh in your mind. We understand there was a director of quality care enhancement which was

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a new position formed in Eastern Health, I think back in September of 2005.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. There's been Ms. Lynn Wade, she's also -

MS. JONES:

A. She's with the lab program.

CHAYTOR, Q.C.:

Q. With the lab in particular. Perhaps you can tell us and explain to the Commissioner the different structures in terms of we've heard of many committees in terms of quality and quality initiatives. So, perhaps you can explain that structure to us.

MS. JONES:

A. The current structure?

CHAYTOR, Q.C.:

Q. The current structure, yes.

MS. JONES:

A. Okay. Current structure and I probably will start the bottom as we work our way through the safety and improvement committee of the board. We have a number of committees. The first one that we would have is every

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portfolio, meaning every COO or VP would have a quality committee itself and they're called portfolio quality committees. And inside of those portfolio quality committees there will be a number of teams that would go on. Generally, there are old accreditation teams that carry forward the accreditation mandate and work on continuous improvement through that process. So, there is a structure around. There's terms of reference around the portfolio quality committees and then there is sub-committees and work that goes on on a portfolio basis.

We have also a sentinel event review committee that was started as part of the original structure when we adopted the framework. We've only had one meeting of that particular committee at this point in time. The terms of reference have been recommended for change in the membership to include ethics in there and as well as some other minor points.

On that particular committee we have at least three, if not four physicians as well as representation from the various sectors, like

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somebody from our community, somebody from our long term care and somebody from our acute care sectors. So, the sentinel event review committee, the idea behind that one was to review sentinel events to make sure that they were closed off, that the appropriate work had been done, recommendation, actions, those kinds of things. I understand from the discussion that they've had that they want to develop a template around the entire process and that they want to come together as quickly as they can at the point in time of a sentinel event. They are not the investigating committee, but they could come together at the, pretty much in concurrently with the event going on. And I'm not sure where their thinking is at that point right now.

CHAYTOR, Q.C.:

Q. So, that's a new committee that's been set up.

MS. JONES:

A. That's a new committee. It's met once, going to revise its terms of reference and talk about a process for itself and how it's going to do the work that was inside of the terms of reference that we had. We have some special

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task force and committees and they can be established by the regional quality council that I'll talk about in a minute. And one example of that that we have ongoing is the work that we've been doing on biological indicators. So, it covers the all portfolios. It's an issue that we want investigated, looked at best practice and then policy work for the entire organization versus what goes on in a specific area.

CHAYTOR, Q.C.:

Q. And that's the group, that the entire executive sits on that -

MS. JONES:

A. No, no, that's regional quality.

CHAYTOR, Q.C.:

Q. Regional quality council.

MS. JONES:

A. I'm below the regional quality right now.

CHAYTOR, Q.C.:

Q. Okay.

MS. JONES:

A. We have an infection control committee that is now regional, has been regional for a few months that has site specific infection

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control committees, but really brings together work that's regional and then feeds the regional quality control committee. We have pharmacy and therapeutics as well that looks at medications and medication reconciliation and, you know, adverse events related to meds. The two, infection control and pharmacy and therapeutics have traditionally always reported up through the medical staff, MAC, medical advisory committee to the board. So, at this point in time we've left it and we have a dual kind of reporting on those two committees.

So, those are the base lines committees underneath, in our quality structure. Above that they all report into the regional quality council which has all of executive plus other members and mostly they are the chair of regional infection control committee, at this point in time and two other physician representatives. So, that's the regional quality council. That then brings together all of the information and issues from around the organization from the portfolio quality committees and all of the rest of it into and

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produces reports for the safety and quality committee of the board which is a sub-committee of the board. And then that -

CHAYTOR, Q.C.:

Q. And then that's the top.

MS. JONES:

A. That's the top. Right now, at this point in time, we have on the side--because we have not put a regional medical staff in place and we don't have regional bylaws at this point in time. We have infection control, pharmacy and therapeutics reporting into MAC and directly reporting to the board. Right now, we're showing a dotted line because until we get a regional MAC, we want to have a relationship with the regional MAC into the regional quality council. At this point in time we haven't cut the direct line for the board with respect to the MAC which is advisory basically to the board, but until the new bylaws are in place, we've left the old structures in place. But we are working on a process with our medical staff around having all of the issues, physician issues as well all other issues coming into the regional quality council. So,

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that's kind of how we're structured right now. The portfolio quality committees have been in place for well over a year. In the fall of 2006 we would have started that work. Prior to the adoption of a framework and working on a framework, the original committees, quality committees, would have been reporting in through the CEOs office because there was not structure from the old to get it to the board. So, it would have come in through the CEO's office. So, in my instance, the old health care corporation of St. John's, Pat Pilgrim maintained the regional quality committee with all of the pieces reporting to it, until such time as we put the portfolio quality committees in place. Because there were parts of things that reported in to St. John's that now were part of a regional structure, not just a local structure.

CHAYTOR, Q.C.:

Q. Okay. And the quality initiatives committee that--there was a quality initiatives committee?

MS. JONES:

A. There was a quality committee inside of the

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old health care corporation of St. John's that came into eastern health and stayed there until it was replaced by this structure.

CHAYTOR, Q.C.:

Q. And Ms. Pilgrim used to chair that?

MS. JONES:

A. Ms. Pilgrim used to chair the -

CHAYTOR, Q.C.:

Q. And I believe you used to chair it too at some point?

MS. JONES:

A. At some point in time when we moved forward, there would have been differently chairpersons, but it was -

CHAYTOR, Q.C.:

Q. So, that old quality initiatives committee, even though we have minutes of that going right up through, that's still--is that now the eastern health committee?

MS. JONES:

A. It would be the regional quality committee.

CHAYTOR, Q.C.:

Q. That would be regional quality council?

MS. JONES:

A. Yes.

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CHAYTOR, Q.C.:
Q. Regional quality council?
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. So the minutes of the quality initiatives committee that morphs into the regional quality council.
MS. JONES:
A. Yes, that's right.
CHAYTOR, Q.C.:
Q. Okay. And at the end of the day, overall responsibility for quality then rests with the board through the board's committee?
MS. JONES:
A. The board's committee really started functioning in about February. They had done some preliminary work.
CHAYTOR, Q.C.:
Q. February of this year.
MS. JONES:
A. February of '07.
CHAYTOR, Q.C.:
Q. Because they had originally not decided to have -

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MS. JONES:
A. Right February of '07.
CHAYTOR, Q.C.:
Q. - a quality committee.
MS. JONES:
A. They started to have some discussion in the fall of '06 into--and then started, I do believe, probably their first minutes are in February of '07. And that was the third sub-committee that the board actually struck. They had finance, they had planning and then moved to a separate committee for safety and quality improvement. But as I said to you, all of the work that goes on in terms of the monitoring and the accountability and the executive limitations comes from that committee, goes directly to the board.
CHAYTOR, Q.C.:
Q. Could we have P-0031, please, page 31.
THE COMMISSIONER:
Q. Are you asking for Exhibit 0031, page 31 or page -
CHAYTOR, Q.C.:
Q. Yes, it's P-0031 and I believe it's also page 31.

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THE COMMISSIONER:
Q. Oh, okay.
CHAYTOR, Q.C.:
Q. 0031, 31.
THE COMMISSIONER:
Q. Yes, it is.
CHAYTOR, Q.C.:
Q. All right. And this was the--maybe this is something different, is it? The corporate quality initiatives committee. Is that something different?
MS. JONES:
A. That would have been what we call the old health care corporation, corporate quality committee.
CHAYTOR, Q.C.:
Q. Okay, so the corporate quality committee.
MS. JONES:
A. Yeah.
CHAYTOR, Q.C.:
Q. So this committee itself no longer exists. It's now the regional -
MS. JONES:
A. No, this committee would have morphed into portfolio quality committees.

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CHAYTOR, Q.C.:
Q. Portfolio quality -
MS. JONES:
A. Because this essentially is a portfolio now. Okay. Because there are many other portfolios in the old health care -
CHAYTOR, Q.C.:
Q. Okay, so this is one of many quality initiative committees.
MS. JONES:
A. That's right. In the old health care corporation, this would have been our committee before we went to board, inside of eastern health, this is a level lower.
CHAYTOR, Q.C.:
Q. Right. But that's not the regional quality council?
MS. JONES:
A. No. It's -
CHAYTOR, Q.C.:
Q. So, what purpose would this committee serve and how does that differ from what the regional quality council would do?
MS. JONES:
A. Until we got the regional quality council,

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this would have been the regional quality council for the old health care corporation, all structures left in place until such point in time as the new structure has been put in place.

CHAYTOR, Q.C.:

Q. Right. So this would be the equivalent of the current regional quality council?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. This would be it?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. And you were--on this particular day anyhow, September 28, 2006, you were chairing the meeting.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. But this now with the regional quality council, all of the executive would attend those meetings.

MS. JONES:

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A. No, because what was left from the old executive for health care corporation would have been myself and Steve Dodge and a few others. So the clinical components of it, we left in place.

CHAYTOR, Q.C.:

Q. So, earlier though today I thought that there was a note in the minutes for executive management that the executive had been updated the day before. Remember that back in November, executive had been updated about the ER/PR at the regional quality council. And you said all of the executive attend the regional quality council.

MS. JONES:

A. There--we may have had a regional quality council in the new structure put in place while all of these things were continuing to feed.

CHAYTOR, Q.C.:

Q. So, who is the current regional quality council? Who are they?

MS. JONES:

A. As I had said, Pat Pilgrim is the chair.

CHAYTOR, Q.C.:

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Q. Yes.

MS. JONES:

A. The executive sit on it and we have three physicians who sit with it.

CHAYTOR, Q.C.:

Q. Right. So, the executive does sit on it?

MS. JONES:

A. Yes. And in the old health care corporation it would have been the executive and if you look at this one, we would have had some program directors which is what Carol Chafe would have been. We would have had professional practice. And if you look at the regrets here, we would have had physician representation, John Harnet and Pat Pilgrim. So, the two clinical people left from the old health care corporation were Louise Jones and Pat Pilgrim running the clinical programs. So, that's what's left of--while we tease out and set up structures for regional areas.

CHAYTOR, Q.C.:

Q. So, any issues regarding a particular program from a quality perspective, the quality initiative report for that program would come through, today, to the Regional Quality

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Council?

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. And this talk at 2.5 about a new quality reporting structure, now this is post Eastern Health time?

MS. JONES:

A. That's right, yeah.

CHAYTOR, Q.C.:

Q. September of 2006?

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. And "Members were informed significant discussions are still ongoing within executive regarding a quality report structure."?

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

Q. "A framework for quality was compiled and presented to executive as a response. A discussion document for executive is being developed for further discussion of issues around performance reporting and components

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linkages for quality, human resources and finance. With the retirement of Dr. Williams Patricia Pilgrim has been appointed lead for quality on an interim basis." And I understand that is -

MS. JONES:

A. That continued.

CHAYTOR, Q.C.:

Q. That continued. So that's now -

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. - a permeant basis, okay. And "The current reporting schedule of departments will continue until the new structure is in place."?

MS. JONES:

A. That's right.

CHAYTOR, Q.C.:

Q. "Members were informed the Eastern Health board met yesterday for the first time under policy governance."?

MS. JONES:

A. Um.

CHAYTOR, Q.C.:

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Q. Is that saying that the board itself met yesterday -

MS. JONES:

A. Under the -

CHAYTOR, Q.C.:

Q. - September 27th, '06 for the first time under policy governance?

MS. JONES:

A. They had, remember I had said that they had worked through to decide how they wanted to structure themselves as a board, so they had done your traditional thing and then moved to policy governance with ELs and that, and this was the first meeting according to this -

CHAYTOR, Q.C.:

Q. Under policy governance?

MS. JONES:

A. Under policy governance.

CHAYTOR, Q.C.:

Q. So September 27th, 2006?

MS. JONES:

A. Yes, if this is correct here, yeah.

CHAYTOR, Q.C.:

Q. So in 2005 what kind of board was it, what kind of--how were they governing themselves?

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MS. JONES:

A. Issues would have been brought to the board through the chief executive officer and through the reports. They had already been doing some work on, in their finance are, they had directors liability statement which in essence is like an EL that we haven't really formatted over into an EL. So they were doing the work. They had a planning committee.

CHAYTOR, Q.C.:

Q. Yes.

MS. JONES:

A. They had a finance committee. So the needs assessments and those kinds of work was being directed through their planning committee and then their finance committee. So all of the other parts of the organization that weren't reporting or bringing information into those two committees were coming through the CEO's office and the CEO was then feeding the board.

CHAYTOR, Q.C.:

Q. And in terms of actual, and we've heard a lot about this is policy, this is operations, was there any change in that once they started in September of '06 formally being under policy

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governance?

MS. JONES:

A. They kept always, and I think they always were talking about teasing out is that an operational issue or is that a governance issue, which issue should we be involved in. So they were conscious right from the very beginning about how they would operate as a board given the breadth and depth of everything that was going in inside of Eastern Health and they did not want to be an operational board.

