COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

October 2, 2008

Appearances:

Bernard Coffey, Q.C. .... Commission Co-counsel
Sandra Chaytor, Q.C. .... Commission Co-counsel

Rolf Pritchard/Jackie Brazil .... Her Majesty in Right of NL

Peter Browne/Jane Hennebury ...... Doctors Kara Laing et al

Daniel Simmons .... Eastern Regional Integrated
.... Health Authority

Laura Brocklehurst......... Members of the Breast Cancer
.... Testing Class Action

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

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Certificate

LIST OF EXHIBITS

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1 THE COMMISSIONER:
2 Q. Please be seated. Mr. Coffey.
3 MS. PATRICIA PILGRIM, EXAMINATION BY BERNARD COFFEY, Q.C.
4 (CONT'D)
5 COFFEY, Q.C.:
6 Q. Good morning, Commissioner. Good morning, Ms.
7 Pilgrim.
8 MS. PILGRIM:
9 A. Good morning.
10 COFFEY, Q.C.:
11 Q. I understand from Mr. Simmons that you've had
12 an opportunity to inquire into the person or
13 persons who spoke to you, the methodology
14 people who spoke to you?
15 MS. PILGRIM:
16 A. Yes. Yes, I did. It was Dr. Patrick Parfrey
17 that came to me with the numbers that he had,
18 you know, the calculations that he had done.
19 COFFEY, Q.C.:
20 Q. And you've also inquired--inquiries in your
21 own office and the numbers were not actually
22 left with you, I take it, or -
23 MS. PILGRIM:
24 A. No.
25 COFFEY, Q.C.:

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1 Q. - if they were, they're not still there?
2 MS. PILGRIM:
3 A. He did--he talked to both myself and Wayne
4 Miller.
5 COFFEY, Q.C.:
6 Q. Yes.
7 MS. PILGRIM:
8 A. And neither one of us kept the pieces of
9 paper.
10 COFFEY, Q.C.:
11 Q. Do you know if Dr. Parfrey actually works for
12 Eastern Health?
13 MS. PILGRIM:
14 A. Dr. Parfrey is a physician. He's a
15 nephologist and he also is the head of the
16 research centre. He's a professor at Memorial
17 University. So he's not an employee of
18 Eastern Health, but he--you know, his patient
19 practice is within Eastern Health.
20 COFFEY, Q.C.:
21 Q. And now, if we could, please, Exhibit P-0030?
22 And page 32, please? This is Corporate
23 Quality Initiatives Committee minutes of a
24 meeting of June 8th, 2005. You're the chair.
25 We looked at a number of these yesterday.

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1 Present also are Carol Chafe, Sharon Lehr,
2 Heather Predham, Sharon Smith, Louise Jones
3 and Dr. Robert Williams, and then regrets from
4 a number of individuals, including Mr. Dodge
5 and Dr. Harnett, and there are others listed
6 here. I'm going to go to page 36 of this,
7 actually go back one. The review of quality
8 initiatives report is paragraph seven, and
9 there's an organizational development. 7.1 is
10 organizational development. 7.2 is pharmacy.
11 7.3 is children/women's health, and then 7. 4
12 is laboratory.
13 Now this is June 8th, 2005, and this
14 reads "the laboratory report was reviewed and
15 the following noted: labour relations--
16 although the grievance rate has declined due
17 to a strong union presence, labour relations
18 issues remain a challenge" and then it goes on
19 from there, balanced score card. "Completion
20 of staff performance evaluations is not
21 reflective of the data that is provided under
22 achievements, i.e. balanced score card
23 indicates 15 evaluations completed in '04/ 05
24 whereas a much higher compliance is reported
25 in the score card. With respect to the

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1 percentage variation, the numbers are not
2 accurately reflected from a minus/plus--I'm
3 sorry, minus aspect, and labour dispute,
4 workload units that were decreased because of
5 the April '04 labour dispute have been marked
6 with an asterisk."
7 I wanted to ask you about the labour
8 relations matter here and the laboratory
9 report. What was that about? In the context
10 of June 8th, 2005 in this Corporate Quality
11 Initiatives Committee, what was the committee
12 looking at?
13 MS. PILGRIM:
14 A. We would have been looking at the report for
15 the prior 12 months. You know, these reports
16 would cover the year before. So if there had
17 been a labour dispute, which there was, a lab
18 x-ray, I think, dispute at that time, there
19 was just some comment about "well, that's why
20 the workload units were down."
21 COFFEY, Q.C.:
22 Q. Yes, and the labour relations, why would the
23 corporate quality initiatives committee be
24 receiving a report relating to--or that would
25 assert, I gather, in the report that--or deal

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1 with grievance rates, the decline in them, and
2 reference to a strong union presence and
3 labour relations issues being a challenge or
4 remaining a challenge? Why would that come
5 before the corporate quality initiatives
6 committee?
7 MS. PILGRIM:
8 A. Well, one of the things that a quality
9 committee would look at would be work life
10 issues for employees and one of the indicators
11 is, you know, indicators of strife or stress
12 or whatever in the workplace and one of the
13 things that you look at is your grievance rate
14 and do you have anything that's outstanding in
15 that area that you probably need to be looking
16 at. The quality reports that we did, it
17 wasn't just patient safety. There were things
18 about the financial situation of the
19 organization, the human resource, a lot of
20 human resource things, and labour relations
21 would certainly fit under there as well as
22 quality of work life.
23 COFFEY, Q.C.:
24 Q. So I take it that labour relations issues were
25 seen by this committee as potentially relating

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1 to the quality of the work?
2 MS. PILGRIM:
3 A. Quality of work life for employees. If you
4 had a really out--if they were really outside
5 the norm, you'd have to question "well, what's
6 going on in that area that you're getting all
7 these grievances." There would be some labour
8 strife there somewhere that you'd want to look
9 into.
10 COFFEY, Q.C.:
11 Q. And just so the Commissioner is clear, you're
12 looking at this in June of '05, but the report
13 would have related to -
14 MS. PILGRIM:
15 A. The year before.
16 COFFEY, Q.C.:
17 Q. The fiscal year before, ending March 31/05?
18 MS. PILGRIM:
19 A. Yeah. People, different departments report at
20 different months. So if they were due to
21 report in June of '05, theirs would have gone
22 from July '04 to July '05 or what--I haven't
23 got it right, but it would have been the 12
24 months before.
25 COFFEY, Q.C.:

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1 Q. Whatever the particular 12-month period was?
2 MS. PILGRIM:
3 A. Yes. People were reporting at different
4 times.
5 COFFEY, Q.C.:
6 Q. Thank you. Now if we could look, please, at
7 P-1418? Here, this is a series of e-mails of
8 June 20th, 2007, and actually before I leave
9 it, while it's on my mind, the whole matter of
10 labour relations within the lab, has there
11 been any discussion involving that and the
12 ER/PR matter that you're aware of?
13 MS. PILGRIM:
14 A. No.
15 COFFEY, Q.C.:
16 Q. Okay, so it hasn't -
17 MS. PILGRIM:
18 A. No.
19 COFFEY, Q.C.:
20 Q. Looking at these, the series of e-mails of
21 June 20th, and if I could, Commissioner, I'm
22 sorry, the one from Dr. Howell to Heather
23 Predham and yourself and many others at 10:28
24 a.m. that day suggesting a conference call
25 with Nash, Don, Terry and Kara to consistently

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1 answer the questions, and this had something
2 to do with the legal proceedings involving the
3 class action, but then it goes--Dr. Howell
4 says "on another note, have we sent the
5 deceased specimens to Mount Sinai yet for
6 retesting?" because you'll recall on May 18th,
7 Mr. Tilley had made a comment to the media
8 about that?
9 MS. PILGRIM:
10 A. That's correct, yes.
11 COFFEY, Q.C.:
12 Q. And then, Ms. Predham, that day, later that
13 morning, responded saying, after referring to
14 the conference call, says--she concludes, she
15 says something about "double checking the list
16 at this moment to get it over to the lab,"
17 which presumably is the list of the deceased
18 and she says "one thing I did discover was
19 that someone called last December about
20 retesting their family member. It was not a
21 name on our lists and the block and report had
22 to be obtained from Western as it had not been
23 sent in for the review." Then she says "I'm
24 not sure if this was someone who was
25 overlooked or did the regions not send in

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1 their known deceased? Terry, Nash, Don, do
2 you know?" Signed Heather.
3 MS. PILGRIM:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. Okay. Now you were a recipient, amongst other
7 people, of this, yourself and Dr. Howell and
8 others.
9 MS. PILGRIM:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. At the time you got this comment from Heather
13 Predham on June 20th, 2007, and you had
14 understood or viewed her as the project
15 manager, did you note or did that give you any
16 pause for concern that Ms. Predham apparently
17 didn't know what the status was concerning the
18 deceased, at least in Western Newfoundland, in
19 terms of whether they had been identified,
20 whether they had been sent for testing,
21 whether they had been identified, set aside
22 for eventual retesting? Did it occur to you
23 at that point, if she was having to ask Terry
24 Gulliver, Nash Denic or Don Cook about whether
25 or not the regions had sent their known

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1 deceased?
2 MS. PILGRIM:
3 A. The person that I would have asked would have
4 probably been Terry Gulliver, because when the
5 decision was made to retest the deceased, we
6 would have been--Heather would have been in
7 charge of making sure that our list, Eastern
8 Health's, but we would have expected the lab
9 and that would have been the understanding
10 that the lab would have contacted the other
11 health authorities. Now some of the health
12 authorities had already sent their deceased
13 into us with the first, and we didn't need to
14 contact them because we already had them, but
15 yes, Heather is bringing it up, but it just
16 raises a question about the lab and did they
17 contact the other labs. Every time there was
18 a question raised about this, and there were
19 many as we went on, Mr. Coffey, what I used to
20 call my shot of adrenaline for today, because
21 it was like what does this mean or what's this
22 about?
23 COFFEY, Q.C.:
24 Q. And -
25 THE COMMISSIONER:

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1 Q. I'm sorry, do I take it from that then, when
2 you say "Heather would have checked our list"
3 meaning the list from Eastern Health?
4 MS. PILGRIM:
5 A. Yes. She would have made -
6 THE COMMISSIONER:
7 Q. Is the implication that she would have already
8 had a complete list of the patients who you
9 would have classified as deceased?
10 MS. PILGRIM:
11 A. She would have had the Eastern Health list,
12 yes.
13 THE COMMISSIONER:
14 Q. So when--just make sure I understand. When
15 the original list was compiled, for the
16 purpose of sending off to Mount Sinai, and we
17 know that at some point, in the early days, a
18 number of those patients who were sent in fact
19 were deceased?
20 MS. PILGRIM:
21 A. Right.
22 THE COMMISSIONER:
23 Q. But a decision was made to priorize the list,
24 as it were, and to put aside the deceased?
25 MS. PILGRIM:

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1 A. That's correct.
2 THE COMMISSIONER:
3 Q. So was it the view of Eastern Health that by
4 the end of the process, you would have had,
5 separated out, a complete list of those
6 patients who would be in that category?
7 MS. PILGRIM:
8 A. Of the deceased?
9 THE COMMISSIONER:
10 Q. Yes.
11 MS. PILGRIM:
12 A. Yes.
13 THE COMMISSIONER:
14 Q. Okay.
15 MS. PILGRIM:
16 A. And that's what Heather would have been
17 checking.
18 COFFEY, Q.C.:
19 Q. And at that point, so she was in a--your
20 understanding was she was check--inquiring at
21 that point as to whether or not the blocks for
22 the deceased on the list that she had?
23 MS. PILGRIM:
24 A. She would--we would have made the decision and
25 then the lab would have gone forward to start

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1 sending, you know, collecting up the blocks
2 and the material to be sent away. But Heather
3 would have been in touch with them and just
4 checking the list to make sure.
5 COFFEY, Q.C.:
6 Q. So this would be not send in their known
7 deceased, would be not send in their known
8 deceased's blocks or their known deceased's
9 names?
10 MS. PILGRIM:
11 A. You mean the other health authorities?
12 COFFEY, Q.C.:
13 Q. Yes.
14 MS. PILGRIM:
15 A. "It was not a name on our list and the block
16 and report had to be obtained from Western."
17 I'm not sure if there was someone who was
18 overlooked, meaning did we not have them on a
19 list at all or did the regions not send in
20 their blocks and their material on the known
21 deceased.
22 COFFEY, Q.C.:
23 Q. So -
24 MS. PILGRIM:
25 A. And she would have had to turn to the lab for

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1 that, just to--I mean, she's just clarifying,
2 in her own mind here, so you know, making sure
3 that we haven't missed anything.
4 COFFEY, Q.C.:
5 Q. And -
6 MS. PILGRIM:
7 A. Or that's how I interpret that.
8 COFFEY, Q.C.:
9 Q. Yes, and that's what I was asking, of course.
10 Ms. Predham will be along, so I just wanted to
11 understand from your perspective, what you
12 understood at the time. Exhibit P-126 (sic.),
13 please, 2126. These are some notes of--well,
14 they're written on an e-mail of July 5/06.
15 It's from Don Cook to yourself, "accepted
16 analysis of ER/PR" and he's got written here
17 "meeting with Pat Pilgrim, Nash Denic, Don
18 Cook, Kara Laing, Heather Predham. Analysis
19 on ER/PR still not done. Spreadsheet has to
20 be formulated with critical event, or into
21 critical events." What was this about at this
22 point in time? This is the beginning of July
23 2007.
24 MS. PILGRIM:
25 A. This would have been--I can't remember that we

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1 had a separate meeting around this, but I
2 know, at this point, that was last summer, we
3 were now, you know, two years into this and
4 physicians were asking and other people were
5 asking "when can we see some of the results?
6 When can we get some of our questions
7 answered? Who's going to come and talk to us
8 about this?" So when they're talking about
9 the analysis, they hadn't--you know, there
10 were things that they wanted to do, like
11 change rates by--whatever the work they wanted
12 to do.
13 COFFEY, Q.C.:
14 Q. Change rates by pathologist you were about to
15 say, yes.
16 MS. PILGRIM:
17 A. Would have been one of them, yeah, and all
18 kinds of other things. But they hadn't--
19 nobody had yet given them the information to
20 do that. They didn't even have the raw data
21 to do that.
22 COFFEY, Q.C.:
23 Q. And why is that?
24 MS. PILGRIM:
25 A. Because we hadn't had it done and we had

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1 started to--as I told you yesterday, I think
2 it was probably late in the fall of 2006 that
3 we had freed up Heather Predham to make sure
4 everything was put together and completed with
5 the database that we had, which was really an
6 Excel spreadsheet, and then before she got to
7 finish that NLCHI came in.
8 COFFEY, Q.C.:
9 Q. So she would have started fall of '06?
10 MS. PILGRIM:
11 A. Late fall '06.
12 COFFEY, Q.C.:
13 Q. November/December '06.
14 MS. PILGRIM:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. Which is around the time of the technical
18 briefing for the media, around that time?
19 MS. PILGRIM:
20 A. That's right.
21 COFFEY, Q.C.:
22 Q. And then NLCHI didn't arrive until, I gather,
23 June of '07, six months later.
24 MS. PILGRIM:
25 A. No, they didn't arrive, but she--we still

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1 didn't have that complete by then.
2 COFFEY, Q.C.:
3 Q. That's what I'm getting at, over that six
4 month period, it hadn't gone any further?
5 MS. PILGRIM:
6 A. That's right, no. Well, we had been working
7 on it, but it wasn't complete.
8 COFFEY, Q.C.:
9 Q. And what was being done with it? I'm sorry.
10 MS. PILGRIM:
11 A. It was just, you know, how complete was it?
12 Was everything in there, all the contact on
13 the patients, you know. We needed to--Heather
14 needed time to put all of the information we
15 had together because the truth is, it wasn't
16 all together, you know. As I told you, I
17 think the first day, we didn't resource this
18 very well and what we ended up with was
19 Heather Predham really trying to manage all of
20 this with the other things that she was doing
21 and, you know, she was doing--she was really
22 multi-tasking. So this was an area that we
23 needed to put some work in.
24 COFFEY, Q.C.:
25 Q. Now, at the time, in the fall, late fall of

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1 2006, what was being requested or talked about
2 by physicians, in terms of change rates and,
3 you know, perhaps results by region, results
4 by hospital, results by time periods,
5 etcetera, etcetera -
6 MS. PILGRIM:
7 A. Right.
8 COFFEY, Q.C.:
9 Q. - that is the sort of work that a statistician
10 or an epidemiologist or both do?
11 MS. PILGRIM:
12 A. Yes, and we certainly -
13 COFFEY, Q.C.:
14 Q. Had any steps been taken?
15 MS. PILGRIM:
16 A. There had been one--prior to that, there had
17 been a meeting with people within the
18 community health division of the medical
19 school. I can't remember his name now, Dr.
20 Gagna, or there was a researcher over there,
21 an epidemiologist, there were two actually,
22 that had been spoken to and would be
23 interested in helping us when we got to this
24 stage, but we never even got there because we
25 just got to cleaning up this database. Then

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1 when NLCHI came, we didn't do anything else
2 with that. We figured that would be finished
3 in four to six weeks and then we would have
4 all of their assistance, which was very
5 helpful to us, and we would go on from there.
6 COFFEY, Q.C.:
7 Q. And has Eastern Health actually ever had an
8 epidemiologist look at this, involving--and I
9 say, I phrase that in terms of if it involves
10 the law suit, I don't want to know. It's not
11 my--I'm not concerned about it. But outside
12 the law suit issue.
13 MS. PILGRIM:
14 A. Other than what NLCHI has done?
15 COFFEY, Q.C.:
16 Q. Yes.
17 MS. PILGRIM:
18 A. And also we did have people with epidemiology
19 experience through Robert Thompson's office as
20 this was happening as well. So yes, prior to
21 this, we had not, but--and that's certainly a
22 lesson we learned, but once NLCHI got
23 involved, there was, you know, lots of skill
24 sets involved with that at that time.
25 COFFEY, Q.C.:

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1 Q. Now in relation to the dealing involving, you
2 know, potentially having an epidemiologist
3 look at this, or epidemiologists look at it,
4 have you been privy to any of the discussions
5 around that? Have you been part of some of
6 the discussions around -
7 MS. PILGRIM:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. You have, okay. Has the topic come up,
11 because the 939, 1,000 and whatever the figure
12 is, because it keeps changing -
13 MS. PILGRIM:
14 A. 1013 and then 1023 as of last week, yes.
15 COFFEY, Q.C.:
16 Q. Yes, and they are the ER negatives?
17 MS. PILGRIM:
18 A. Right, correct.
19 COFFEY, Q.C.:
20 Q. Has the topic come up about well, in terms of
21 primary breast cancer lesions, the positives,
22 like adding them into the--ER positives adding
23 them into the database of the ER negatives, so
24 you have a complete picture of the ER testing
25 for that time period, has that come up?

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1 MS. PILGRIM:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. And when did that first surface?
5 MS. PILGRIM:
6 A. Well, it came up right when they started
7 talking about how they were going to do the
8 retesting, when they decided to just go with
9 the negatives.
10 COFFEY, Q.C.:
11 Q. Back in July of '05?
12 MS. PILGRIM:
13 A. Yeah, that was a different group of people
14 then, that was internal people talking about
15 that. But I would say more so when we got
16 involved with Robert Thompson, the adverse
17 drug event task for group and with the
18 Newfoundland and Labrador Centre for Health
19 Information. More Robert Thompson's group, I
20 think.
21 COFFEY, Q.C.:
22 Q. Has there been any actual step taken or steps
23 taken by Eastern Health to have the data
24 concerning the ER positives added to the
25 database?