CHAYTOR, Q.C.:

Q. But that didn't formally happen until September, 2006?

MS. JONES:

A. Although they were working from a governance perspective throughout 2005. This is just a way of formatting the way information gets to the board.

CHAYTOR, Q.C.:

Q. Okay. If we could look then at P-0031, page 28? No, I'm sorry, we just did that. P-0058, please? And I don't want to take you through this entire document, Ms. Jones. There may be

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someone else from quality here and perhaps Ms. Pilgrim could better speak to it.

MS. JONES:

A. Yes, that's right.

CHAYTOR, Q.C.:

Q. Okay. But I take it the quality and risk management framework it's dated January, 2007 and updated June, 2007, this is the document that you were referring to?

MS. JONES:

A. Absolutely.

CHAYTOR, Q.C.:

Q. Okay. And do you remember what was--how was it updated in June, 2007, were there any significant changes?

MS. JONES:

A. I'm not sure, but there may have been something to the terms of reference and maybe in January of 2007 the safety and quality committee would not have been reflected in there, I don't believe.

CHAYTOR, Q.C.:

Q. Okay.

MS. JONES:

A. Because we would have been working on this

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starting the portfolio quality committees in the fall of 2006, going into 2007.

CHAYTOR, Q.C.:

Q. And did this have to be approved, I appreciate June, 2007, who would approve this framework?

MS. JONES:

A. We would have approved the framework in terms of executive.

CHAYTOR, Q.C.:

Q. The executive, okay. And prior to January, 2007 was there a similar framework? This is -

MS. JONES:

A. Not for Eastern Health.

CHAYTOR, Q.C.:

Q. Not for Eastern Health. But for the Health Care Corporation?

MS. JONES:

A. For the Health Care Corporation there would have been the framework that we were working under.

CHAYTOR, Q.C.:

Q. And would that have continued, then, until from, it's about an 18 month or almost two-year period?

MS. JONES:

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A. Yes. That's what I was referencing when you saw the Corporate Quality Council and that, the components of them were left in place. And the reporting, the annual reporting and the schedule of reporting for departments continued on until we replaced it with a portfolio.

CHAYTOR, Q.C.:

Q. And who sees this document within the organization, where does this document go or who would know about it?

MS. JONES:

A. This document would have went out for feedback. We would have had our quality people--the document would have originated in quality with the director of quality, Pam Elliott doing a lot of the legwork and doing a lot of the work in there. Would have went out for feedback through our program directors and potentially down to our division managers through the programs to identify, you know, what else needs to be added in there, is this realistic, how can we operate inside of the organization. And there's reference in the earlier discussion that we had today about

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feedback from executive. So we would have seen earlier drafts and had a lot of discussion around whether, in fact, we would have site specific quality committees, whether we would have portfolio quality committees, how would we do it, did we want to have cross sector, whatever. At the end of the day we settled on having portfolio quality committees and having the COO or the VP responsible for the quality inside of the area that they were responsible for.

CHAYTOR, Q.C.:

Q. Okay. And again, I'll have a number of other questions around that, but perhaps best left for others.

MS. JONES:

A. Yeah.

CHAYTOR, Q.C.:

Q. One other thing, I saw your name obviously comes up a lot in the chief operating officers' minutes.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. And you attended those fairly, fairly

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religiously, those meetings?
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:
Q. The chief operating officers of Eastern Health before you assumed your current role would have been you and -
MS. JONES:
A. Would have been Pat Pilgrim.
CHAYTOR, Q.C.:
Q. Pat Pilgrim.
MS. JONES:
A. We would have had Alice Kennedy from long-term care and supportive services, Bev Clarke with the community portfolio, children's and women's now in St. John's, and mental health, we would have had rural Avalon, which would have been Fay Matthews, and Pat Coish-Snow in the peninsulas areas, both the rural areas are integrated portfolios.
CHAYTOR, Q.C.:
Q. Okay. The ER/PR issue, was that ever raised at those meetings?
MS. JONES:
A. I can't recall. There may very well have been

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some discussion, but that wouldn't have been the focus of those meetings. Those meetings were around clinical issues, developing, looking at policies, trying to get the work done on in terms of working across the entire organization.
CHAYTOR, Q.C.:
Q. Okay.
MS. JONES:
A. From a clinical perspective.
CHAYTOR, Q.C.:
Q. Okay. And the minutes that we've had or we've just received them recently, but the preliminary review we have and we have them for almost a three-year period, about a two and a half year period starting at some point in 2005, up until 2008. And we didn't see any reference to ER/PR.
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. So that wouldn't surprise you?
MS. JONES:
A. No.
CHAYTOR, Q.C.:

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

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MR. PRITCHARD:
Q. Thank you, Commissioner. Good afternoon, Ms. Jones.
MS. JONES:
A. Good afternoon.
MR. PRITCHARD:
Q. Ms. Jones, I just have one question for you this afternoon. I'm sure you're relieved to hear that. On a number of occasions during the last few days you've been fairly consistent in saying that on disclosure matters your policy or belief or the organization's policy is that there has to be disclosure to the individual before any sort of public disclosure or disclosure en mass?
MS. JONES:
A. Yes.
MR. PRITCHARD:
Q. And we saw how in 2005 before that individual disclosure was completed, of course, the media disclosed the event on October 2nd.
MS. JONES:
A. Um.
MR. PRITCHARD:
Q. And I'm just wondering if your organization or

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you have had some time to give some thought to that issue that where you have a number of individuals that have to be contacted the possibility always exists that that disclosure can sort of overtake you and the public -

MS. JONES:

A. That's right.

MR. PRITCHARD:

Q. - finds out about it before you complete the individual disclosure. Is that something that you've had an occasion to consider, you or your organization, and what, if any, conclusions have you come to on that?

MS. JONES:

A. We've not made any conclusions at this time. Obviously you've reiterated that we would have--we've always said it needs to be patients first and we would attempt in every way to make that happen. Inevitably there will eventually end up being public disclosure, whether it is because the media have picked up on it or whatever. And I guess in some ways there needs to be contingency plans to be able to react to that rather than on a proactive because we really would want

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the front end of it done, which is individual disclosure. We were waiting for the Canadian Patient Safety Institute because we had asked, they had guidelines that they were developing on disclosure and in their consultation phase Eastern Health had clearly asked them about what--were there going to be any guidelines or had they given any thought to public disclosure. And we see that there's not very much that has come out of that. And we also know that through the task force on adverse events, not really understanding where that or the recommendations are going to come out in that way, that there may be some opportunity to have some discussion inside of that. So Eastern Health has not taken a position on it, but we're looking to things like the Canadian Patient Safety Institute and when nothing came out of that with their new guidelines that have just recently been released, we will have to turn our heads to that again.

MR. PRITCHARD:

Q. Thank you, Ms. Jones.

MS. JONES:

A. You're welcome.

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THE COMMISSIONER:

Q. Mr. Pritchard. Mr. Browne?

MS. LOUISE JONES, CROSS-EXAMINATION BY MR. PETER BROWNE

MR. BROWNE:

Q. Thank you, Commissioner. Good afternoon, Ms. Jones.

MS. JONES:

A. Good afternoon, Mr. Browne.

MR. BROWNE:

Q. Now, I just want to go back over some of the nomenclature that has been used throughout your testimony this week. And I want to begin by looking at some of the nomenclature that's been used in relation to the organization structure of the old Health Care Corporation and Eastern Health. And the nomenclature I want to focus on is accountability and responsibility.

MS. JONES:

A. Yes.

MR. BROWNE:

Q. Those are concepts that I think existed under both organizations, is that correct?

MS. JONES:

A. Yes.

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MR. BROWNE:

Q. And with regard to that I just want to focus on physician and medical services and get an understanding, if I could, about some of the VP positions. I think it's very well understood by everybody here that the VP of medical affairs has a number of physician responsibilities underneath that portfolio as you -

MS. JONES:

A. Yes.

MR. BROWNE:

Q. The term you use. Are there other portfolios, and I look at in particular your old portfolio, the VP of adult acute care.

MS. JONES:

A. Yes.

MR. BROWNE:

Q. Did that have physician responsibilities under that, as well?

MS. JONES:

A. We had co-leadership teams in those areas and so would have been a clinical chief and a program director. So physicians work in each side of those programs, but from the physician

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accountabilities and that, it really is through the other structures. So we--from a planning perspective that's where we involve the clinical chief and that and move forward in that way. So we never, I never, ever had responsibility for individual physician actions.

MR. BROWNE:

Q. Okay. Thank you for clarifying that. What about the VP of quality and clinical services, again, would that be the same response for that portfolio, would it still go under -

MS. JONES:

A. Yes.

MR. BROWNE:

Q. - medical. Thank you.

MS. JONES:

A. And the medical advisory committees in those structures.

MR. BROWNE:

Q. Thanks. So effectively, then, responsibility and accountability, that concept would primarily rest with the VP of medical?

MS. JONES:

A. Yes, it would.

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MR. BROWNE:

Q. And you mentioned just a second ago of the role of MAC.

MS. JONES:

A. Um.

MR. BROWNE:

Q. Would the VP medical affairs be the person interfacing with MAC for that, for the notion of accountability and responsibility?

MS. JONES:

A. The VP for medical affairs is the resource person to the MAC.

MR. BROWNE:

Q. Right.

MS. JONES:

A. The MAC is a body that has its own chair and reporting structure through to the board.

MR. BROWNE:

Q. Okay. Now, I want to go back again to the various VPs and their role in planning and priorizing budget items.

MS. JONES:

A. Yes.

MR. BROWNE:

Q. Okay. We've, I think you weren't the only

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witness, but several witnesses, including yourself, have talked about the Hay report and the very obvious fact that's come out of, of the Hay report, is the focus on efficiencies, the emphasis on efficiencies.

MS. JONES:

A. Yes.

MR. BROWNE:

Q. Did or do--and again, looking at both Eastern Health and its predecessor, did the VPs of the various portfolios have a role in planning and priorizing budget items?

MS. JONES:

A. Yes, we did.

MR. BROWNE:

Q. Okay. And was there again an emphasis brought to play both at that level and at lower levels on efficiencies?

MS. JONES:

A. Absolutely.

MR. BROWNE:

Q. And I'm looking at program managers and so on.

MS. JONES:

A. Absolutely.

MR. BROWNE:

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Q. Okay. And I guess if we could, just looking at that role, if we could, just look at the clinical chiefs' role. Do they have a role in the efficiencies of the budgetary planning process or is that mostly with the program managers?

MS. JONES:

A. The clinical chief would have been involved in not necessarily the building of the budget but the kinds of initiatives that were inside the budget and understanding the budget and what implications it would have on the service delivery.

MR. BROWNE:

Q. Okay. Nevertheless, though, would the main persons be in terms of the chain of command the program managers and then the VPs in terms of that greater input -

MS. JONES:

A. Around the staff piece, yes.

MR. BROWNE:

Q. Okay. Thank you. And in terms of the role and responsibilities for monitoring the level of training of staff members, in particular, say technical staff or whoever may be under

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the respective portfolio, does that rest primarily with the various VPs or is that shared between the program managers and the -

MS. JONES:

A. The program managers. The VPs would not really be into that level of detail.

MR. BROWNE:

Q. And I think you mentioned, I think it was yesterday, that, in fact, the program directors, program managers are responsible for the day-to-day operations on the technical side when we talk about the lab and the clinical on the pathology side?

MS. JONES:

A. That's right.

MR. BROWNE:

Q. Again, looking at sort of the new Eastern Health model and the previous, the predecessor model of Health Care Corporation, do program directors carry any clinical or technical workloads?

MS. JONES:

A. Some program--not at the director level, but some managers carry some technical responsibilities, as well.

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MR. BROWNE:

Q. Okay. So would possibly at the manager, but definitely not at the program director's?

MS. JONES:

A. Definitely not at the program director level.

MR. BROWNE:

Q. Okay. However, that is not the case for clinical chiefs, they are required to have clinical responsibilities, are they not?

MS. JONES:

A. At this point in time we don't have any full-time clinical chief that does not carry a clinical responsibility.

MR. BROWNE:

Q. Right. But their counterparts, program directors do have full-time responsibility?

MS. JONES:

A. (No audible response).

MR. BROWNE:

Q. Now, is that partly due to, I guess, a number of factors there, is it potentially the expense potentially that may have to be paid for salaries for physicians if they were in a full-time administrative capacity?

MS. JONES:

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A. That has nothing to do with salaries.

MR. BROWNE:

Q. Would it have to do also or potentially with the requirement on certain professionals that they need to have so many hours for their licensure and to maintain their licensure?

MS. JONES:

A. No. If we talk about physicians and in their administrative role, we look at physicians in their administrative role, the role that they carry and the job description that we provide them with and we look at the amount of time that's required to do that. And that is a joint agreement between the physician, the role that we want them to play and that they accept that role and then we determine how they determine and talk to us about how much time they need to take that role.

MR. BROWNE:

Q. In terms of the managers and program directors, is there an expectation, apart from, say, any professional regulation, that they keep current on developments relevant to their various services?

MS. JONES:

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A. To the extent that it's possible, yes, and that would be going out of the province or at least keeping current with the literature or doing conferences, those kinds of things.

MR. BROWNE:

Q. And again, looking at the organizational structure of both the old, and if there is a distinction, please clarify that for me, but a non sort of physician positions and--let me make that broader, for the non-professionally regulated positions, who would be responsible for creating job descriptions, performance evaluations, program policies, promotion, those sorts of things?

MS. JONES:

A. That would be the administrative side.

MR. BROWNE:

Q. And at what levels? Would there be various levels that would be involved there? Say, managers, program directors.

MS. JONES:

A. The job descriptions generally there's a classification issue and that comes underneath the union. Like if we're talking lab, the LX. So there is--from a pay perspective, there is

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various technicians, technologists, those kinds of classifications. The duties and responsibilities under that would have developed over time and been part of job descriptions that managers and as well as classification pay inside of government would have approved the level of compensation, based upon the duties.

MR. BROWNE:

Q. What about promotions, job performance and investigations of job performance?

MS. JONES:

A. That would be on the administrative side, unless there was an issue where sometimes we involved a clinical chief, depending on the kind of investigation. If you're talking staff, we sometimes even, in a program leadership team, would have the clinical chief as well as a program director do evaluations if there happen to be issues in areas.

MR. BROWNE:

Q. Now yesterday you mentioned that, I think, the statistics in your organization is that probably only 25 to 30 percent of the organization completes performance

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evaluations. Is that--did I get that right?

MS. JONES:

A. On a regular basis, and there was some question about the standard in terms of CCHSA, does that mean yearly or every -

MR. BROWNE:

Q. Right.

MS. JONES:

A. Well, we haven't made a stance to say regular, but in our minds, it's a yearly basis, even though regular doesn't necessarily mean a year.

MR. BROWNE:

Q. And I think in answering Ms. Chaytor's question, you said nevertheless, there was still informal feedback?

MS. JONES:

A. That's right.

MR. BROWNE:

Q. Can I ask, how is that information channelled back into the organization, especially in relation to patient safety issues?

MS. JONES:

A. In terms of issues that may arise or performance -

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MR. BROWNE:

Q. From a performance evaluation.

MS. JONES:

A. - from a performance--then it would end up being back into the program director or to the manager level and be resolved or issues, if it meant additional education because there was a skill set that we didn't have in an area, then we would put the resources in place to address that issue.

MR. BROWNE:

Q. So it would be focused on the program director?

MS. JONES:

A. Focused on the area that we were talking about.

MR. BROWNE:

Q. Thank you. As well, you mentioned in relation to--and I don't propose to call it up, but it is Exhibit P-0745 and that's the CCHSA accreditation report. I think I got your comment yesterday that in respect of occurrence reports, there was a comment that everyone will deal with an issue, but not necessarily report it, I think was -

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MS. JONES:

A. Yes.

MR. BROWNE:

Q. - what I captured as part of your response. Now in relation to that, is there--I guess, as had been pointed out by yourself and Mr. Tilley, Eastern Health is a large, very large institution and part of what I received from your answer was that there tends to be, at some departmental levels, a microscopic or a microanalysis of their own in a micro-environment in which they operate and therefore they respond to issues as they arise within the department. But at the same time, they may not recognize the implications on a macro level or organizational level.

MS. JONES:

A. That's right.

MR. BROWNE:

Q. And do I understand there are now efforts under way as part of your goals, current goals, to address those and bring those forward up as part of the organization?

MS. JONES:

A. I think Madame Justice Cameron asked that

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yesterday too, in terms of, you know, a caring profession, if there is an incident that occurs, we deal with the incident.

MR. BROWNE:

Q. Right.

MS. JONES:

A. And not necessarily sometimes go to the end degree of completing an occurrence report and that. Part of the quality department, in their education around occurrence reports, is emphasizing the importance of getting all of that because that's where you get your trends and your learnings and the bigger piece. So yes, that is work that the quality facilitators and the quality department do on an ongoing basis to try to raise awareness on that, and not just deal with the individual issue.

MR. BROWNE:

Q. Okay. I'm going to refer to a document. I'm starting to feel like I'm becoming the CPSI man. IT is Exhibit 0161, if I could please, Registrar? And this is the Canadian Patient Safety Institute disclosure guidelines.

MS. JONES:

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A. Yes.

MR. BROWNE:

Q. And on Monday, you will recall there was a series of questions from Commissioner Cameron, I think to, as I understood the line of questioning, the seemingly disconnect that she saw between quality assurance peer review and the disclosure adverse events, and I want to sort of ask you some questions around that exchange in light of the disclosure guidelines.

One of the things that Commissioner Cameron asked of you was is there a definition of systems failure, and if I could begin there, and ask you to turn to page 30 of that document, and you will see as you scroll down--maybe I can scroll down here. In fact, there is. You see the last definition.

MS. JONES:

A. Yes.

MR. BROWNE:

Q. And it's described as a "fault, breakdown or dysfunction within the organization's operational methods, processes or infrastructure." And again, that is

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footnoted, just for further reference, and it actually comes from a--if we go to the next page, 31--sorry, let me--my apologies, actually 33, Registrar. No, my apologies, 34.

That is from--I think it's footnote 31 and that is an international classification for patient safety. So I understand that definition is coming from an international draft guideline.

MS. JONES:

A. Okay.

MR. BROWNE:

Q. Is that--just to ask you the question, is that your general understanding of what constitutes systems failure?

MS. JONES:

A. Systems failure is multiple issues that may contribute to or may not contribute to. You're not really--maybe it's along a process. It's along multiple players as part of a process. So the causation is very difficult, in terms of a system, in systems issues or systems failures.

MR. BROWNE:

Q. Okay, so you would sort of put that into what-

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-in addition to what's here in this definition?

MS. JONES:

A. That's right.

MR. BROWNE:

Q. And as well, you used--if we can go back to--my apologies, Registrar, for jumping around here, page 30. The notion of root cause analysis, that as well is defined here and you can take a moment to read that, and it says "an analytical tool that can be used to perform a comprehensive system based review of critical incidents. It includes identification of the root and contributory factors, identification of risk reduction strategies and development of action plans along with the measurement strategies to evaluate the effectiveness of the plans."

MS. JONES:

A. Yes.

MR. BROWNE:

Q. Again, is that a definition that -

MS. JONES:

A. That we would use and there's a whole methodology around root cause analysis that

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the quality people would be well aware of how to use.

MR. BROWNE:

Q. Okay, and again, without going back through the document, that definition comes from a main document which is footnoted here as well.

MS. JONES:

A. Okay.

MR. BROWNE:

Q. I do want to just spend a bit more time with this, these guidelines and have you go back to the line of questioning from Madame Justice Cameron, or Commissioner Cameron, on Monday. Page 12, if we could please, Registrar?

This is entitled "Building the Foundation for Disclosure" and it speaks to creating a culture of patient safety, and just following on those definitions, if you go down to the third paragraph there, you'll see, beginning with the sentence "many adverse events in health care are now recognized as system failures where safeguards to protect patient safety were not in place or a series of safeguards that were in place failed in sequence which resulted in harm for the

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patient." Again, would you share that or adopt that notion of adverse event?

MS. JONES:

A. Absolutely, and I think I may have made just one or two comments about redundancy in the system and having extra checks and balances in the system so that if one--if there is an issue in one area, then it's picked up in another area.

MR. BROWNE:

Q. Okay, and I just want to drop down to the next paragraph there, because again, there's a reference to terminology that has been used, I think, throughout the Commission in various sectors, and that is the notion of just culture and that says "a just culture is a key element of broader patient safety culture that seeks to reconcile professional accountability and the need to create a safe environment in which to report adverse events. Health care providers in a just culture are fully aware of the expectations of the organization and are held professionally accountable for the quality of the work." Again, is that principles your organization subscribes to?

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MS. JONES:

A. When we talk about just and trusting culture, those would be the things that we would be looking to move forward and have our staff understand what it means and to work with.

MR. BROWNE:

Q. Okay. I now want to move to--so that, I just want to sort of deal with that in terms of the disclosure component, and now talk about that, how that fits in relation to the peer review. And if we can turn now to page 21?

And you'll see in item E there what to disclose, and they list a number of components there, the first of which is the facts of the harm and/or event known at the time and then follows down with "including the steps taken, the recommended options," and so on. At the bottom of all that, and then finally ends with "the plan for further investigation and treatment, if required." Is it your understanding, in terms of the relationship between disclosure of adverse events and peer review and quality assurance that peer review and quality assurance doesn't protect the fact that--or prevent facts from being disclosed to

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patients or from being disclosed to the public?

MS. JONES:

A. Absolutely. That would be the same as if we had incident reports or whatever. The issues are documented in the patient chart and are accessible in that fashion.

MR. BROWNE:

Q. Okay, and -

THE COMMISSIONER:

Q. So are we talking about the peer review under the law of Newfoundland or peer review generally?

MR. BROWNE:

Q. Peer review generally, and I would suggest under the law in Newfoundland.

THE COMMISSIONER:

Q. Okay, I'm sure I will hear from you about that later.

MR. BROWNE:

Q. Just dropping down there, "when conducting an investigation such as root cause analysis in a legally protected quality of care similar committee," this is talking about peer review, it goes on to say "providers and patients

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should be made aware that there are explicit limitations to discussing some of the investigative information, such as opinions, speculation shared as defined in legislation within the provinces or territories with quality care protections." Is that your understanding of the environment here in Newfoundland?

MS. JONES:

A. Yes, that things are protected inside of that report.

MR. BROWNE:

Q. But what is protected only relates to opinions and speculation shared in the umbrella of peer review?

MS. JONES:

A. That's what peer review is.

MR. BROWNE:

Q. Right. It's not the facts.

MS. JONES:

A. It's not the facts.

MR. BROWNE:

Q. What is protected are these components.

MS. JONES:

A. Is the opinions, these components.

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MR. BROWNE:

Q. Okay. Now just before Ms. Chaytor finished today, in terms of her questioning, she had you go over the framework for quality assurance committees, and I think you spoke to both the old Health Care Corporation structure and the current Eastern Health structure. Does your organization have a flow chart to explain that in sort of a more -

MS. JONES:

A. The current one, yes, was what I was reading from.

MR. BROWNE:

Q. Okay.

THE COMMISSIONER:

Q. Flow chart for?

MR. BROWNE:

Q. For how these committees -

THE COMMISSIONER:

Q. For the committees?

MR. BROWNE:

Q. Yes. I mean, I -

THE COMMISSIONER:

Q. The quality committee?

MR. BROWNE:

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Q. The quality committee.

MS. JONES:

A. The quality and--this was a one that I was referencing. This is a January of '07 with the committee structure. So that was my reference point just to remind people.

MR. BROWNE:

Q. Is that an exhibit?

THE COMMISSIONER:

Q. I don't know. We all have to ask.

MS. JONES:

A. Is it attached to the quality and risk management framework?

CHAYTOR, Q.C.:

Q. I don't think so.

MR. BROWNE:

Q. If it isn't, I'd appreciate that, if anybody -

CHAYTOR, Q.C.:

Q. It's not attached to this.

MS. JONES:

A. It's not attached to this, but this is -

CHAYTOR, Q.C.:

Q. It may be elsewhere (inaudible).

THE COMMISSIONER:

Q. Mr. Simmons, can we ask that you get us a copy

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of that?

MR. SIMMONS:

Q. No problem.

THE COMMISSIONER:

Q. Do you wish to see it before you ask the further question?

MR. BROWNE:

Q. No, no, actually, I would just like it in terms of the framework of the answer that it may sort of make it a little bit easier to understand.

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. Sure, yes. Well, I think Mr. Simmons is going to arrange for us to get it, if I catch that nod over there, Mr. Simmons?

MR. SIMMONS:

Q. Yes.

MR. BROWNE:

Q. Thank you, Mr. Simmons.

MS. JONES:

A. You don't want my written up copy.

MR. BROWNE:

Q. I hate to impose on you, but I will ask for

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that. And lastly, I just want to go and deal with sort of the patient safety initiatives, and I want to sort of ask some questions regarding at the grass root level. Is there any type of system within Eastern Health, created within Eastern Health, at sort of the bottom, at the bottom level, for staff, and it could be anybody, it could be a janitor or it could be a nurse, it could be a technician, it could be a physician, to make positive suggestions on patient safety initiatives? If they see something that happens, say for instance, a suggestion box -

MS. JONES:

A. Have an idea, I have an idea.

MR. BROWNE:

Q. They have an idea. Are those things--are those sort of things in place?

MS. JONES:

A. In legacy organizations and including the Health Care Corporation of St. John's, we had "I have an idea" programs and occasionally, we would do, through our newsletters, you know, a contest and bring forward your issues and your ideas. So yes, those things happened.

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MR. BROWNE:

Q. But are they directed strictly or specifically toward patient safety?

MS. JONES:

A. When there is focus in education, patient safety week, you would see activities such as that to jog people's memory on those kinds of things. So we don't do it throughout 365 days of the year.