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1 MS. PILGRIM:
2 A. No.
3 COFFEY, Q.C.:
4 Q. Why not?
5 MS. PILGRIM:
6 A. Eastern Health had made the decision that we
7 were not going to do any further review of
8 this--any further enlargement or review of
9 this issue, and that is still being discussed.
10 The one that we had the most discussion with,
11 which again started before but was really came
12 to the front again was when one of the ladies
13 testified here at the Inquiry, a lady who was
14 a weak positive.
15 COFFEY, Q.C.:
16 Q. Daphne Coffey was at 23 percent.
17 MS. PILGRIM:
18 A. Yes, the 23 percent. And that's the one that
19 we have focused on the most. And I think as
20 of yesterday, I wasn't there, I know there was
21 a meeting yesterday and I think as of
22 yesterday they have decided that they are
23 going to review that group, they've decided on
24 a way that they're going to do it.
25 COFFEY, Q.C.:

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1 Q. And who is they?
2 MS. PILGRIM:
3 A. They being Nash Denic, Kara Laing, Oscar
4 Howell, Wayne Miller and they may have had Dr.
5 Brendan Barrett, because they were using--we
6 were, I'm sounding like I wasn't part of that
7 just because I wasn't at that meeting
8 yesterday, we were also asking the advice of
9 Dr. Brendan Barrett, as well. And we had
10 talked with Dr. Maureen Trudeau from
11 Sunnybrook about that group.
12 COFFEY, Q.C.:
13 Q. Back in the spring?
14 MS. PILGRIM:
15 A. Back in the spring, yes. So and that's been
16 back and forth and back and forth. But there
17 is, I think there was a decision made
18 yesterday that we will definitely be looking
19 at that group. The other group, Mr. Coffey,
20 that are--is still being looked at is the
21 group coming out of people who have been
22 calling in self identifying, and whether we
23 should be doing some kind of a more expansive
24 search, a different way of searching the
25 database.

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1 COFFEY, Q.C.:
2 Q. A word search?
3 MS. PILGRIM:
4 A. A word search.
5 COFFEY, Q.C.:
6 Q. A word search, essentially?
7 MS. PILGRIM:
8 A. Yes. Well, they're not--some of them are
9 called--now, this is not my field but, and I
10 always say the wrong thing when I'm talking to
11 these people, but some of them are word
12 searches and some of them are not. There's
13 other ways to do it. But anyway, that's been
14 talked about. We know that certainly coming
15 from the government, meaning from the part
16 where Mr. Thompson is, there is a -
17 COFFEY, Q.C.:
18 Q. Just on that point.
19 MS. PILGRIM:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. He first started to push that, that idea -
23 MS. PILGRIM:
24 A. Yeah, back -
25 COFFEY, Q.C.:

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1 Q. - Mr. Thompson did, back in April?
2 MS. PILGRIM:
3 A. Back in April when there was one patient, I
4 think.
5 COFFEY, Q.C.:
6 Q. Yes.
7 MS. PILGRIM:
8 A. And they were doing their technical briefing
9 and he, at that time he did say to us that he
10 still thought that that was the correct thing
11 to do, that we should do that. So that one is
12 still being talked about.
13 COFFEY, Q.C.:
14 Q. If I could, just to clarify that, so because
15 at the time this is the one, you referred to
16 this yesterday, there was one patient like in
17 the period around March of 2008 who self
18 identified and people within, who were
19 examining this, were asking themselves how
20 could we have missed the searches?
21 MS. PILGRIM:
22 A. Well, Dr.--and Dr. Howell said, well, if
23 there's one, there's more.
24 COFFEY, Q.C.:
25 Q. More.

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1 MS. PILGRIM:
2 A. Right, yes. And we found out there were ten
3 more.
4 COFFEY, Q.C.:
5 Q. And you referred to that yesterday?
6 MS. PILGRIM:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. As the--and then when you knew there was one
10 and Dr. Howell said if there's one, there's
11 more?
12 MS. PILGRIM:
13 A. Right.
14 COFFEY, Q.C.:
15 Q. Mr. Thompson, in terms of his involvement and
16 there's a fair amount of material here on
17 this, had NLCHI provide ideas on, well, how
18 the searches could be done again?
19 MS. PILGRIM:
20 A. They came up with three different ways to do
21 it and we came up with a way ourselves.
22 COFFEY, Q.C.:
23 Q. Yes. So if there are -
24 MS. PILGRIM:
25 A. But they immediately eliminated ours because

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1 it was way too complicated.
2 COFFEY, Q.C.:
3 Q. So there are a number of different ways. It
4 was proposed, Mr. Thompson was a proponent of
5 utilizing this?
6 MS. PILGRIM:
7 A. Absolutely.
8 COFFEY, Q.C.:
9 Q. And -
10 MS. PILGRIM:
11 A. They tested it out.
12 COFFEY, Q.C.:
13 Q. Yes. And it would have caught the woman who
14 has just self identified?
15 MS. PILGRIM:
16 A. She would have been picked up.
17 COFFEY, Q.C.:
18 Q. Picked up.
19 MS. PILGRIM:
20 A. By either one of those word searches.
21 COFFEY, Q.C.:
22 Q. And you referred to that yesterday.
23 MS. PILGRIM:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Okay, so that happened? What then happened,
2 because it wasn't done, the search using those
3 three criteria wasn't done?
4 MS. PILGRIM:
5 A. No.
6 COFFEY, Q.C.:
7 Q. And why not?
8 MS. PILGRIM:
9 A. Back in March or I think it was March when we
10 were really having the discussion on this,
11 Robert was, well, Mr. Thompson, I suppose, I
12 should be calling him, but he was talking
13 about, you know, we need to do this. But the
14 reality was the way we had to do this was you
15 had to go in and search and you would produce
16 thousands of pathology reports. And I think
17 the one year they did was like 3000 for that
18 one year. And then you have to, as far as we
19 know, manually go through the 1000 pathology
20 reports and start putting patients in
21 different categories.
22 COFFEY, Q.C.:
23 Q. Yes.
24 MS. PILGRIM:
25 A. And because of what we were into then, this

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1 became a real capacity issue for us within
2 Eastern Health and so I think, well, I know
3 that Louise Jones at the time, in consultation
4 with the executive team, we decided we were
5 not going to do that, so Robert was told -
6 COFFEY, Q.C.:
7 Q. And that was communicated to Mr. Thompson?
8 MS. PILGRIM:
9 A. That was communicated and it was communicated
10 to Robert that we're not doing this. If you
11 can come up with a way to do it which is not
12 going to generate thousands of reports, well,
13 then we would look at it. But it was a real
14 capacity issue for us. It raised its head
15 again -
16 COFFEY, Q.C.:
17 Q. Now, was it the fact that it was a capacity
18 issue?
19 MS. PILGRIM:
20 A. Absolutely.
21 COFFEY, Q.C.:
22 Q. Was that communicated to Mr. Thompson?
23 MS. PILGRIM:
24 A. Absolutely, yes.
25 COFFEY, Q.C.:

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1 Q. Okay. I'm sorry, go ahead.
2 MS. PILGRIM:
3 A. And it raised its head again then last month
4 when the other ten patients -
5 COFFEY, Q.C.:
6 Q. By the time -
7 MS. PILGRIM:
8 A. Which we had not known about because some of
9 those were in the other regions. We knew
10 about our four. And so now there are ten
11 more, so Robert, as I told you before, he got
12 NLCHI to come in again and do that review with
13 that one lady and they found her in each way
14 that they did it. So then he realized that
15 the RHAs had done the search differently.
16 COFFEY, Q.C.:
17 Q. Yes.
18 MS. PILGRIM:
19 A. We had done it by ER/PR order, and what we
20 found with most of the people who were missed
21 in our region was that there hadn't been an
22 order written on them.
23 COFFEY, Q.C.:
24 Q. There had been a test done, basically -
25 MS. PILGRIM:

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1 A. Yeah, but it hadn't been ordered -
2 COFFEY, Q.C.:
3 Q. - and it had been -
4 MS. PILGRIM:
5 A. - in the system. So because we searched by
6 order, we missed people.
7 COFFEY, Q.C.:
8 Q. Yes. So just so the Commissioner understands,
9 appreciates that, by the spring, summer,
10 certainly by the summer of 2008 when these
11 ten, and you looked at, well, what of the ten
12 are yours?
13 MS. PILGRIM:
14 A. Right.
15 COFFEY, Q.C.:
16 Q. Eastern Health's?
17 MS. PILGRIM:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. In looking at it you realized, okay, there was
21 no order done for those?
22 MS. PILGRIM:
23 A. Right.
24 COFFEY, Q.C.:
25 Q. Therefore searching the order wouldn't pick it

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1 up?
2 MS. PILGRIM:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. But in the meantime in the vast database
6 involving pathology there was a recording that
7 the test had been actually performed because
8 there was a report saying the results?
9 MS. PILGRIM:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And that's a -
13 MS. PILGRIM:
14 A. When you search by breast and other such
15 words. But the thing is, what you searched
16 was gave you thousands of reports.
17 COFFEY, Q.C.:
18 Q. Yes.
19 MS. PILGRIM:
20 A. And then you had to go in to see if they were
21 really ER/PR reports.
22 COFFEY, Q.C.:
23 Q. Yes.
24 MS. PILGRIM:
25 A. And what we would be looking for.