MR. BROWNE:

Q. And that was my question.

MS. JONES:

A. No, but we absolutely do those kinds of things in terms of focused activities so that you can create more momentum around a particular issue, and patient safety week is a good example of that because there's lots of activities that go on throughout the entire organization, in all sectors of the organization, to raise awareness and to get ideas around patient safety.

MR. BROWNE:

Q. As well, and this may not be sort of a practical suggestion, but in terms again, at the lower departmental levels, is there any

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sort of system in place for potentially a ten-minute meeting once a month for people to come forward with ideas and then put them up through the chain of command?

MS. JONES:

A. Not regularly in every single, but we do have just--and I wouldn't say 100 percent of our departments have staff meetings and that that would--where those kinds of things would be brought forward and suggested and things like that, but if you're talking about taking a break ten minutes in one hour in a month or whatever to do that, there isn't a formal program like that.

MR. BROWNE:

Q. Thank you. I appreciate all that.

MS. JONES:

A. Thank you, Mr. Browne.

THE COMMISSIONER:

Q. Always somebody who just tries to -

MR. BROWNE:

Q. Well, there you go, try to steal the show.

THE COMMISSIONER:

Q. Before you leave, Mr. Browne, because I wanted to ask a question regarding the Canadian

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Patient Safety Initiative, just in case something arises out of my question. Mr. Browne has taken you through a number of definitions saying is that your understanding, etcetera.

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. Now this is a relatively new document?

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. Has your organization adopted it as yours?

MS. JONES:

A. This document, there is not a lot of changes from some of the guidelines that were earlier and a lot of the definitions that are in there come from Canadian Patient Safety work that was done in the late 1990s, into the early 2000, so you would see them consistent in the earlier document that we had in 2004 and '05. As well -

THE COMMISSIONER:

Q. Which is still operative, is it?

MS. JONES:

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A. Well, the disclosure document is a new one of August of this year, but the principles would be consistent. Our quality department, in terms of root cause analysis and FMEAs we talked about yesterday.

THE COMMISSIONER:

Q. The long and short of what I'm trying to get to is that my understanding is that this document, being as new as it is, would not have been yet--and you can correct me, adopted by the organization as your policy.

MS. JONES:

A. No, but the earlier one was.

THE COMMISSIONER:

Q. My second question is if there is something which is not defined in your document -

MS. JONES:

A. Yes.

THE COMMISSIONER:

Q. Can I take that definition as what you would have interpreted it to be or should I go back to the earlier document?

MS. JONES:

A. I think that there are not many changes, in the ones that you went through, they really

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have not had any fundamental changes in those definitions.

THE COMMISSIONER:

Q. But should I go to the current document or go back the old document on which you have been operating on -

MS. JONES:

A. Current document.

THE COMMISSIONER:

Q. - to determine what the definition is.

MS. JONES:

A. Current document.

THE COMMISSIONER:

Q. So while you haven't adopted it, you're using the definition in the current document, which maybe the same as before, but may have some changes.

MS. JONES:

A. May have some changes.

THE COMMISSIONER:

Q. So if there are changes, you're going under the new one?

MS. JONES:

A. We'll move to the new one because -

THE COMMISSIONER:

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Q. You will move.

MS. JONES:

A. We will move and we've looked at -

THE COMMISSIONER:

Q. But have not yet done so.

MS. JONES:

A. - we've looked at our document now on disclosure and realized that it is consistent with this document. We had seen the draft documents on this, this has been in works for well over a year.

THE COMMISSIONER:

Q. Yes, I understand that.

MS. JONES:

A. So we were working with that.

THE COMMISSIONER:

Q. Okay. I'm still not understanding though if I--maybe that won't be a problem, maybe you're correct in that everything will line up nicely, but if there are any conflicts in definitions, I'd presumably go to the old definition and not the new one because you as yet have not adopted this formally, although you may be doing so in the short order.

MS. JONES:

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A. That's right and we would not adopt a document like this in its entirety, we would use parts of it to form our policy and we'd use it as background work, in terms of reference points. If you notice our new policies, there is reference points on all of it, references for where we have taken individual definitions and that in our new way that we do policy format inside of Eastern Health. So there's always a reference point of where we got the definition from.

THE COMMISSIONER:

Q. Okay, thank you.

MR. BROWNE:

Q. Nothing arising, Commissioner, thank you.

THE COMMISSIONER:

Q. Thank you, Mr. Browne. I'm sorry, I always get the order wrong, Ms. O'Dea?

MS. O'DEA:

Q. We have no questions, thank you.

THE COMMISSIONER:

Q. Thank you. Ms. Newbury.

MS. LOUISE JONES, CROSS-EXAMINATION BY MS. JENNIFER NEWBURY

MS. NEWBURY:

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Q. Good afternoon, Ms. Jones.
MS. JONES:
A. Good afternoon.
MS. NEWBURY:
Q. Jennifer Newbury, appearing for the Canadian Cancer Society, Newfoundland and Labrador division. First of all, there's several exhibits that I would like to have entered.
THE COMMISSIONER:
Q. Yes.
MS. NEWBURY:
Q. P-0785 through to P-0789.
THE COMMISSIONER:
Q. Okay, P-0785 to P-0789 inclusive entered.
EXHIBITS ENTERED AND MARKED P-0785 TO P-0789 INCLUSIVE
MS. NEWBURY:
Q. Thank you. Ms. Jones, I'd like to ask you some questions about, starting with the positivity rates that you referred to in your evidence. And I think generally, as I understood your evidence, that you had indicated that there's lots of research going on around the issue of positivity rates and that you know that we, I take that to mean Eastern Health, had called around the country

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

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

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Q. And that was, again, I just want to understand, I'll obviously ask the pathologist or commission counsel will ask the pathologist in detail what that means, but your understanding of the calls that were made across the country, it related to the entire testing breast cancer for ER/PR.
MS. JONES:
A. Entire group, that's right.
MS. NEWBURY:
Q. And all of those calls were completed in the summer of 2005?
MS. JONES:
A. I think because there was some kind of a report, July, August, as they were trying to get a handle on this particular issue.
MS. NEWBURY:
Q. Okay. And to the best of your knowledge or your understanding, other labs were not collecting that information.
MS. JONES:
A. Were not doing it, yeah.
MS. NEWBURY:
Q. Do you know how many labs were contacted or what percentage -

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MS. JONES:
A. No, I have no idea, I have no recall. I didn't read that report and it's just been, you know, I do know that those calls were made.
MS. NEWBURY:
Q. And do you know at the time that these calls were made whether or not the caller requested any other information, such as whether they had any quality assurance programs, whether they had any alternate methods of monitoring the results or verifying results or to ask, you know, how are you doing your ER/PR testing?
MS. JONES:
A. You're going to really have to ask somebody other in the organization, that would be somebody in the quality area because they actually did do that piece of work for Dr. Williams.
MS. NEWBURY:
Q. So you were made aware that there were calls about positivity?
MS. JONES:
A. Yes.

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MS. NEWBURY:
Q. But you weren't made aware of any other types of questions that were made during those calls?
MS. JONES:
A. I didn't ask about other types of questions.
MS. NEWBURY:
Q. And did you ask about positivity? That information was relayed to you, you didn't ask -
MS. JONES:
A. No.
MS. NEWBURY:
Q. Okay. So the only information that was volunteered to you related to collecting or calling around to see if people were collecting positivity rates?
MS. JONES:
A. I think in terms of what was kind of done in terms of this file and when I came into this job, that was one of the pieces of information we did calls early on, but that was two years ago.
MS. NEWBURY:
Q. And that's basically a broad statistical tool,

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would that be fair to say, from -
MS. JONES:
A. I don't know if you'd call it a broad statistical tool, to me it's, you know, if you did 1000 and you had 70 percent of them that were positive or 60 or whatever, what should you expect in this lab and is that realistic, I don't know if you'd call that stats, but it may very well be.
MS. NEWBURY:
Q. But if you had, you know, for example, if you found out what a positivity rate should be and say the positivity rate should be 80 percent, but your actual rate for that year, for whatever reason, stats are stats.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Your actual rates for that year might be 85 percent in reality.
MS. JONES:
A. Uh-hm.
MS. NEWBURY:
Q. And if you looked at your stats for the year, you might see 75 percent and think, well 75,

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that's pretty close to 80, that's okay.
MS. JONES:
A. Uh-hm.
MS. NEWBURY:
Q. But you might actually have a 10 percent difference.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. So it's a pretty blunt tool, is that fair to say?
MS. JONES:
A. Yes, but not understanding what this means in the context of the work that they do and the quality assurance that is asked for.
MS. NEWBURY:
Q. So you don't know then why the focus was on positivity rates?
MS. JONES:
A. No, no, as I said, I just know that they did make calls around that because a question was asked whether in fact we did monitor them.
MS. NEWBURY:
Q. Okay, I'd like to refer to exhibit P-0783, please? This is the ethics consultation,

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there's several dates, this is the fax that was sent to you.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Now, generally in your evidence over the last day or so, I understood that in terms of what has lead to the problem with ER/PR testing between 1997 and 2005, it's your conclusion that there are many contributing factors, but I think it was your understanding that there's never been any conclusion on the particular issue and that you can't say yet what the actual cause -
MS. JONES:
A. On an individual patient basis what that particular result, why there was a change in that particular result on that particular day.
MS. NEWBURY:
Q. On a patient basis.
MS. JONES:
A. On a patient basis.
MS. NEWBURY:
Q. But can you, looking at the group -
MS. JONES:

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

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MS. JONES:
A. We can't say.
MS. NEWBURY:
Q. Okay. Now in the ethics consultation and you referred to this yesterday.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Under "Important facts to the history and understanding of this case include the following: there were no mistakes or technical errors at the root of this problem." And my question is if you can't say which of those recommendations actually was at the root of the problem, how can you be confident that there were no mistakes or technical errors?
MS. JONES:
A. This is a document not written by myself, this is one that you really do need to talk to the individuals who were there, that was the information that was provided. I hadn't seen the reports or the technical reports and I still don't know if ""A lined up with "B" and the swiss cheese analogy that was used last week, how that--how the actual issues

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

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proceeded in a fashion consistent with this, which was a notification in terms of a generic notification.

MS. NEWBURY:

Q. Are you personally comfortable with that statement, "there were no mistakes or technical errors at the root of this problem"?

MS. JONES:

A. I--if you really look at that, I don't know what the mistakes are or what the technical errors are, I know there were issues in the lab and I guess I would still say there were issues in the lab or the reading of the tests that caused a need for treatment changes for clients.

MS. NEWBURY:

Q. There's three possibilities as I see it, you could say there were mistakes or there were technical errors or you could say that there weren't mistakes or there weren't technical errors, or you could say something in between, I don't know which way, one or the other, are you in that third category?

MS. JONES:

A. I don't know what the mistakes were, I don't

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know what the technical errors are, I don't work in that lab. If I understood it, I would may be able to say A plus B equals that error. This particular issue was over a seven-year period of time and I would expect that what we saw in 2005 or 4, might have been entirely different than 1997 or '98. So the whole idea is that there was something, I'm not sure individually on an actual case by case basis what that might have been.

MS. NEWBURY:

Q. But can you stand behind that statement and I know that you're not a technical person -

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. I know that you can't speak to the pathology or what have you, but you're the CEO and you've been involved in disclosure to deceased patients recently based on this consultation and this consultation has, as background information, there were no mistakes or technical errors at the root of this problem. And I'm wondering whether you, personally, an stand behind that statement.

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MS. JONES:

A. I don't think that any of us can personally stand behind this statement, but I would suspect that the disclosure that went on with the deceased patients, exactly the same disclosure that we had with living patients when we had to talk to them and when they were asking the question what went on, we couldn't actually say A, B, C or D, what went on with your test because they were individual disclosures and what happened on March 31st, 2007 verses April 1st of 2001 or 1997.

MS. NEWBURY:

Q. But that deals with the content of the disclosure as opposed to do we disclose and if so, how do we disclose, as opposed to what do we disclose.

MS. JONES:

A. I'm not sure what the--what question you were asking.

MS. NEWBURY:

Q. This consultation here, as I read it, the fact that there were purportedly no mistakes or technical errors -

MS. JONES:

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A. Yes.

MS. NEWBURY:

Q. - had some bearing on what the consultant said at the end of the day.

MS. JONES:

A. How the consult played out, yes.

MS. NEWBURY:

Q. And my concern is, you know, do you stand behind this statement and you've relied upon this recently, I guess, do you have any concerns, did you have any thoughts about going back to do another ethical consultation based on, you know, what you understand to be the case.

MS. JONES:

A. Yeah, that didn't come forward in terms of should we do another consultation about how we move forward with this. And I didn't ask for one.

MS. NEWBURY:

Q. And you've indicated a few minutes ago that you don't know if anyone will ever be able to say specifically which of the recommendations or which of the activities in the lab caused the problem. Do you know if there's actually

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been an effort by anyone at Eastern Health to examine that?

MS. JONES:

A. I think that the external reviews and everything that was commissioned over time to ensure that the lab was meeting best standards and what recommendations were all focused on providing a quality care and a standard of service that we could be safe and sure to go forward on. When we started this, it was what--it was always around was there care changes or treatment changes for individual clients, so I can't answer that question whether in 2005 that that actually went retrospective or as part of doing the reviews there would be a number of issues that would come forward that people would then say, okay, because of all of this, this is what happened. So individually did they say what happened and I don't know whether you could have said actually what happened over the seven years. But what we've learned through that, through the recommendations and that, is that if you were to make a fail safe system, this is what you need to do.

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MS. NEWBURY:

Q. Right, and that's more to address immediate concerns and future concerns, as opposed to let's have a look back and see where we went wrong.

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. No one has tried to say these are the recommendations that led to this problem.

MS. JONES:

A. No.

MS. NEWBURY:

Q. They're just saying listen, you need to get your lab up to scratch, here's your shopping list.

MS. JONES:

A. And these are the things that on any one individual issue we're not sure, but these are the things and we've heard things such as fixation and we've heard things such as education and all of those things need to be in place to assure that you're providing the best quality.

MS. NEWBURY:

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Q. And to your knowledge, no one has looked back?

MS. JONES:

A. You'll have to ask the questions--nobody has provided me with that information.

MS. NEWBURY:

Q. Okay. I'd like to refer to exhibit P-0046 please? So on the review under review of cases there, Dr. Banerjee states, he has a few comments there about retrospective testing.

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. And he says, "I've reviewed a number of cases from the retrospective testing set with Dr. Donald Cook. All of the cases that had converted from negative to positive by switching platforms had one or more of the following characteristics: poor fixation, negative internal controls, normal ductal epithelium when present was completely negative, absent internal controls, no normal ductal epithelium present to evaluate. It is apparent that too much reliance is being placed on external positive controls with no attention paid to internal controls". And

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

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MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Now, can you say that that is not, in your view or your understanding either technical error or mistake?
MS. JONES:
A. I think that this lists a number of factors that on an individual--you talk about the negatives to positives. This lists a number of things, it takes some things out of the system which was, was DAKO or Ventana, which was one of the initial questions and there is some documentation that one was overpredicting and one was underpredicting and you'll probably hear that later on. So, it takes some of those questions out of. It also adds some questions around fixation and positive and internal controls. And then if you marry that with the technical report, there is a whole bunch of issues around standard operating procedures and documentation and those kinds of things.
MS. NEWBURY:
Q. Okay, but do you consider these to be

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

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

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

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on what the issue was. And I'm not sure on those.

MS. NEWBURY:

Q. Okay. Were those dealing with just one specific patient or were they broader -

MS. JONES:

A. No, that was policy, direction and issues around the old health care corporation of St. John's. The gambling was pull tickets in the gift shops and whether, in fact, that, from a gambling perspective, as a health care organization, we should have that activity going on. So, that's the nature of that particular one. And food choices was, should the french fries and all of that kind of stuff be sold in our cafeteria, especially with the obesity rates.

MS. NEWBURY:

Q. Okay. Now, in terms of the testing of samples for the deceased patients -

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. - was it your understanding at the time of the ethics consultation that the tested samples of

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deceased patients that was in their possession had been, by happenstance, hadn't been planned, it was just how it ended up.

MS. JONES:

A. Hadn't been planned, yes.

MS. NEWBURY:

Q. Okay. And are you aware whether prior to that ethics consultation there had every been a plan to eventually retest the samples of all of the deceased patients?

MS. JONES:

A. I wouldn't be because at that point in time, I wasn't close to the ER/PR file. And I think it clearly says we found ourselves with results for deceased patients as a result of just pulling all of the files from that particular point in time and sending them on for retesting.

MS. NEWBURY:

Q. So, it was never made known to you that there might have been, at some point in time, a plan to test all of the deceased patient samples, one -

MS. JONES:

A. No, that was in May of 2007 that Mr. Tilley

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made that determination.

MS. NEWBURY:

Q. Okay. And right up until this day, it's still up to families of deceased patients to contact eastern health -

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. - for information. And since your press release and your conference in February 2008, that was February 22 or -

MS. JONES:

A. 22nd.

MS. NEWBURY:

Q. - and the release went out on the 21st, did it?

MS. JONES:

A. I'm not sure. That may have been the press release that was released on the 22nd when the press conference with the minister was. But the 22nd stays in my mind, but I was away that week, and I think the 22nd is a Friday, Thursday or Friday.

MS. NEWBURY:

Q. Okay. You indicated that you've received 60

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to 80 calls from family members.

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. Has that all been since February 2008 or does that include calls before that?

MS. JONES:

A. I can't--I just ask a question, how many families of deceased have called and looking for--and that may not be inclusive of the people who had asked for the retesting or that the oncologist had dealt with earlier on. So it was 60 - 80 clients have since this, I had understood, but it may very well be 60 - 80 total.

MS. NEWBURY:

Q. Okay.

MS. JONES:

A. I didn't ask for that real clarification.

MS. NEWBURY:

Q. Okay. And what is the rationale for not actually going that extra step and notifying the families directly of the retesting results?

MS. JONES:

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A. I think it still lies in the consult that was done. And you're asking if, in fact, we have redone that consult based upon that and we haven't. So, we had not gone down that road.
MS. NEWBURY:
Q. Okay. Now, is there anything in that consultation--and if you want to go back to have a look at it, is there anything there that suggests that it would inappropriate to directly contact the patients?
MS. JONES:
A. I don't know.
MS. NEWBURY:
Q. Or the patient's families or -
MS. JONES:
A. I don't know.
MS. NEWBURY:
Q. It's 0783.
MS. JONES:
A. It's still there.
MS. NEWBURY:
Q. If you want to scroll down and have a look.
MS. JONES:
A. There's nothing there that would be contrary to it.

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MS. NEWBURY:
Q. Okay. And would you agree that since this consultation, June of 2006, there has been some other events transpiring? Number one, the decision was made to take all of the samples and send them off for retesting. So, whereas in June of 2006 you had samples that had been retested, not by plan, but by circumstances.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Whereas in February of 2008 when you did your press release, you have now in your possession all of the retested samples and that happened due to a decision of Mr. Tilley, as we understand. So, that's one of the differences since June 2006.
MS. JONES:
A. Yes, it is.
MS. NEWBURY:
Q. And would you also agree that there's been a fair amount of criticism, I guess. You've mentioned in your May 23, 2007 executive management meeting that there was a concern

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about public confidence in the system.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. And so there's a certain, I guess, criticism by the public, you know, people calling to open lines concerned about the transparency and openness, I think, underlying that. And would you also agree that there's been some confusion about some of the issues, you know -
MS. JONES:
A. Absolutely, we've said that all along.
MS. NEWBURY:
Q. - staining versus ER/PR.
MS. JONES:
A. We use the words "misconcepts" today with the media.
MS. NEWBURY:
Q. And that there have been missed results. People have had results retested and have not been contacted even recently.
MS. JONES:
A. Yes, yes.
MS. NEWBURY:
Q. Other people were never retested at all. So,

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there's a database issue as well.
MS. JONES:
A. And we've been clear to say that, yes.
MS. NEWBURY:
Q. And not everyone, even--aside from the database issue and your inability to contact the living patients directly, a lot of these people, even though you've had announcements out in the past have not called -
MS. JONES:
A. Called or come forward.
MS. NEWBURY:
Q. - and found out the results that way. So, you've go that certain lack of comfort that the family members will indeed get the message, that they can contact eastern health. That's if they actually understand it.
MS. JONES:
A. That's always an issue, yes.
MS. NEWBURY:
Q. Okay. So there's been no sort of re-evaluation of those factors?
MS. JONES:
A. I'm not aware, though, and this is -- you know, you asked the question, no, we didn't go

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

MS. NEWBURY:

Q. Okay, but even if you, you know, accept the ethics consultation as it is, it doesn't prevent you from contacting patients directly?

MS. JONES:

A. No, it doesn't prevent us.

MS. NEWBURY:

Q. So you could take that and you can refine it and --

MS. JONES:

A. Yeah, and we made a decision in terms of how to communicate and that decision I've talked about here.

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MS. NEWBURY:

Q. I'd like to refer to Exhibit P-0745, please, page 49 of that exhibit. This is the accreditation report.

THE COMMISSIONER:

Q. Did you say page 40?

MS. NEWBURY:

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

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. And there are particular comments there regarding the issue of disclosure to patients whose breast cancer status had some changes.

MS. JONES:

A. Uh-hm.

MS. NEWBURY:

Q. And there's a simple statement there that this was done as soon as new information was available to the team and the patient had been traced. Disclosure was conducted in an

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

MS. JONES:

A. I wouldn't be aware because this would have been inside. Most of this information discussed inside of the cancer team interviewer with individual clients that they may have picked up information on.

MS. NEWBURY:

Q. Okay, and you had indicated as well that there could be a self-assessment report, some documentation sent to the accreditors in advance?

MS. JONES:

A. Yes.

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MS. NEWBURY:

Q. And who would be the person who could obtain any such documentation?

MS. JONES:

A. That documentation would be in our -- in our hands in terms of documents that we prepared to send to accreditation and then the accreditors use them as part of moving forward and developing their question lines and what they wanted to view when they came inside of Eastern Health.

MS. NEWBURY:

Q. Okay. So you would have access to that information?

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. Okay, I wonder if it would be possible to get that information?

MS. JONES:

A. On which team? We have --

MS. NEWBURY:

Q. That would -- the two areas that are of interest would be the one dealing with the breast cancer disclosure.

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MS. JONES:

A. The required organizational practises are across the entire organization, so there's no documentation on this. The answer that I just gave you was where did the people get the information. It may very well have been in discussion with the team, and there is no minutes of the team's discussion, but there would be a completion of the standards for cancer care that would have gone through. So that information would be available, and this report actually has what council has reported back in terms of their assessment. So cancer care team, for sure there would be documentation around what they answered or how they scaled themselves, but there is no documentation around -- there is an evidence binder, but being that this is a generic implement of formal transparent policy and process for disclosure of adverse events, individual disclosures wouldn't be in it, but a policy and the work that we had done around the education. So that would be the information that would be in that kind of a -- what we would call an evidence binder. I

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would suggest, based upon interviews with the cancer care team, that -- I'm not sure what the discussion would be, but what the cancer care team had sent forward as part of their documentation about how they responded to particular standards, that is available.

MS. NEWBURY:

Q. Okay. So you're confident that there are no documents provided to the surveyors --

MS. JONES:

A. No.

MS. NEWBURY:

Q. That specifically related to the disclosure regarding the ER/PR issue.

MS. JONES:

A. ER/PR. I wouldn't be as specific as that. It would have been in their interview process that they would have asked questions.

MS. NEWBURY:

Q. And do you know if there were any focus groups on this particular issue that would have captured either, you know, as a small focus group or part of a larger focus group, the issue of disclosure on ER/PR?

MS. JONES:

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A. No, not on ER/PR. There were focus groups with clients all throughout the organization, but I'm -- I can't answer you whether, in fact, there was a focus group that had -- I would think that inside of the client focus group, which is the way we call it inside of accreditation, there may have been cancer patients. Were they ones that had issues of ER/PR, I have no idea at this point.

MS. NEWBURY:

Q. Okay, and who selects the participants for focus groups?

MS. JONES:

A. The participants for focus groups is really -- sometimes it's a call to patients who are known to us, like in our Advisory Committee on Mental Health, and we will ask for volunteers to come forward, or people who have access to multiple parts of our service that are willing to come and sit in a group setting.

MS. NEWBURY:

Q. Now it's my understanding that the Canadian Cancer Society, who is considered to be a community partner --

MS. JONES:

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A. Yes.

MS. NEWBURY:

Q. Was not invited to participate in any focus group as part of this recent accreditation?

MS. JONES:

A. A stakeholder, yeah.

MS. NEWBURY:

Q. I don't think you knew one way or the other --

MS. JONES:

A. No, I didn't know one way or the other.

MS. NEWBURY:

Q. There will ultimately be evidence on this.

MS. JONES:

A. Um.

MS. NEWBURY:

Q. Now this accreditation report, 2007, it follows on -- I guess the one prior to that would have been 2004.

MS. JONES:

A. '04.

MS. NEWBURY:

Q. So between 2004 and 2007 you've got three key years; 2005, 2006, 2007, where ER/PR issue has, I would suggest, remained a top clinical issue for Eastern Health.