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1 COFFEY, Q.C.:
2 Q. And in relation to that, so the Commissioner
3 understands this, there's a, I take it, a box
4 or a place in Meditech to check that an ER/PR
5 test has been ordered?
6 MS. PILGRIM:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. It's an order indication?
10 MS. PILGRIM:
11 A. Yeah.
12 COFFEY, Q.C.:
13 Q. And that wasn't always being checked?
14 MS. PILGRIM:
15 A. That's right.
16 COFFEY, Q.C.:
17 Q. Apparently that's -
18 MS. PILGRIM:
19 A. Yes. The pathologists or even sometimes, my
20 understanding, the technologists would tick
21 it. Because it was automatically done so the
22 results were in there, but if you didn't
23 search by results, you searched by order, you
24 missed people and that was how we did that.
25 That was what happened with, you know, the

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1 ones that we had. But -
2 COFFEY, Q.C.:
3 Q. What's the current status of that?
4 MS. PILGRIM:
5 A. The current status of that was in August
6 Robert had the staff from NLCHI went out and
7 met with each of the regional health
8 authorities to have them document, because
9 this is something that they hadn't done with
10 their NLCHI review, they hadn't documented the
11 search strategy.
12 COFFEY, Q.C.:
13 Q. Yes.
14 MS. PILGRIM:
15 A. So they went out to document the search
16 strategy. Robert met with the CEOs. He did
17 not get support from--there was unanimous non-
18 support from the CEOs.
19 COFFEY, Q.C.:
20 Q. Yes.
21 MS. PILGRIM:
22 A. For doing this search would generate thousands
23 of records. And Robert said to the CEOs that
24 he would be pursuing this to get the, you
25 know, to get the search methodologies and then

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1 he would be coming back to have some further
2 discussion. So that's where that is as far as
3 I know. I wasn't at those meetings, I'm
4 hearing that from Louise Jones.
5 COFFEY, Q.C.:
6 Q. Yes. And just so--and you were about to tell
7 the Commissioner, well, you've told the
8 Commissioner that you understand that the
9 search parameters originally used within
10 Eastern Health were to search by order?
11 MS. PILGRIM:
12 A. That's right.
13 COFFEY, Q.C.:
14 Q. ER/PR order -
15 MS. PILGRIM:
16 A. That's correct. This is -
17 COFFEY, Q.C.:
18 Q. That's what Eastern Health did?
19 MS. PILGRIM:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. And I say Eastern Health, that's within St.
23 Clare's, the Grace and the General?
24 MS. PILGRIM:
25 A. Right.

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1 COFFEY, Q.C.:
2 Q. What was done out in Carbonear may have been
3 something different?
4 MS. PILGRIM:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. What was done in Clarenville may have been
8 something different?
9 MS. PILGRIM:
10 A. And I think -
11 COFFEY, Q.C.:
12 Q. And you also were told that, you understand
13 that the other three regions each back in 2005
14 and '06 and '07, for that matter, really up
15 today, had utilized their own search
16 strategies to identify ER/PR primary breast?
17 MS. PILGRIM:
18 A. Right. And it seems like--well, I think you
19 did have some evidence, I think it might have
20 been from Paul Neil.
21 COFFEY, Q.C.:
22 Q. Yes.
23 MS. PILGRIM:
24 A. Some of them did use the word search.
25 COFFEY, Q.C.:

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1 Q. Some did?
2 MS. PILGRIM:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. So did, some didn't, some used paper, and the
6 Commissioner has heard different -
7 MS. PILGRIM:
8 A. And we know that there's not a problem in Dr.
9 Dankwa's area because he actually reviewed
10 every pathology report up there.
11 COFFEY, Q.C.:
12 Q. So, Ms. Pilgrim, from your perspective, in
13 sitting where you have within Eastern Health,
14 when did you first become aware of the fact
15 that different regions used different search -
16 MS. PILGRIM:
17 A. Oh, only the summer when -
18 COFFEY, Q.C.:
19 Q. Summer of '08?
20 MS. PILGRIM:
21 A. - I had--there had been no discussion around
22 that and I hadn't even considered that there
23 would have been different search strategies
24 used. That just came up when I heard about
25 this this summer. And I was on vacation when

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1 most of this was going on.
2 COFFEY, Q.C.:
3 Q. And so, and the current situation is that Mr.
4 -
5 MS. PILGRIM:
6 A. Current situation is Robert has spoken with
7 the CEOs, I think he actually met with them in
8 Corner Brook, they were at a meeting a couple
9 of weeks ago, and he has asked NLCHI to do
10 their reviews and -
11 COFFEY, Q.C.:
12 Q. Of the search strategies?
13 MS. PILGRIM:
14 A. Of the search strategy. And he will be going
15 back to the CEOs, I guess, with whatever
16 proposal he's going to go back with. If he
17 still wants to do it, it would have to be done
18 on a provincial, kind of a provincial project.
19 COFFEY, Q.C.:
20 Q. And just so, again, so we're clear on this,
21 this particular search strategy or if it--
22 search, not search strategy, search strategy
23 or strategies, an actual process?
24 MS. PILGRIM:
25 A. Right.

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1 COFFEY, Q.C.:
2 Q. When implemented, if and when implemented?
3 MS. PILGRIM:
4 A. Right.
5 COFFEY, Q.C.:
6 Q. Would be with the intention of identifying
7 anyone who had an ER/PR test done for primary
8 breast cancer between '97 and 2005 in
9 Newfoundland?
10 MS. PILGRIM:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. Who has yet to be identified to even be
14 retested?
15 MS. PILGRIM:
16 A. That's right.
17 COFFEY, Q.C.:
18 Q. That's so -
19 MS. PILGRIM:
20 A. That's correct.
21 COFFEY, Q.C.:
22 Q. - there could be one or there could be a
23 number of people?
24 MS. PILGRIM:
25 A. That's correct.

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1 COFFEY, Q.C.:
2 Q. And that's unknown?
3 MS. PILGRIM:
4 A. And we know some have called us and have been
5 picked up in that way. And we still encourage
6 women if they have any doubts, to certainly
7 call us.
8 COFFEY, Q.C.:
9 Q. If we could, please, Exhibit P-2379? This is
10 just to pick up the narrative of the deceased
11 patients, Ms. Pilgrim. This is an e-mail from
12 Terry Gulliver of July 9th to yourself and
13 others indicating that "Pat"--I'm sorry,
14 "Barry Dyer," he says, "Pat, Barry Dyer and I
15 have now finalized the list that was given on
16 Friday." And he says, "We are now ready to
17 start pulling original block slides for review
18 and retest, so we need," and he goes on from
19 there. So he's engaged then, I take it, in
20 getting the deceased -
21 MS. PILGRIM:
22 A. Preparing the specimens to go away -
23 COFFEY, Q.C.:
24 Q. Specimens to be sent?
25 MS. PILGRIM:

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1 A. Yes, that's correct.
2 THE COMMISSIONER:
3 Q. Excuse me, Mr. Coffey, but before we leave
4 this matter of sort of the more recent events
5 and what is and isn't going to be covered.
6 You started the description, Ms. Pilgrim, with
7 a reference to the decision that had been made
8 yesterday regarding the "weak positives".
9 MS. PILGRIM:
10 A. Yes.
11 THE COMMISSIONER:
12 Q. And who would they be?
13 MS. PILGRIM:
14 A. That is the lady, Mrs. Coffin.
15 COFFEY, Q.C.:
16 Q. Daphne Coffin.
17 MS. PILGRIM:
18 A. Who -
19 THE COMMISSIONER:
20 Q. Yes. Well, I understand the analogy, but I
21 think what I'm looking for is your definition
22 of weak positive, as to who you're going to
23 cover?
24 MS. PILGRIM:
25 A. Well, that's part of what they have to get

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1 into.
2 THE COMMISSIONER:
3 Q. Oh, okay.
4 MS. PILGRIM:
5 A. They haven't yet.
6 THE COMMISSIONER:
7 Q. So the defining of that particular group with
8 precision hasn't yet occurred?
9 MS. PILGRIM:
10 A. No. And I think I know enough to know that
11 there probably wouldn't be a defining of that
12 group. I think it would be very difficult to
13 do that given that there's no consistency or
14 standardization with how things were reported.
15 I mean, a lot of those reports just have weak
16 or positive and one even had a rosy hue of
17 positivity. I mean, there's everything in
18 those. So I think what the decision is going
19 to be, because this is all about giving
20 patients an opportunity to receive hormonal
21 therapy. So what they are going to do, I
22 think, is they're going to put in a strategy
23 to try to identify patients who were not given
24 Tamoxifen, patients in that--you know,
25 patients who were not given Tamoxifen and then

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1 work back and sort them as to some of them it
2 would be very easy to see why they weren't
3 given, there's very good documentation, they
4 had all these risk factors with blood clots
5 and endometrial cancer. But then they'll come
6 to another group that--and that's the group
7 we're looking at, were there any more like
8 this lady who actually made a decision based
9 on the level of positivity that she had.
10 COFFEY, Q.C.:
11 Q. And in -
12 MS. PILGRIM:
13 A. And that whole area as well as over time,
14 remember when the results changed. So like,
15 2000, 2001, 2002, what was really going on in
16 people's minds and what level of positivity
17 were they taking. So I think they're going to
18 be firstly concentrating on that period of
19 time.
20 COFFEY, Q.C.:
21 Q. Bearing in mind that, for example, a result in
22 2002 locally as reporting as 20?
23 MS. PILGRIM:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Mount Sinai or even here locally now retested,
2 on retest might come up to an 80?
3 MS. PILGRIM:
4 A. Yeah. And we use ten now.
5 COFFEY, Q.C.:
6 Q. Sure, I appreciate that.
7 MS. PILGRIM:
8 A. As you were told, anybody less than that they
9 bring them to the tumour board.
10 COFFEY, Q.C.:
11 Q. What I was getting at just then in that
12 example is is that in 2002 ten was, according
13 to Dr. Laing -
14 MS. PILGRIM:
15 A. The cutoff.
16 COFFEY, Q.C.:
17 Q. - she was using locally?
18 MS. PILGRIM:
19 A. Yeah.
20 COFFEY, Q.C.:
21 Q. A person who was 20 would be in Ms. Coffin's
22 position, kind of on the -
23 MS. PILGRIM:
24 A. Yes, that's right.
25 COFFEY, Q.C.:

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1 Q. - borderline for treatment, maybe?
2 MS. PILGRIM:
3 A. That's the group that they're -
4 COFFEY, Q.C.:
5 Q. But, in fact, they have not been retested to
6 date as a group?
7 MS. PILGRIM:
8 A. No.
9 COFFEY, Q.C.:
10 Q. If they were to be retested, a particular one,
11 it might remain 20 but it might go to -
12 MS. PILGRIM:
13 A. But they might go to 90.
14 COFFEY, Q.C.:
15 Q. 90.
16 MS. PILGRIM:
17 A. Like Mrs. Coffin, yes.
18 COFFEY, Q.C.:
19 Q. Okay. And is there--and I appreciate you were
20 here yesterday, you didn't get to attend the
21 meeting, so. Do you have any sense -
22 THE COMMISSIONER:
23 Q. I don't know if that's good news or bad news.
24 COFFEY, Q.C.:
25 Q. That was -

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1 THE COMMISSIONER:
2 Q. You could ask her where she'd rather be.
3 COFFEY, Q.C.:
4 Q. That's what -
5 MS. PILGRIM:
6 A. I was there in spirit.
7 COFFEY, Q.C.:
8 Q. Okay. Ms. Pilgrim, do you have any sense of,
9 as of now, as to what time period might be
10 required to have this required to have this -
11 MS. PILGRIM:
12 A. I do not, no. I just got a very quick e-mail
13 to say, "Pat, just to let you know, we had
14 this meeting." The other thing I just
15 probably should mention is that, you know,
16 prior to this any discussions that we did have
17 about doing the weak positive, you know, what
18 we're calling them, we all know what we're
19 talking about there, but it's probably not
20 very scientific, but -
21 COFFEY, Q.C.:
22 Q. The weak positive scientifically, apparently
23 it's one to ten -
24 MS. PILGRIM:
25 A. You'd have to have a definition then.

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1 COFFEY, Q.C.:
2 Q. One to ten is usually what they said.
3 MS. PILGRIM:
4 A. Yes. But what we--you know, we certainly
5 didn't have buy in from our pathologists or
6 oncologists initially with this, because they
7 just didn't have the capacity to help with
8 this. So now we did talk to Dr. Maureen
9 Trudeau. She was certainly an outside
10 opinion. She said to us that this would
11 certainly be the right thing to do and said to
12 Kara, obviously Kara disagreed--but didn't
13 disagree with her, but you know, Kara said,
14 well, Maureen, where you live you could
15 probably just go in and press a button and
16 find out who's on Tamoxifen and who isn't. I
17 can't do that. We have to do a chart review.
18 And that's when they got into Maureen saying
19 to Kara, well, you know, maybe this is your
20 opportunity now to get your database, if the
21 system wants this done, this may be the
22 opportunity to do it. So that will start, as
23 well, with this initiative.
24 COFFEY, Q.C.:
25 Q. And in terms of managing or quarter backing

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1 the database or the database, this is Mr.
2 Miller in a technical sense, I take it, is
3 Wayne Miller?
4 MS. PILGRIM:
5 A. Oh, yes.
6 COFFEY, Q.C.:
7 Q. He's the -
8 MS. PILGRIM:
9 A. It won't have anything to do with me, no.
10 COFFEY, Q.C.:
11 Q. No.
12 MS. PILGRIM:
13 A. Research and planning or whomever. They may
14 bring in an outside. We've learned lessons
15 about this, Mr. Coffey, so I don't know who
16 would be doing it.
17 COFFEY, Q.C.:
18 Q. To date it has been Mr. Miller?
19 MS. PILGRIM:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. Within -
23 MS. PILGRIM:
24 A. Mr. Miller has gone off with some suggestions
25 from them and then he will come back after

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1 consulting with various people and who may
2 even be external, I would think, to our
3 organization.
4 COFFEY, Q.C.:
5 Q. If we could, please, Exhibit P-3188. This is
6 an e-mail from Don MacDonald to yourself and
7 Heather Predham, July 10th, 2007, just over a
8 year ago. It says, "Following a review of
9 options put forward to the ministry, the
10 decision to use primary data sources whenever
11 possible and practical was made. As a result,
12 I'm asking for assistance in obtaining the
13 following data", and he goes on through it,
14 lists certain parameters. The reference to
15 the primary data sources, I take it, which
16 began back in early July, 2007, based upon
17 what you just told the Commissioner this
18 morning, I take it is really, in effect, come
19 full circle because now, like, the really
20 primary data sources which is the actual data
21 in the computer systems -
22 MS. PILGRIM:
23 A. Uh-hm.
24 COFFEY, Q.C.:
25 Q. Or on the paper depending upon the paper

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1 records, to date has not actually been
2 exhaustively searched?
3 MS. PILGRIM:
4 A. Well, there's still work being done.
5 COFFEY, Q.C.:
6 Q. Yes, work being done on it.
7 MS. PILGRIM:
8 A. But with NLCHI coming in, I mean, basically it
9 was--I mean, they were the researchers and the
10 epidemiologists and that, and you didn't just
11 tell them it was done, they wanted it in their
12 hand, show me the pathology reports, show me
13 the panel letter.
14 COFFEY, Q.C.:
15 Q. If we could look, please, at Exhibit P-0485,
16 page 49--actually, page 46, I apologize. This
17 is a meeting of regional quality council, July
18 10th '07. You're the chair. Go back to 49,
19 please. Thank you. This is a review of, 7.4,
20 review of sentinel events, process of
21 identifying patients involved. The chair,
22 that's yourself, provided members with details
23 of a discussion by executive members about the
24 process we have been using to develop master
25 lists to identify the patients involved in

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1 ER/PR and radiology issues, and if there's a
2 way to improve what we are doing. Should
3 Eastern Health assign a project manager to
4 task, such as developing master lists, and if
5 so, is there a skill set that we need.
6 Discussion ensued and there was agreement by
7 the regional quality council members that
8 Eastern Health would benefit from assigning a
9 project manager and statistician for larger
10 multi-patient review processes in the future.
11 So that's what you--you kind of alluded to
12 that earlier this morning. That has not been--
13 has that been done by Eastern Health for the
14 ER/PR matter now?
15 MS. PILGRIM:
16 A. Well, for what was left to be done with it, I
17 guess I was the executive lead, which we
18 hadn't really clarified even in the beginning
19 of that because I think you've heard from Dr.
20 Williams and probably Dr. Howell that they
21 were concentrating on one thing, thinking
22 somebody else was concentrating on something
23 else, and for the purposes of the NLCHI
24 database, we really did have Heather Predham,
25 because of her knowledge, as the project

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1 person for that.
2 COFFEY, Q.C.:
3 Q. And so here from assigning--Eastern Health
4 would benefit from assigning a project manager
5 and statistician for larger multi-patient
6 review processes in the future.
7 MS. PILGRIM:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. Whenever they may occur.
11 MS. PILGRIM:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. I'm asking you in terms of Eastern Health and
15 ER/PR itself -
16 MS. PILGRIM:
17 A. Uh-hm.
18 COFFEY, Q.C.:
19 Q. Has that been done?
20 MS. PILGRIM:
21 A. We didn't do that -
22 COFFEY, Q.C.:
23 Q. Has it been done since July of 2007?
24 MS. PILGRIM:
25 A. Well, it's been done in terms of people being

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1 dedicated. Myself, with a lot of my time
2 freed up, and a very definite knowledge that I
3 am in charge of it from an executive lead, and
4 with Heather not multi-tasking, but having her
5 time assigned to it.
6 COFFEY, Q.C.:
7 Q. The project manager end of it, but a
8 statistician is what I'm -
9 MS. PILGRIM:
10 A. Oh, the statistician has come from the--well,
11 NLCHI really. That's who we've been working
12 with. We didn't need anybody else once we had
13 them. One thing I would mention to you, we
14 have--just to try ourselves out, we talk about
15 the lessons learned from this, but one of the
16 things we did do a while ago, we did a table
17 top exercise, and it was very good, actually,
18 but we exercised--so there was another thing
19 that happened and it happened in the lab. It
20 was real, it was a fictional, but it happened
21 and it affected 7,000 patients, and we had to
22 go through a paper exercise of how we would
23 respond to that and what we would do, and
24 we're writing that up now in the learning--but
25 even going through that exercise, there were

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1 things that department heads had to go back
2 and check out in their departments and things.
3 COFFEY, Q.C.:
4 Q. And if we could, please, Exhibit P-0705. This
5 is some e-mails of July 11th, 2007. This is
6 the ATIPP request from Mark Quinn for the
7 identified testing results. This is what this
8 relates to, I gather. Here, July 11th,
9 there's an e-mail from Joyce Penney to
10 yourself and others saying, "Pat, Discussion
11 and direction from executive and further to
12 the discussion at Quality yesterday regarding
13 Mark Quinn's ATIPP request ER/PR, please
14 advise Dan Boone that the organization is
15 not", and it's in caps, "NOT releasing the
16 information requested. Trust this is clear".
17 See that?
18 MS. PILGRIM:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. I take it at the time at that point the
22 executive's position was they were not going
23 to accede to Mr. Quinn's request. That was
24 despite the -
25 MS. PILGRIM:

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1 A. At that time.
2 COFFEY, Q.C.:
3 Q. At that time, yes.
4 MS. PILGRIM:
5 A. That changed.
6 COFFEY, Q.C.:
7 Q. And whose--from your perspective, whose mind
8 changed ultimately?
9 MS. PILGRIM:
10 A. Mrs. Jones made an executive decision on that
11 one.
12 COFFEY, Q.C.:
13 Q. I just want to make sure the Commissioner
14 understands this. Within Eastern Health
15 itself, would it be fair to say that the
16 senior people involved, all of them, almost to
17 a person perhaps, didn't want it released?
18 MS. PILGRIM:
19 A. The discussion that -
20 COFFEY, Q.C.:
21 Q. Would that be correct then?
22 MS. PILGRIM:
23 A. It was discussed at the executive, and there
24 was a decision made that based on the
25 information the executive was given, that we

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1 wouldn't release it. Not everybody was--that
2 wasn't a unanimous decision or anything, and
3 then as Louise--well, you'll have to ask
4 Louise, I don't know, but -
5 COFFEY, Q.C.:
6 Q. She has testified. She has testified here
7 about that.
8 MS. PILGRIM:
9 A. Okay, so she told you about that.
10 COFFEY, Q.C.:
11 Q. And she made an executive decision, same
12 words.
13 MS. PILGRIM:
14 A. Yes, she did.
15 COFFEY, Q.C.:
16 Q. But I'm asking you as a senior executive at
17 the time -'
18 MS. PILGRIM:
19 A. Uh-hm.
20 COFFEY, Q.C.:
21 Q. Observing what you did, okay, and just
22 reflected here, you're being told that the
23 executive's position is we're not going to
24 release it.
25 MS. PILGRIM:

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1 A. Right.
2 COFFEY, Q.C.:
3 Q. Not too long after this, Ms. Jones took it
4 upon herself and she's explained why, she just
5 said it's my decision, I'm going to release
6 it.
7 MS. PILGRIM:
8 A. Right.
9 COFFEY, Q.C.:
10 Q. And it was contrary to the views of many
11 others, the position she finally took?
12 MS. PILGRIM:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. Exhibit P-0979.
16 MS. PILGRIM:
17 A. But I just should for one second go back and
18 say once Louise came out of that meeting, she
19 did consult with some other people outside the
20 organization.
21 COFFEY, Q.C.:
22 Q. Yes.
23 MS. PILGRIM:
24 A. And we weren't privy to their information that
25 they gave, but that helped her make her

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1 decision.
2 COFFEY, Q.C.:
3 Q. And here this is a letter from Louise Jones to
4 Robert Thompson, July 23rd '07. This is
5 telling Mr. Thompson that--informing him that
6 you are going to be--will be the contact
7 person within Eastern Health for the task
8 force. See that?
9 MS. PILGRIM:
10 A. I do.
11 COFFEY, Q.C.:
12 Q. Yes. So it's the official notification to
13 him. Could you tell the Commissioner then
14 because in June and July you would have
15 understood, look, I'm the person to deal with
16 the Commission, I'm the person to deal with
17 Mr. Thompson. How about the person to manage
18 the ER/PR matter itself internally, who was
19 doing that? It comes back to the project
20 manager issue. Was there ever actually a
21 discussion within the organization about,
22 well, here we are in the summer of '07,
23 internally who is going to head this?
24 MS. PILGRIM:
25 A. It would have been me.

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1 COFFEY, Q.C.:
2 Q. I appreciate it ended up you. Was there a
3 discussion about it?
4 MS. PILGRIM:
5 A. Well, that wouldn't have been by chance, Mr.
6 Coffey. I don't think anybody was unclear as
7 to anything to do with ER/PR, it would have
8 been me.
9 COFFEY, Q.C.:
10 Q. Okay.
11 THE COMMISSIONER:
12 Q. At what point did that occur, in your view?
13 MS. PILGRIM:
14 A. Just before, I guess, George left--just when
15 the Commission of Inquiry was announced -
16 THE COMMISSIONER:
17 Q. Uh-hm.
18 MS. PILGRIM:
19 A. I was asked to--you know, asked by George to
20 be the person that would prepare--you know,
21 get the organization prepared for this and be
22 the contact person, and then we got into the
23 NLCHI database review, and then I was asked to
24 stay on top of that. So really once you got
25 into the NLCHI database and you got into the

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1 COI, I mean, you had the ER/PR issue.
2 COFFEY, Q.C.:
3 Q. This might assist you, P-3187. This is the
4 minutes of the Board of Trustees meeting of
5 June 27th '07, and here at the bottom of the
6 page it's noted--well, first of all here, 7.1
7 deals with Commission of Inquiry on ER/PR. At
8 the bottom, the following points were noted in
9 the discussion, bullet at the bottom, "The
10 organization has appointed one point person
11 within the organization to take the lead and
12 manage this file. Pat Pilgrim will assume the
13 role". So it was management involved, dealing
14 with Mr. Thompson, dealing with the
15 Commission, and just managing the file.
16 MS. PILGRIM:
17 A. Whatever had to be done, yes.
18 COFFEY, Q.C.:
19 Q. If we could look, please, at Exhibit P-0488,
20 page 56. This is an executive management
21 meeting of July 25th '07. Look down here and
22 the second last bullet there at the top, in
23 paragraph 2.2, and this deals with Commission
24 of Inquiry, ER/PR. It says, "NLCHI has been
25 requested to develop data information for the

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1 Deputy Minister of Health based on three
2 pointed questions for the period '97 and '98",
3 and would it be '97 and '98, or would it be
4 perhaps '97 through 2005?
5 MS. PILGRIM:
6 A. Should be.
7 COFFEY, Q.C.:
8 Q. '05. One, who were the patients affected;
9 two, how many results changed; three, were
10 they notified. So that was--was that your
11 understanding then as a member of Eastern
12 Health's executive as to what NLCHI was being
13 tasked with?
14 MS. PILGRIM:
15 A. It doesn't--I mean, there were terms of
16 reference for that.
17 COFFEY, Q.C.:
18 Q. Okay.
19 MS. PILGRIM:
20 A. Pretty much, I think. Not stated exactly the
21 way, but there had to be a list of who was
22 tested, did they--did their results change,
23 and were they given the results.
24 COFFEY, Q.C.:
25 Q. Who was tested is not the same thing as asking

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1 who should have been tested using the
2 criteria?
3 MS. PILGRIM:
4 A. No, they had to do a list of all the patients
5 that were tested.
6 COFFEY, Q.C.:
7 Q. Were tested?
8 MS. PILGRIM:
9 A. Yes. They really came in and replicated what
10 we did.
11 COFFEY, Q.C.:
12 Q. But the whole issue of who perhaps should have
13 been tested which is a wider -
14 MS. PILGRIM:
15 A. Came up after.
16 COFFEY, Q.C.:
17 Q. Came up after?
18 MS. PILGRIM:
19 A. Uh-hm. I guess, as I told you before, it
20 might be hard for you to believe, Mr. Coffey,
21 but there was a point at which we thought we
22 had done this pretty well. You know, we were
23 on top of this.
24 COFFEY, Q.C.:
25 Q. Certainly Mr. Thompson has told the

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1 Commissioner that when he first got involved,
2 he certainly thought or he understood--that
3 was his understanding.
4 MS. PILGRIM:
5 A. Right.
6 COFFEY, Q.C.:
7 Q. Exhibit P-1514. This is an e-mail, July 30th
8 from Ms. Jones to yourself and Dr. Howell, re;
9 ER/PR notification of deceased relatives, and
10 she writes, "Pat, as per our discussion, this
11 appears to be a reasonable way to proceed. I
12 will defer to Oscar about the panelling, but
13 as per our discussion, if there was a change
14 and the family does wish the results, we
15 should be able to indicate like we have with
16 the other clients whether a patient treatment
17 change would have been proposed. I will be
18 interested in seeing the proposed letter to
19 next of kin before we do any mail outs, and
20 did the group have any discussion with respect
21 to whether this would be a phone call or a
22 letter". I take it this is the whole idea of
23 notifying the relatives of the deceased about
24 the retesting fact and the results?
25 MS. PILGRIM:

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1 A. That's correct, yes. We started down one path
2 with this, but we had to go to plan B.
3 COFFEY, Q.C.:
4 Q. So the path--I would just ask you to perhaps--
5 perhaps without even taking you through
6 because there's a lot of documentation here
7 which refers to that, the path initially
8 decided upon was what?
9 MS. PILGRIM:
10 A. The path initially is that we were really
11 going to do with the next of kin of the
12 deceased the same as we did with the living.
13 They were going to be retested, we were going
14 to give them their results, there would be
15 panelling of the ones that changed and there
16 would be meetings set up with oncologists to,
17 you know, meetings set up with next of kin to
18 give results.
19 COFFEY, Q.C.:
20 Q. Uh-hm.
21 MS. PILGRIM:
22 A. That was--you know, that was just an
23 assumption, I guess, on everybody's part.
24 COFFEY, Q.C.:
25 Q. And, in fact, it got so far, though, didn't it

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1 as involving you notifying the other regions
2 that that was the case?
3 MS. PILGRIM:
4 A. It was, yes, we did.
5 COFFEY, Q.C.:
6 Q. So it got to the point where you actually sent
7 out a very detailed e-mail?
8 MS. PILGRIM:
9 A. We did about that.
10 COFFEY, Q.C.:
11 Q. To all the other--your counterparts in other
12 regions.
13 MS. PILGRIM:
14 A. This is what we're going to do.
15 COFFEY, Q.C.:
16 Q. And the plan, which you've just summarized, is
17 laid out in very much detail there in terms of
18 this and we will, in fact, panel the deceased
19 situation.
20 MS. PILGRIM:
21 A. Correct.
22 COFFEY, Q.C.:
23 Q. And be prepared to tell them whether--their
24 relatives, whether or not the deceased person
25 probably would have been offered Tamoxifen or