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MS. JONES:
A. Yes, um.
MS. NEWBURY:
Q. And, if anything, the significance of this issue or the importance of the issue to Eastern Health intensified in 2007.
MS. JONES:
A. Um.
MS. NEWBURY:
Q. To the point that the inquiry was called.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. And throughout this process, the Canadian Cancer Society has been probably the primary community partner engaged in the ER/PR issue throughout each of those years, and would you expect in those circumstances that the participation of such a community partner in a focus group would have added an important perspective to the work of the surveyors?
MS. JONES:
A. It could very well be that that is a particular perspective, but in putting together focus groups, and I didn't kind of

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have -- you know, say that we had the Government and whatever, there are multiple stakeholders across the organization, and there's a limited number of people who can be involved, so --
MS. NEWBURY:
Q. I realize that, that there are probably lots of people who'd be interested in coming --
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. And participating in a focus group, but this is a key area.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. It's probably your top one, two, three clinical issue for each of those years.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Would you not agree that it's probably an omission not to have invited someone from the Canadian Cancer Society to present?
MS. JONES:

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

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

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MS. NEWBURY:
Q. Sure, and --
MS. JONES:
A. Right.
MS. NEWBURY:
Q. Would you expect that if Eastern Health, even if Peter Dawe did an interview on a Monday --
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. That if Eastern Health managed to get a physician who was willing and able to talk to the issues, that the media would be more than willing to speak with that physician Tuesday or Wednesday?
MS. JONES:
A. It depends on the news cycle because sometimes the issue -- they're on to another new issue, and sometimes they would and sometimes they wouldn't. It depended on what they were looking for on that particular day.
MS. NEWBURY:
Q. Okay, but this issue has been a fairly constant issue throughout 2005 up until 2008?
MS. JONES:

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A. Yes, absolutely.
MS. NEWBURY:
Q. Earlier this morning, you mentioned that there's a clinical epidemiologist from Health Canada now at Eastern Health?
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Could you explain what that individual is doing?
MS. JONES:
A. It is really -- it was some kind of an agreement that we made in the fall of the year, that it was like a regional position looking at surveillance for communicable diseases probably just in Newfoundland, but it could be Atlantic Canada. I'm not really sure of the details, but I do remember it being brought to Executive to say that as communicable disease and the Public Health Agency of Canada were putting resources across the country, that Newfoundland was able to secure an individual and that individual would be housed inside of Eastern Health.
MS. NEWBURY:

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

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A. Yes.
MS. NEWBURY:
Q. And they would work to assist in the developing of the framework so that new modules are not only user friendly, but are maximized with respect to their ability to extract data in the future.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Each team would also educate -- work to educate clinicians and to migrate the organization to the new system.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Is that a temporary or permanent position?
MS. JONES:
A. In terms of the resources, those people that you would see there would be -- would be part of number three, which is the decision support people, bio-statisticians and --
MS. NEWBURY:
Q. Right.
MS. JONES:

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

MS. NEWBURY:

Q. Okay. Now that description there under Item #1, it sounds like the start up description of that person's job, developing the framework. Once the framework has been developed --

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. What role would the epidemiologist or bio-statistician have?

MS. JONES:

A. Yes, that would be -- they would be really -- in terms of the number three item here, which is decision support framework, and

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

MS. NEWBURY:

Q. And would they have any role in monitoring of cancer data, per se?

MS. JONES:

A. Eventually, when you look at the decision support in that, those skills could be used across multiple parts of the organization.

MS. NEWBURY:

Q. Okay. So not just for cancer, but a number of things?

MS. JONES:

A. A number of things.

MS. NEWBURY:

Q. Okay. You've referred a couple of times during your evidence to redundancies being built into the system and referred to the swiss cheese model.

MS. JONES:

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A. Yes.

MS. NEWBURY:

Q. And would a redundancy include a quality assurance person? Is that a type of a redundancy built into the system?

MS. JONES:

A. It's some of the processes may in fact be a person, okay, and it would be audits kind of thing that that person would be involved.

MS. NEWBURY:

Q. Or quality assurance program is what -

MS. JONES:

A. Or quality assurance programs or somebody to be able to tease out best evidence and those kinds of things.

MS. NEWBURY:

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

MS. JONES:

A. I can't answer that question as specifically

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

MS. NEWBURY:

Q. Dr. Denic, okay.

MS. JONES:

A. With the proficiency testing and the quality assurance work that they've done in there, I'm not sure what the exact details would be.

MS. NEWBURY:

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

MS. JONES:

A. I can't answer that.

MS. NEWBURY:

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

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. - what would be encompassed in the duties of a patient navigator. Is there anyone at Eastern Health who would be more familiar with the

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concept of a patient navigator?
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Who?
MS. JONES:
A. It would be the program director for cancer care, as well as Mrs. Pilgrim who sat with the cancer control strategy and I know that that has been discussed in that forum as well.
MS. NEWBURY:
Q. So in terms of names, Pat Pilgrim would be one person. Is there any -
MS. JONES:
A. And Sharon Smith would be the other.
MS. NEWBURY:
Q. Sharon Smith, okay. And can you say whether there's been any active consideration given by Eastern Health to engaging a patient navigator?
MS. JONES:
A. I can't say, and I don't remember it being in the budget process, at least for this year.
MS. NEWBURY:
Q. Okay. Now Exhibit P-0075, please? Now this

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is a briefing note that you're probably not familiar with, not having generated it.
MS. JONES:
A. No.
MS. NEWBURY:
Q. But I just wanted to refer you to a comment on page three. If you look at the second paragraph there. This is a briefing note, I should show you from the beginning. It's a chronology of events and it was prepared by Eastern Health.
MS. JONES:
A. Okay, yes.
MS. NEWBURY:
Q. And starts at November--May 11th, 2005.
MS. JONES:
A. Okay.
MS. NEWBURY:
Q. And it was prepared July 20th, 2005.
MS. JONES:
A. Okay.
MS. NEWBURY:
Q. And on page three, if you look at the second paragraph, "extra resources have been identified within the Health Care Corporation

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of St. John's lab to undertake identification and retesting. The list of patients will be double checked with the names on the cancer registry to ensure none have been missed." So I just wanted to bring that to your attention.
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. And were you aware that this double checking of the cancer registry had ever happened?
MS. JONES:
A. I have no idea, because this is -
MS. NEWBURY:
Q. That's new to you, is it?
MS. JONES:
A. - this is two years--this information is two years old.
MS. NEWBURY:
Q. Sure, okay. If I could refer to Exhibit P-0785, please? Now this is another document that you may not be familiar with. It's from summer of 2005.
MS. JONES:
A. Yes.
MS. NEWBURY:

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Q. It's an e-mail from Heather Predham to Pamela King Jesso, Deanne Emberly, David McCormick, regarding the database.
MS. JONES:
A. Okay.
MS. NEWBURY:
Q. Now perhaps this came up during your discussions with Department of Health and the development of the database. You can't recall this, can you?
MS. JONES:
A. No, this would not--we wouldn't have referenced a memo, but is there--there might be content in the memo, but I don't know.
MS. NEWBURY:
Q. Okay. I just want to refer you to some of the comments made there under the heading "database."
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. And the original message here is actually from Heather Predham to Dr. Williams, Dr. Cook, Terry Gulliver and Patricia Pilgrim.
MS. JONES:

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A. Yeah, okay.
MS. NEWBURY:
Q. And under that heading "database" it says "I've got the lab database and the NCRTF database combined, but I still have issues to clarify. There are data quality issues such as people with the same name and address and different MCP numbers and people with different names and addresses -
MS. JONES:
A. But the same MCP.
MS. NEWBURY:
Q. - but with the same MCP.
MS. JONES:
A. That's right.
MS. NEWBURY:
Q. Also, there are a lot of individuals with incomplete MCP numbers. I'll work on that today."
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Down at the next paragraph, "there are a couple of issues that came to light through during this process," and if you look down to

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

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they were living or deceased?
MS. JONES:
A. I have no idea about the cancer registry. Haven't had any discussion around the cancer registry. It hasn't been brought to my attention in the time I've been here.
MS. NEWBURY:
Q. And who at Eastern Health would be responsible for the cancer registry? That is something that is under the -
MS. JONES:
A. It's housed in Eastern Health and it would have been in the old--it's listed here as the NCTRF, so it would have been inside of our cancer program.
MS. NEWBURY:
Q. Okay.
MS. JONES:
A. And I'm not sure how information gets to the cancer registry or how it's logged in the registry or even if there's mandatory registration or mandatory reporting to the cancer registry.
MS. NEWBURY:
Q. And who at Eastern Health would I ask to get

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that information?
MS. JONES:
A. Probably Sharon Smith, because the program director, the registry would be underneath, in that program area.
MS. NEWBURY:
Q. Sharon Smith?
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. And the people that work at the cancer registry, the staff members, would they be paid by Eastern Health?
MS. JONES:
A. Yes.
MS. NEWBURY:
Q. Employees of Eastern Health?
MS. JONES:
A. There is employees of Eastern Health. It was one of the legacy boards that came into Eastern Health.
MS. NEWBURY:
Q. I'd like to refer now to Exhibit P-0786. Now this document, Canadian Cancer Statistics 2005, and if you scroll down to the bottom of

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the page there, it's produced by the Canadian Cancer Society, the National Cancer Institute of Canada, Statistics Canada, provincial/territorial cancer registries and the Public Health Agency of Canada.

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. Are you familiar generally with this document?

MS. JONES:

A. No.

MS. NEWBURY:

Q. Okay. If I can go to page 26, please? On page 26, the heading for this particular section of the report is "geographic patterns of cancer occurrence" and if you look at the very first paragraph on that page, it says "finally, there are differences in the reporting procedures used in cancer registration, eg. registration of second primary cancers and use of death certificates, see appendix 2 regarding cancer registry methodology. For example, death certificate information has not been available for registry purposes in Newfoundland until now,

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and this falsely lowers the number of incident cases with short life expectancy, such as cases of lung and pancreatic cancer."

I'll refer now to page 98, please? And this page states, at the very--this is the appendix two that was referred to earlier.

MS. JONES:

A. Yes.

MS. NEWBURY:

Q. And it deals with methods, and the very first paragraph says "for all cancers, even those with poor survival, such as pancreas and lung, the annual number of incident cases is expected to be similar to or larger than the number of deaths. However, there are situations in which the number of deaths, either observed or projected, is larger than the corresponding number of new cases. In the case of Newfoundland and Labrador, this is caused by the registry not receiving information on death certificates that mention cancer. This results in an under estimate of the number of cases for the years used to generate the estimates. Once the Newfoundland registry begins receiving information in order

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to register these cases, the difference will disappear. Deaths may correspond to cases diagnosed in previous years so a year-to-year variation is also a factor for rare cancer sites."

Now I don't propose to go through these other documents, but I can say that the information is very similar, even including 2008, and I'll just, for the benefit of the people in the room, the next exhibit is 0787. That's the Canadian Cancer Statistics for 2006, and there are similar references there on page 23, the first full paragraph, starting with the word "finally" and on page 101, the first full paragraph again has a reference. And the next exhibit is 0789, or sorry, 0788 and that's the Cancer Statistics for 2007.

MS. JONES:

A. Okay.

MS. NEWBURY:

Q. And the two relevant pages are 20 and 98, and now if we go to the final of those exhibits, 0789, P-0789 for 2008, looking at, first of all, page 18, under geographic patterns of cancer occurrence, about halfway down the

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page, it says "issues that should be kept in mind when interpreting interprovincial variations." Bullet number two, "while the completeness of registration of new cancer cases is generally very good across the country, there are exceptions. For example, death certificate information has not been available for registry purposes in Newfoundland and Labrador and this falsely lowers the number of newly diagnosed cases, mainly among those cancers with a poor prognosis, such as lung and pancreatic cancer."

And on page 89, under the appendix two methods, at the very bottom of the page, "for all cancers, even those with poor survival, such as pancreas and lung, the annual number of incident cases is expected to be similar to or larger than the number of deaths. However, there are a number of--there are situations in which the number of deaths, either observed or projected, is larger than the corresponding number of new cases. In the case of Newfoundland and Labrador, this is caused by the registry not receiving information on

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death certificates that mention cancer. The limitation of not having access to death certificates is greater for cancers with a poor prognosis. This results in an under estimate of the number of cases for the years used to generate the estimates. Once the Newfoundland and Labrador registry begins receiving information in order to register these cases, the difference will disappear."

So Ms. Jones, were you aware of these apparent, I guess, deficiencies? It seems that Newfoundland is the only one pointed out to have that particular problem. You're not aware of that?

MS. JONES:

A. I'm not aware of it, and it talks about here in all of those that the registry is not receiving death certificates, and I don't know what process there is for death certificates, what process that happens inside of Newfoundland.

MS. NEWBURY:

Q. Right, but is that something that Eastern Health would think would be important to look into?

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MS. JONES:

A. Yes, but not understanding the registry, how it's set up, is there mandatory reporting or that, then that really needs to--those questions need to be asked of who's providing the information and why it's not being provided.

MS. NEWBURY:

Q. It seems that Heather Predham, from her e-mail back in August of 2005, had expected to find some more information at the cancer registry than she was ultimately able to get there.

MS. JONES:

A. Able to find.

MS. NEWBURY:

Q. And based on your familiarity with the NLCHI database project, do you think that the whole process of having this NLCHI database process could have been simplified or perhaps unnecessary if the cancer registry contained more information of the type that Ms. Predham was looking for?

MS. JONES:

A. Yes, or if in fact we had accessed the vital stats in Newfoundland to get the information,

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because I think that's ultimately where NLCHI did get the issue of the deaths, inside that database.

MS. NEWBURY:

Q. But to have the cancer registry, you would identify individuals -

MS. JONES:

A. Yes, you would obviously want the cancer registry to be as complete as it possibly can be.

MS. NEWBURY:

Q. Yes, okay, and that's not something that you're aware of has been on the radar for Eastern Health?

MS. JONES:

A. No. Well, it's not on--hasn't been on my radar, but it may very well be on other people's radar.

MS. NEWBURY:

Q. There have been some recent media reports, I guess, about the concern about retention of pathologists triggered by a recent resignation, as I understand it, by a pathologist here and the possibility of other pathologists who may resign in the future, I

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think, was the tenor of the report.

MS. JONES:

A. That's right.

MS. NEWBURY:

Q. I'm not sure how accurate that all is. But can you speak generally about the reasons for any resignations or any concerns that Eastern Health has?

MS. JONES:

A. I think that Dr. Denic has been clear. We are very concerned about the number of resignations that we've had. We have had turnover in pathology for a number of years and I think there's some exhibits here that will show the rate of turn over and the length of stay. There has always been issues in the last couple of years about compensation and we continue to talk about issues with compensation and whether, in fact, we're appropriately compensated. And there has been work done with respect to identifying workloads and to see if, in fact, we need more pathologists. So all of those issues have been and continue to be discussed and are a problem inside of Eastern Health right now.

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MS. NEWBURY:
Q. Thank you, Ms. Jones. Those are all the questions that I have for you.
THE COMMISSIONER:
Q. Thank you. Do you have any questions?
MS. LOUISE JONES, CROSS-EXAMINATION BY MS. DARLENE RUSSELL
MS. RUSSELL:
Q. Good afternoon, Ms. Jones, I'm Darlene Russell on behalf of the class action for breast cancer testing.
MS. JONES:
A. Okay.
MS. RUSSELL:
Q. I just have a few questions.
MS. JONES:
A. Yes.
MS. RUSSELL:
Q. Could I please have Exhibit 0488? Excuse me, 0488, page 40. Got the wrong page. Okay. Could I try 0287?
THE COMMISSIONER:
Q. Exhibit 0287 or page 287?
MS. RUSSELL:
Q. Exhibit 0287. Yes, this is it. These are

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minutes of an executive management meeting held June 13th, 2007.
MS. JONES:
A. Yes.
MS. RUSSELL:
Q. And I believe you were present at this meeting?
MS. JONES:
A. Yes.
MS. RUSSELL:
Q. And if I could go down to bullet 1.6 on page 2? And it says here that, "The CEO is scheduled to meet with the deputy minister of health and community services on June 14th and requested input on these key messages."
MS. JONES:
A. Um-hm.
MS. RUSSELL:
Q. Do you recall this discussion?
MS. JONES:
A. No, and this says deputy minister, the board chairs and the CEO. No.
MS. RUSSELL:
Q. You would have been the COO at the time?
MS. JONES:

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

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Q. And he's looking for some input on these key messages?
MS. JONES:
A. Um.
MS. RUSSELL:
Q. And one of the messages is HIROC's concern with full disclosure and the impact on insurability. What can you tell me about that?
MS. JONES:
A. I can't tell you anything around that at all.
MS. RUSSELL:
Q. You have no recollection?
MS. JONES:
A. I have no recollection on that. This is in June of 2007.
MS. RUSSELL:
Q. Yes. This would have been your last meeting, I think, before you were appointed?
MS. JONES:
A. Yeah, we would have been having some discussion around--not we, but there would have been some discussion around insurance premiums or whatever or liability coverage or whatever, but I don't know what that is. You

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really do have to ask him. It didn't resonate even when I looked at this list of things. Usually I remember something very, you know, poignant about something, but that doesn't resonate with me at all.

MS. RUSSELL:

Q. Okay. And you wouldn't have kept any notes?

MS. JONES:

A. No.

MS. RUSSELL:

Q. With respect to that?

MS. JONES:

A. No. I just keep minutes of meetings, right. Location of services, that, you know, like I would understand what that one was. Again, the need for highly skilled human resources and the capital equipment because we'd been talking about capital equipment for a long time. But in the context of this meeting in June, I have no recall on that.

MS. RUSSELL:

Q. Difference between patient disclosure and public disclosure, do you recall anything about that?

MS. JONES:

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A. No, only probably the same as we've been discussing now, individual patient disclosure and at what point in time to go to the public with that. And just culture along falling in the same way.

MS. RUSSELL:

Q. Okay. So what you're saying is we would have to ask Mr. Tilley about HIROC's concern?

MS. JONES:

A. Absolutely, that's right.

MS. RUSSELL:

Q. You don't have a recollection?

MS. JONES:

A. No.

MS. RUSSELL:

Q. Okay. Thank you. Could I also refer to Exhibit 0125, please? I don't know if you're familiar with this document?

MS. JONES:

A. I wouldn't, not briefing notes.

MS. RUSSELL:

Q. These are briefing notes.

MS. JONES:

A. Yeah.

MS. RUSSELL:

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Q. Okay. Could I go to page 19? These are briefing notes prepared by Health Predham.

MS. JONES:

A. Um.

MS. RUSSELL:

Q. July 31st, 2006. If I could scroll down to the bottom? Okay, that's good. Are you familiar with the term "retro converters"?

MS. JONES:

A. I've heard it. I hardly understand what it means, though. I do understand it is positive -

MS. RUSSELL:

Q. What's your understanding of what it means?

MS. JONES:

A. It's the reverse of going from negative to positive, from positive to negative.

MS. RUSSELL:

Q. So would it be like a false positive, maybe?

MS. JONES:

A. I'm not sure that you would even put that kind of context on it.

MS. RUSSELL:

Q. Okay. Well, maybe I'll just read through what it says here.

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MS. JONES:

A. Yeah.

MS. RUSSELL:

Q. For retro converters. "All patients who are negative for ER were included in the retesting process."

MS. JONES:

A. Yes.

MS. RUSSELL:

Q. "As the clinical definition of negative changed over the years all patients with an ER of 30 percent or less were retested. That means that in the group retested there are women who, although their ER level met this definition of negative, they were considered positive at the time and received hormonal treatment." So some people who were actually, I guess you can use the term clinically positive were retested?

MS. JONES:

A. Yes.

MS. RUSSELL:

Q. "In four cases retesting by Mount Sinai identified that women in this category now have an ER/PR status of zero percent, which

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has been confirmed by subsequent retesting at Mount Sinai."

MS. JONES:

A. Yes.

MS. RUSSELL:

Q. Did you know that?

MS. JONES:

A. I've heard the use retro converters and I've heard the number four in terms of four patients.

MS. RUSSELL:

Q. Okay. And then it says, "Representatives of Eastern Health and the clinical chiefs of pathology in cancer care will meet with them in the near future to disclose this information."

MS. JONES:

A. Yes.

MS. RUSSELL:

Q. Are you aware of whether that happened?

MS. JONES:

A. If that's said there, then I'm anticipating it did, but I -

MS. RUSSELL:

Q. You have no personal knowledge?

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MS. JONES:

A. I have no personal knowledge on that.

MS. RUSSELL:

Q. Okay. But you know that there were four people that tested zero percent?

MS. JONES:

A. I've heard this, I've heard this and I've heard exactly what's said here, that it's been disclosed. But, you know, I haven't gone asking "Can you confirm to me that that has been disclosed? What does it mean?"

MS. RUSSELL:

Q. Okay. Are you curious as to what it means?

MS. JONES:

A. Most of this file has been around the ER negative going to positive. There are other aspects of this file that this is one of and that I haven't delved into to wonder if, in fact, there are other issues that need to be there.

MS. RUSSELL:

Q. Okay.

MS. JONES:

A. This is, I think you showed me that this is a 2006 document.

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MS. RUSSELL:

Q. Okay. Could I go over to page 25, please? Okay. The impacts of treatment with Tamoxifen.

MS. JONES:

A. Um-hm.

MS. RUSSELL:

Q. "The drug Tamoxifen is believed to prevent the growth of cancer in ER/PR positive patients. It does have possible side effects, which includes endometrial cancer, blood clot to the legs, stroke, abnormal growth of uterine tissue, hair and nail thinning and fertility problems." So these are some of the side effects.

MS. JONES:

A. Yes, I understand those.

MS. RUSSELL:

Q. That are associated.

MS. JONES:

A. That's right.

MS. RUSSELL:

Q. So the four people who were receiving hormonal treatment.

MS. JONES:

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A. Yes.

MS. RUSSELL:

Q. Could have suffered these side effects needlessly?

MS. JONES:

A. Yes.

MS. RUSSELL:

Q. Okay. My question, I guess, is are there others? Like, did you retest any of the other positives besides the ones that were just incidentally retested?

MS. JONES:

A. No, we haven't. Unless there's been individual patients, we have had many individual patients who have been positive who have come forward and asked to be retested and we have not denied retesting. If an individual has concerns, we will--if they are still connected with an oncologist, we will ask them do they want to talk to their oncologist to see, and sometimes they talk to their oncologists. If they don't have an oncologist, we just send them off for retesting.

MS. RUSSELL:

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Q. So that is happening, so people who are approaching Eastern Health -
MS. JONES:
A. Yes.
MS. RUSSELL:
Q. - and saying that they are positive and they weren't retested in the initial group -
MS. JONES:
A. In the original, because they weren't in the negative -
MS. RUSSELL:
Q. - you are prepared to retest those people?
MS. JONES:
A. We have been retesting as they have come forward. We have not denied anybody the testing.
MS. RUSSELL:
Q. And people are being told this? People who are calling in to Eastern Health?
MS. JONES:
A. People are calling in, and what we normally will do is ask them if, in fact, they have an oncologist.
MS. RUSSELL:
Q. Um-hm.

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

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MS. RUSSELL:
Q. Do you have a plan to go forward with that information publicly?
MS. JONES:
A. We haven't discussed a plan to go forward with that one.
MS. RUSSELL:
Q. Do you know whether there's any confusion out there among people?
MS. JONES:
A. We've always talked about this as being an ER/PR.
MS. RUSSELL:
Q. Um-hm.
MS. JONES:
A. Negative issue. Anybody who's -
MS. RUSSELL:
Q. Yes, that's the confusion.
MS. JONES:
A. Yeah. Anybody who has called in and asked for their ER/PR results, if we have them inside of our database, we will give them their results or we will connect or find the results from the other parts of the region that we don't have.

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MS. RUSSELL:
Q. Okay.
MS. JONES:
A. So we've always done that.
MS. RUSSELL:
Q. So you're not aware of any phone calls to Eastern Health whereby people have been told that they won't be retested?
MS. JONES:
A. I'm not aware of that because the only question that has been asked is if, in fact, people have called in, and I know they are calling in because I've heard, you know, they've been referred to oncologists and, in fact, you know, that we just send it out.
MS. RUSSELL:
Q. Okay. So I just want to clarify one final point. You're prepared to retest anybody who's looking to be retested in that period of time, from 1997 to 2005?
MS. JONES:
A. If that is their wish.
MS. RUSSELL:
Q. If that's their wish?
MS. JONES:

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A. That's right.
MS. RUSSELL:
Q. Thank you. I have no further questions.
THE COMMISSIONER:
Q. Mr. Pike?
MR. PIKE:
Q. I had a couple of points that I intended to cover, but they've been covered by Ms. Chaytor and Ms. Newbury. Thank you.
THE COMMISSIONER:
Q. Thank you. Mr. Simmons.
MS. LOUISE JONES, CROSS-EXAMINATION BY MR. DANIEL SIMMONS
MR. SIMMONS:
Q. Ms. Jones, I expect you're glad to finally see me, and you'll be even gladder to see Ms. Chaytor again when I'm done. So I'll -
MS. JONES:
A. Go on.
MR. SIMMONS:
Q. I'll try and give Ms. Chaytor the chance to get back here as quickly as I can. Can I have P-0773, please? Ms. Jones, this is the confidentiality acknowledgement document that you were questioned on earlier today.
MS. JONES:

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A. Yes.
MR. SIMMONS:
Q. And I want to bring you down here to the third page of it, which you've been asked questions about already.
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. Which describe types of confidential information. And my question to you rises out of some questions you were asked earlier about people who might have, within the organization of Eastern Health who might have concerns about patient safety.
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. And whether they're able to bring those concerns forward and make sure that they are dealt with.
MS. JONES:
A. Um.
MR. SIMMONS:
Q. And my question is, are you aware of anything in this confidentiality acknowledgement or

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this policy or what you see here that would in any way prevent anyone from within Eastern Health bringing forward, either within the organization or outside of it a patient safety concern?
MS. JONES:
A. No.
MR. SIMMONS:
Q. There's a portion here that's marked "Business initiatives" there near the bottom.
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. And that's the description on the left in the box on the left is business initiatives and then it's further described as "Any information related to the organization's initiatives, example, organizational restructuring, mergers, outsourcing of business units" and also says, "recruitment". And when you read those examples there, would you read those in the context of any type of initiative the organization would take about recruitment or in the context of business initiatives related to -

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MS. JONES:
A. It talks about on the top of that, types of confidential information and that clearly is tied to the box that talks about business initiatives.
MR. SIMMONS:
Q. Right. Now you told us earlier in relation to recruitment that there could be arrangements made with particular staff of physicians, financial compensation arrangements, arrangements dealing with their personal benefits.
MS. JONES:
A. Yes, moving expenses, any of those things.
MR. SIMMONS:
Q. That would relate to recruitment, right. Is that what this restriction on disclosure of confidential information is intended to apply to?
MS. JONES:
A. I would expect because when you talk about recruitment things, such as moving expenses, personal expenses that we cover and those are part of individual staff or physician's information.