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1 not?
2 MS. PILGRIM:
3 A. And we even offered our panel to them.
4 COFFEY, Q.C.:
5 Q. Yes, to the other regions.
6 MS. PILGRIM:
7 A. We did.
8 COFFEY, Q.C.:
9 Q. At that point had the oncologists been
10 consulted about being involved?
11 MS. PILGRIM:
12 A. Again I can only speak from my perspective,
13 but I probably was the one who knew the most
14 about this. I would have to say to you that
15 we made a big assumption and there wasn't the
16 correct consultation with the oncologists
17 because when we actually sat down to talk to
18 he oncologists and the pathologists, it became
19 very clear that they were not going to be
20 directly involved in this.
21 COFFEY, Q.C.:
22 Q. And did they give a reason for it?
23 MS. PILGRIM:
24 A. Yes, they certainly--well, first of all, they-
25 -well, the main thing was that to sit down

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1 with next of kin of family members of those
2 that had deceased, you would not be able to
3 give them a lot of the answers that they would
4 be seeking, and you would be very much into a
5 what if kind of conversation, and, you know,
6 they really didn't think that that would be
7 that helpful for people, and they certainly
8 did not want themselves get involved in those
9 discussions. So we then had to go to plan B,
10 and first of all we looked to see if there
11 were other oncologists who would come and help
12 us because we knew that our oncologists,
13 obviously, were up to their ears in work,
14 would there be somebody who for a price might
15 come and help us with this. There were--Dr.
16 Howell, I think, had contacted a couple of
17 areas that he knew people just to see. We
18 went to the Canadian Association of Medical
19 Oncologists to see if--I don't think we
20 actually made contact with them, but we were
21 thinking about going through them, and we had
22 a letter written to go to the Canadian
23 centres. We knew--we had addresses for all of
24 those. So there was some phone calls made, I
25 think, through Dr. Howell, and there was

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1 nobody who could help us. We did contact, I
2 think, Cancer Care Ontario, and probably BC
3 Cancer Institute just asking the executive
4 directors there if the thought there would be
5 anybody who could help us with this, and the
6 answer was no. We didn't get anything to our
7 few queries that we made. Then we wrote a
8 letter and we had a meeting with Joy McCarthy
9 and Kara Laing, actually, to show them the
10 letter that we were going to send, and, you
11 know, they basically said to us, if I read
12 that letter, I would never get involved in
13 this, because basically in the letter we had
14 to say--give a sense of what was happening in
15 the province, tat there was a Commission of
16 Inquiry going on, etc, etc, and their advice
17 to us would be that any oncologists would stay
18 as far away from this as they could get, don't
19 expect to get very many volunteers. So then
20 we had a problem because now -
21 COFFEY, Q.C.:
22 Q. Was any thought given to going to the United
23 States?
24 MS. PILGRIM:
25 A. Yes, it was. We talked about that as well.

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1 COFFEY, Q.C.:
2 Q. And what happened?
3 MS. PILGRIM:
4 A. There was more of a concern there as to who
5 you would get, and, you know, you can put out
6 a request sometimes, but you really don't know
7 the calibre of the person that you're getting.
8 Now I left that kind of to the doctors to talk
9 about that, but I know there was nobody really
10 keen on doing that.
11 COFFEY, Q.C.:
12 Q. You left that--so your impression at the time
13 was from the physicians you were talking to
14 locally -
15 MS. PILGRIM:
16 A. Yeah.
17 COFFEY, Q.C.:
18 Q. That they were not prepared -
19 MS. PILGRIM:
20 A. They knew centres that you could contact
21 certainly, and--but now you were going to
22 another country, you were contacting people
23 outside the country, how available would they
24 be to you, how long would it take for this to
25 happen, and, you know, at that point we just

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1 said this is not a good idea.
2 COFFEY, Q.C.:
3 Q. Ms. Pilgrim, on that point, by that point in
4 time--this would have been happening
5 approximately when?
6 MS. PILGRIM:
7 A. This would have been in, I don't know, March,
8 April, whenever--whenever we started this
9 retesting. So it would have been probably the
10 spring or the--I don't know when--when did we
11 actually start retesting?
12 COFFEY, Q.C.:
13 Q. The retesting started in the summer into the
14 fall of '07.
15 MS. PILGRIM:
16 A. Okay, so it would have been before that,
17 before that time.
18 COFFEY, Q.C.:
19 Q. Before that?
20 MS. PILGRIM:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Before that, because you actually communicated
24 to the other boards in the fall of '07 that we
25 plan to use panelling for the deceased, so you

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1 wouldn't have known that you had to go looking
2 for outsiders until the local oncologists -
3 MS. PILGRIM:
4 A. Okay, so it would have been in the fall.
5 COFFEY, Q.C.:
6 Q. The fall.
7 MS. PILGRIM:
8 A. Of that year.
9 COFFEY, Q.C.:
10 Q. Of '07?
11 MS. PILGRIM:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. On that point, okay, by that point, were you
15 aware that how this all got started involved a
16 consultation with an oncologists in New York?
17 MS. PILGRIM:
18 A. Oh, yes, and I -
19 COFFEY, Q.C.:
20 Q. So the idea of consulting outside -
21 MS. PILGRIM:
22 A. No, no, no, but this wasn't just a
23 consultation now. This was a lot of time that
24 would have to be committed, would we have to
25 fly these people in to talk to patients, could

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1 this be done over the phone. It just got a
2 bit far fetched when we were getting into
3 that. It wasn't just doing a consultation or
4 sending one patient down to a doctor in Boston
5 or sending some specimens off.
6 COFFEY, Q.C.:
7 Q. I just--if I could on that point, explore that
8 a bit. If you were going to utilize an
9 oncologist, for example, out of Vancouver,
10 Boston is an awful lot closer, and New York is
11 than Vancouver. So I -
12 MS. PILGRIM:
13 A. Yeah, but I guess what I'm -
14 COFFEY, Q.C.:
15 Q. If you could tell the Commissioner then -
16 MS. PILGRIM:
17 A. Well, I guess this wasn't well thought through
18 in the beginning, and as we started thinking
19 through it, it became less and less feasible
20 and less and less practical whether you were
21 talking about bringing them from Halifax or
22 you were talking about bringing them from
23 Vancouver. It was something that we assumed
24 was going to happen and the more we talked
25 about, the least practical and feasible it

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1 appeared. So we aborted any further
2 discussion of that. Then we went forward with
3 the plan where we would make the results
4 available. You know that we did have an
5 ethics review on this.
6 COFFEY, Q.C.:
7 Q. Yes.
8 MS. PILGRIM:
9 A. And sometimes I ask myself why I would have
10 had an ethics review on this.
11 COFFEY, Q.C.:
12 Q. Because you're the one who requested it, in
13 fact?
14 MS. PILGRIM:
15 A. I was, yeah, but the ethics review was more,
16 you know, based on our values and things as an
17 organization, what should we be doing here
18 with, you know, what is the least, I guess,
19 that's expected of us from the patients and
20 families point of view.
21 COFFEY, Q.C.:
22 Q. Now the ethics review, first of all, the one
23 that you were involved in, was the one
24 involving contacting--the idea of sending a
25 letter or contacting patients generally?

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1 MS. PILGRIM:
2 A. Well, that's the apology letter, but I knew
3 there was an ethics -
4 COFFEY, Q.C.:
5 Q. Oh, you knew about the other one, okay.
6 MS. PILGRIM:
7 A. I wasn't there, but I knew about it.
8 COFFEY, Q.C.:
9 Q. You knew about the one involving the deceased?
10 MS. PILGRIM:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. In terms of this--and what then happened?
14 MS. PILGRIM:
15 A. Well, out of the ethics review, I guess, that
16 kind of helped us make a decision.
17 COFFEY, Q.C.:
18 Q. Which -
19 MS. PILGRIM:
20 A. As to how we were going to proceed.
21 COFFEY, Q.C.:
22 Q. Which ethics review was that?
23 MS. PILGRIM:
24 A. This is the one for the deceased.
25 COFFEY, Q.C.:

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1 Q. Back in '06 that would have been?
2 MS. PILGRIM:
3 A. Yes, that we were going to--but we still
4 referred back to that when we were getting
5 ready to--because we're only now getting ready
6 to become active with this, right.
7 COFFEY, Q.C.:
8 Q. Go ahead.
9 MS. PILGRIM:
10 A. So we know the specimens have been sent off
11 for retesting and now we're trying to figure
12 out how are we going to notify next of kin
13 about the results. Again in consultation with
14 our oncologists, in particular, and also, you
15 know, with the usual group, I guess. We would
16 have had Kara Laing, probably Joy McCarthy,
17 Dr. Howell, probably Pam Elliott from Quality,
18 talking about this, and the decision that we
19 made was there was some concern that if you--
20 and, I mean, in my mind there's no right
21 answer to these things, but there was some
22 concern that if you just go ahead and send the
23 results, you could be seen as imposing
24 something upon families that maybe they do not
25 want to have imposed upon them, and because of

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1 where they are in the grieving process, or,
2 you know, in their lives. So the decision was
3 made that we would have the tests come back
4 and we would announce to the public that the
5 test results were back and there is a number,
6 and if you would like to call to have the
7 results, we will make them available to you.
8 We knew that in doing that there would be some
9 people who would want more information than we
10 were able to give them. We being again now--
11 this was coming through Sharon Smith's office
12 at this time, and the oncologists had said to
13 us if you are dealing with our patients,
14 patients of ours who have been deceased, do
15 not hesitate to call us because we will talk
16 to the next of kin, and if you are dealing
17 with others, you can talk to us as well, and
18 we will try to help you out. So we went
19 forward with we're going to give this
20 information out, we're going to try to put
21 these people onto somebody, and I think our Q
22 and A's that we went forward with was
23 initially we were going to ask families to
24 talk to their family doctor, and then the
25 family doctor could contact an oncologist if