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MR. SIMMONS:
Q. Right, okay. So although there may not be an organization wide overarching policy which explicitly says anyone who has a patient safety concern can bring it forward in this way and there is no restriction -
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. Though that may not exist and you've told us that there are other policies in legacy organizations that may in other ways address some of those issues.
MS. JONES:
A. Uh-hm.
MR. SIMMONS:
Q. There is nothing in this acknowledgement that stands in the way of anyone doing that?
MS. JONES:
A. No.
MR. SIMMONS:
Q. You were referred to P-0743 which was the submission made for funding for a number of things.
MS. JONES:

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A. Yes.
MR. SIMMONS:
Q. And it's been described in some of the questioning as information technology requests.
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. And if we run down, here beginning on the fifth page, there's three areas of funding requests listed.
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. And you've been asked a number of questions about these already, I just wanted to ask you a bit more about the decision support, that's the third one.
MS. JONES:
A. Uh-hm.
MR. SIMMONS:
Q. Is decision support really an information technology thing or is it something really different from information technology.
MS. JONES:

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

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

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support capacity, is that correct?
MS. JONES:
A. Yes.
MR. SIMMONS:
Q. And was that primarily limited to areas of finance and efficiencies?
MS. JONES:
A. Absolutely.
MR. SIMMONS:
Q. And would I be correct to assume that that probably grew out of the circumstances that lead to the Hay review and the results of the Hay review and the focus on finding financial savings within the Health Care Corporation?
MS. JONES:
A. Yes, it did.
MR. SIMMONS:
Q. Among the 30 people that you contemplate forming the decision support group, what kind of professions--you spoken of a clinical epidemiologist, who else would comprise those 30 people?
MS. JONES:
A. Well you see some of them here, you've got budget analysts that we would bring in, health

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

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

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

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that we have developed and a lot of areas that want to develop registries that at the end of the day, can provide valuable information, so yes, that could be part of this work as well.

MR. SIMMONS:

Q. Okay, and the budget request was $880,000 for to implement decision support. How far would that have brought you towards putting in place your 30 staff that you contemplate?

MS. JONES:

A. We figure at this point in time if you were to take the budget analyst of the people that are already out in those functional departments, we probably got about 12 to 15 people. If you were to bring them, you needed to marry them with another 10 or 15 people, so this would be well on our way to developing a solid core of individuals, develop the expertise and then see where we needed to go because you couldn't do it altogether.

MR. SIMMONS:

Q. Based on the announcements that were made before the budget yesterday, and I understand you're not completely conversant with what yesterday's budget gave you.

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MS. JONES:

A. Budget was, yes.

MR. SIMMONS:

Q. Based on those announcements, how much of those requirements had you been told that you were getting?

MS. JONES:

A. Two and that would not have been enough to consolidate with two extra individuals.

MR. SIMMONS:

Q. Are, do other--are you aware whether other health care organizations in the country have this type of decision support capability?

MS. JONES:

A. In the way that we're looking at setting it up, yes, absolutely and the reference here is to Hamilton Health Sciences because that was one of the areas that was almost like the gold star when we were looking in 2001, 2001, so all large health care organizations would have departments pull together in this fashion.

MR. SIMMONS:

Q. Okay. Just a couple of questions about the issue of the method to use to disclose retesting results to families of deceased

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patients.

MS. JONES:

A. Yes.

MR. SIMMONS:

Q. Would I be correct in suggesting that there are a couple other factors to be taken into account when comparing the method for disclosing to families of deceased to disclosures to living patients and that one of those would be that for living patients, quite obviously there is the potential to give them an option for change in treatment and that that would drive the need to disclose directly to them.

MS. JONES:

A. Yes.

MR. SIMMONS:

Q. And another factor, would I be correct in suggesting that with disclosures to the families of decreased, there's an added complication in that it's not always possible to readily determine who is the appropriate family member of next of kin to make the disclosure to, if you're going out and actively looking to make those disclosures.

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MS. JONES:

A. We would end up having to use the current databases and we wouldn't know whether they were accurate or not and lots of times in terms of the next of kin that we would list in terms of our databases on registration, would be contact individuals verses next of kin, so it maybe, if we were to disclose to next of kin, you would be going down almost like the advanced health care director route, which would be in that hierarchy and lots of times what we have in our current databases is who to notify, not necessarily next of kin.

MR. SIMMONS:

Q. Okay, and the final question that I will ask you is that Ms. Newbury asked you some questions about related to trying to identify the cause of changed results for people who had an original test and then a retest result that was different.

MS. JONES:

A. Yes.

MR. SIMMONS:

Q. And in your answer, you said, if I understand correctly, that there were a range of

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potential causes identified and the recommendations were put in, were acted on to address those range of potential causes, but that for any particular test at any particular time, it would be very difficult to identify which of those causes were in play for that particular -

MS. JONES:

A. Yes.

MR. SIMMONS:

Q. - that particular test.

MS. JONES:

A. That's what I believe.

MR. SIMMONS:

Q. And let me ask you this, if you had taken the approach of saying there's 50 potential causes that we've identified, and we do the work or find a way to identify--to determine that only half of those actually caused changes in results here and the other 25 hadn't been actual causes of these change in results.

MS. JONES:

A. Uh-hm.

MR. SIMMONS:

Q. Would you have been able to just fix the 25

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that had been actual causes or would you have had to deal with them all?

MS. JONES:

A. I would have to deal with them because the whole idea is to put as much of assurance in the system, to plug as many holes there possibly could be there, so that redundancy that I talk about is absolutely there, it's not one, it's two, it's three, it's four different ways.

MR. SIMMONS:

Q. Right, and by dealing with all the potential causes, do you then feel reasonably assured that you will deal with the ones that were the actual causes at any particular time?

MS. JONES:

A. At any particular time.

MR. SIMMONS:

Q. Okay, fine. Thank you very much.

MS. JONES:

A. Thank you.

THE COMMISSIONER:

Q. Thank you, Mr. Simmons. Ms. Chaytor?

MS. LOUISE DAWE, RE-EXAMINATION BY MS. SANDRA CHAYTOR

CHAYTOR, Q.C.:

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Q. I know it's late, just three very quick questions.

MS. JONES:

A. Okay.

CHAYTOR, Q.C.:

Q. If I could have P-0069 please? And this picks up on the last question of Mr. Simmons on potential causes and as well, I think Ms. Newbury asked you about individual causes.

MS. JONES:

A. Yes.

CHAYTOR, Q.C.:

Q. You may not be aware of this document -

MS. JONES:

A. This is 2005, yes.

CHAYTOR, Q.C.:

Q. 2005 and it's a letter actually by Dr. Carter to Dr. Cook.

MS. JONES:

A. Dr. Cook, okay.

CHAYTOR, Q.C.:

Q. And it concerns efforts that she was going to undertake at the time to review individual slides.

MS. JONES:

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A. Okay.

CHAYTOR, Q.C.:

Q. Was the executive ever made aware of Dr. Carter's proposed efforts in this regard?

MS. JONES:

A. No, not as executive and this is July, so we wouldn't have been meeting through the summer too much, so -

CHAYTOR, Q.C.:

Q. So have you ever been made aware, up to now in your current role as CEO that Dr. Carter had undertaken a review of individual slides back in July of 2005?

MS. JONES:

A. Only in reviewing this file for the Commission.

CHAYTOR, Q.C.:

Q. Pardon me?

MS. JONES:

A. Only in reviewing the file for the Commission, I didn't talk to Dr. Carter herself.

CHAYTOR, Q.C.:

Q. So you only learned about that in, when? The last couple of months?

MS. JONES:

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A. The last couple of months.
CHAYTOR, Q.C.:
Q. That Dr. Carter had set out in reviewing the slides on an individual basis?
MS. JONES:
A. I had asked the question because Dr. Carter was a breast pathologist, as we were going through this, what role did she take on and did she make herself available to assist with this, because she was a breast pathologist and the answer was yes, and that she did start in very early on to work through this.
CHAYTOR, Q.C.:
Q. And the fact that she was going to need resources for that, that was never brought to the executive's attention by Dr. Williams?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. So Dr. Williams never told the executive that Dr. Carter had set out on this initiative?
MS. JONES:
A. No.
CHAYTOR, Q.C.:
Q. And recently having become aware of that, did

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

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Eastern Health offered themselves or any individual up to the media and the media declined the opportunity because the news cycle, as you had phrased it, had passed?
MS. JONES:
A. I'm not aware, I couldn't say on September whatever that that actually happened. I wasn't part of, you know -
CHAYTOR, Q.C.:
Q. But on any occasion, have -
MS. JONES:
A. On any occasion?
CHAYTOR, Q.C.:
Q. Yes, have you ever heard of that, that the Eastern Health -
MS. JONES:
A. Yes, yeah, not on ER/PR.
CHAYTOR, Q.C.:
Q. - went forward to the media and the media declined on ER/PR?
MS. JONES:
A. Not on the ER/PR, but yes, there have been times when that particular issue was out of the news cycle and that they don't doctor such and such to speak or whoever it is today.

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I've been caught in that myself, you know, and not -
CHAYTOR, Q.C.:
Q. But not on the ER/PR issue?
MS. JONES:
A. But not on ER/PR. I've been caught in that myself, not available until the next day and the issue was -
CHAYTOR, Q.C.:
Q. But not on ER/PR, I just want to be clear.
MS. JONES:
A. Not--I can't--yeah.
CHAYTOR, Q.C.:
Q. And would it be fair to say or would it be fair to say that there were probably numerous occasions on which the media sought Eastern Health's position or to comment on it, but there are no occasions in which the media declined Eastern Health in coming forward to speak on the issue?
MS. JONES:
A. I can't really answer that question.
CHAYTOR, Q.C.:
Q. You don't know. Would you be surprised if that were to be the case?

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MS. JONES:
A. I probably would be surprised, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. That there were times when Eastern Health -
MS. JONES:
A. Offered our self -
CHAYTOR, Q.C.:
Q. - declined--oh, you'd be surprised just that they offered themselves.
MS. JONES:
A. That's right.
CHAYTOR, Q.C.:
Q. Yes, I'm suggesting to you that would be a surprise.
MS. JONES:
A. Because you had two parts to that question.
CHAYTOR, Q.C.:
Q. Okay, the first part--I'm trying to hurry.
MS. JONES:
A. That's okay.
CHAYTOR, Q.C.:
Q. The first part is that there may have been occasions and perhaps numerous occasions in which the news media came looking to Eastern Health for information and -

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MS. JONES:
A. And we weren't able to respond.
CHAYTOR, Q.C.:
Q. - and it was declined, the interview, for whatever the reason was declined.
MS. JONES:
A. Was declined, yes.
CHAYTOR, Q.C.:
Q. But not the other way around, that Eastern Health made itself available and that the media declined Eastern Health?
MS. JONES:
A. We tended not to be out there making ourselves available. If we made ourselves available, it would be through press conferences or technical briefings or whatever and generally, the media would come to us, because that was--at that point in time, they wouldn't have known what we were going to say. So it would have been a story.
CHAYTOR, Q.C.:
Q. On the confidentiality agreement -
MS. JONES:
A. Yes.
CHAYTOR, Q.C.:

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Q. - and I just want to be clear, because I know I've gone down that road with you already, but I want to be clear out of answering questions that Mr. Simmons put to you on that. Are you saying that if it's an issue of patient safety, that employees and independent contractors of Eastern Health are free to go outside the organization and discuss that issue?
MS. JONES:
A. Yes, and all I would say to you in that respect is that I would hope, from out of a respectful relationship, that they would have talked to us.
CHAYTOR, Q.C.:
Q. First?
MS. JONES:
A. First, and we would have attempted to resolve, because we can't fix an issue if we don't understand the issue. So that would be in any respectful relationship.
CHAYTOR, Q.C.:
Q. Can you point to me anywhere in that document where patient safety is listed as an exception?

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MS. JONES:
A. No, there--but it doesn't say patient safety anywhere in that document. It talks about confidentiality.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. Those are my questions.
THE COMMISSIONER:
Q. Thank you. Well, it's been a long three days.
MS. JONES:
A. I'm still going to a board meeting.
THE COMMISSIONER:
Q. Well, your stamina is to be admired. We thank you very much.
MS. JONES:
A. Thank you.
CHAYTOR, Q.C.:
Q. Thank you.
THE COMMISSIONER:
Q. 9:30 in the morning.
(UPON CONCLUSION AT 5:42 P.M.)

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 30th day of April, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 30th day of April, A.D., 2008

Judy Moss

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