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1 someone wanted to come and talk to them. So
2 that's what we went forward with, that's what
3 we did.
4 COFFEY, Q.C.:
5 Q. And so it's been left then to the family
6 members to contact if they're aware of the
7 availability -
8 MS. PILGRIM:
9 A. We talked to them, we had an information sheet
10 for them, and we encouraged them to talk to
11 their primary physician.
12 COFFEY, Q.C.:
13 Q. But have they been contacted directly by
14 Eastern Health?
15 MS. PILGRIM:
16 A. No, if they phoned in.
17 COFFEY, Q.C.:
18 Q. No, that's what I understood.
19 MS. PILGRIM:
20 A. No, no, no, only people who called, yeah, and
21 we did public service announcements and some
22 newspaper ads, and, you know, locally,
23 provincially, and also nationally.
24 COFFEY, Q.C.:
25 Q. If I could then in terms of the way this

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1 finally turned out, the local oncologists have
2 told you that if the relative of a deceased
3 does contact Eastern Health about ER/Pr, and,
4 for example, I take it if the person's results
5 haven't changed, well, that's relatively
6 straightforward, presumably the treatment
7 wouldn't have changed.
8 MS. PILGRIM:
9 A. Right.
10 COFFEY, Q.C.:
11 Q. The retest results--results from retest are
12 the same, but if they have changed, they've
13 converted, that if the relatives wished to
14 speak with--initially they'll speak with
15 Sharon Smith, I take it, if they call locally?
16 MS. PILGRIM:
17 A. Right.
18 COFFEY, Q.C.:
19 Q. And the understanding is that Ms. Smith can
20 consult the oncologist about a case?
21 MS. PILGRIM:
22 A. That's correct.
23 COFFEY, Q.C.:
24 Q. And the oncologist, if they are local
25 patients, they deceased were local patients,

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1 the oncologists will get involved in the
2 discussions if they're asked?
3 MS. PILGRIM:
4 A. It didn't have to be local patients.
5 COFFEY, Q.C.:
6 Q. I appreciate that.
7 MS. PILGRIM:
8 A. Not St. John's.
9 COFFEY, Q.C.:
10 Q. Not St. John's, the Cancer Clinic is what I'm
11 talking about.
12 MS. PILGRIM:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. Yes.
16 MS. PILGRIM:
17 A. Patients of a present oncologist. Obviously,
18 they'd have no problem speaking to them
19 because they knew the case.
20 COFFEY, Q.C.:
21 Q. And if they were patients of a former
22 oncologist here in St. John's or -
23 MS. PILGRIM:
24 A. Or never a patient of oncology.
25 COFFEY, Q.C.:

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1 Q. They are prepared to?
2 MS. PILGRIM:
3 A. They didn't say they wouldn't. They said, you
4 know, you know we'll always try to help you
5 out. I mean, that's what Kara Laing and them
6 are like, anyway, so--but, you know, they
7 certainly weren't going to put themselves in a
8 position where we're going to be setting up
9 meetings and they're going to be sitting down
10 with people that they didn't even know the
11 cases, but they certainly said that, you know,
12 we'll help you in whatever way we can.
13 COFFEY, Q.C.:
14 Q. So in those sorts of meetings, you would
15 anticipate, would you, that if they were to
16 occur, might very well involve the deceased
17 relatives asking an oncologist, well, would my
18 wife -
19 MS. PILGRIM:
20 A. Would my wife still be alive today or -
21 COFFEY, Q.C.:
22 Q. Or would she have been treated, based upon
23 these new results?
24 MS. PILGRIM:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. And they have expressed an indication that
3 they would engage in that?
4 MS. PILGRIM:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. Which is, in effect, a panelling?
8 MS. PILGRIM:
9 A. Yeah, but these patients--the results of the
10 deceased were not panelled.
11 COFFEY, Q.C.:
12 Q. I appreciate that, but that process itself, in
13 effect, in one way -
14 MS. PILGRIM:
15 A. See that was their difficulty with patients
16 that they didn't know, you see. You know,
17 their own patients, they knew the cases and
18 they could talk about that, but it was even
19 difficult for them to talk about that, you
20 know. We're talking about, well, what if,
21 what if she had had, and I think it was at
22 that point--they even had--I think Joy
23 McCarthy might have talked about it. They had
24 like a software package that they used to do
25 some -

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1 COFFEY, Q.C.:
2 Q. Yes, she's told the Commissioner about that.
3 MS. PILGRIM:
4 A. Yeah.
5 COFFEY, Q.C.:
6 Q. So if I could then to take up the narrative,
7 Exhibit P-1517. This is an e-mail from
8 yourself, August 5th, 2007, to Louise Jones
9 and others involving a CBC media meeting, and
10 you described, "Hi, just let you know that I
11 accompanied Nash Denic on an interview and
12 tour of the lab, IHC lab on Friday. The
13 reporter is a CBC producer of radio
14 documentaries", and you say Nash did very
15 well, and you go on to talk about what had
16 occurred. Toward the end of this you say, "At
17 the end, he [that would be Nash] asked her,
18 the reporter, to please use her ability to get
19 the message out that this is a test that is
20 evolving and getting better, but we are not
21 there yet, and what we have done here has not
22 been done anywhere else that he knows about.
23 She did not commit to anything really, but
24 answered, "But what about all of those women
25 I've talked to over the past few days". So

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1 this is the overview of what went on. God
2 knows what this will sound like when she puts
3 it together. "Susan, can we find out when
4 that will air?" Signed, "Pat." I take it in
5 terms of that last comment that's reflective
6 of the attitude you've indicated to the
7 Commissioner yesterday in your experience of
8 health personnel vis-a-vis the media and
9 interaction with them, you're uncomfortable
10 dealing with the media, that sort of
11 expression there?
12 MS. PILGRIM:
13 A. "God knows what this will sound like when she
14 puts it together." I guess, you know, any
15 time you do this kind of a walk about and talk
16 about so many things, you never know what it's
17 going to look like when it comes out.
18 COFFEY, Q.C.:
19 Q. Now, here the reference to Dr. Nash having
20 said these things, "Ask her to please use her
21 ability to get the message out."
22 MS. PILGRIM:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. "This test is evolving, getting better." And

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1 the "Not done anywhere else," I take it, is
2 the retest issue, that it had never been done
3 anywhere?
4 MS. PILGRIM:
5 A. That's right, that's right.
6 COFFEY, Q.C.:
7 Q. But the notion that "This is a test that is
8 evolving and getting better," at the time, as
9 you would have accompanied Nash Denic with the
10 reporter, or accompanied the reporter during
11 the interview with Nash Denic, do you recall
12 whether Dr. Denic advised the reporter at that
13 time about the nature of what had been found
14 about why the problem had occurred, we didn't
15 have sufficient QA here, we had problems with
16 interpretation, we had problems with not using
17 internal controls, things like that? Did he
18 tell her actually anything about why this had
19 occurred?
20 MS. PILGRIM:
21 A. I don't remember. I don't think he did get
22 into that with her. She was very, she was
23 obviously going to be doing a human interest
24 story on this. She wasn't really--she was
25 more interested in asking questions about, you

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1 know, asking me were you shocked about the
2 lawsuit. And she wanted to see what a lab
3 looked like because she was going to be
4 running this story on it. She had obviously
5 talked to a lot of the ladies and their
6 families who had been affected by this before
7 she came here. And she wasn't really that
8 interested in the technical piece of this at
9 all. This was going to be a human, whatever
10 you call it, a human--I was going to call it -
11 COFFEY, Q.C.:
12 Q. Human interest story?
13 MS. PILGRIM:
14 A. Human interest story, yes.
15 COFFEY, Q.C.:
16 Q. Exhibit P-0714, please? This is an e-mail of
17 August 6th, 2007 from Louise Jones to Robert
18 Thompson saying, "We have already indicated to
19 Heather that she is to work with Reza and get
20 this work complete when she returns from
21 holidays. Heather is essentially released
22 from all" I'm sorry, "other duties and is
23 solely working on the ER/PR file." I take it
24 that was because NLCHI needed time from her?
25 MS. PILGRIM:

1 A. Well, they had asked, you know.
2 COFFEY, Q.C.:
3 Q. Yes.
4 MS. PILGRIM:
5 A. Are we going to make her available, and we
6 said, well, she's already solely working on
7 that file, so.
8 COFFEY, Q.C.:
9 Q. So that was, by that point in time that was
10 her job?
11 MS. PILGRIM:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. The file, period?
15 MS. PILGRIM:
16 A. Yeah, really, yeah. She was probably doing a
17 few other things, but for the most part I had
18 made it clear to Pam Elliott that that was
19 really Heather's job.
20 COFFEY, Q.C.:
21 Q. Exhibit P-0998? This is a series of e-mails
22 of August 6th and 7th between yourself and
23 others. And they involve, Ms. Pilgrim, it
24 relates to the covering letter that, potential
25 covering letter that was going to go with

1 that, de-identified data that was going to
2 Mark Quinn. And you're giving some editorial
3 input here on August 6th. And you do note
4 here that you were going to ask that any such
5 letter be run by the lawyers involved, which
6 would be Dan Boone or his associate and Mr.
7 Simmons, as well, I take it?
8 MS. PILGRIM:
9 A. At this point this would -
10 COFFEY, Q.C.:
11 Q. At that point, yes.
12 MS. PILGRIM:
13 A. - have been both.
14 COFFEY, Q.C.:
15 Q. And here is, here at the top of the page
16 you've written to Marion Crowley saying "I was
17 talking to Susan yesterday and that is when
18 this suggestion was made to actually come out
19 and tell him about trying to get an error
20 rate." Signed, "Pat." What was that about?
21 MS. PILGRIM:
22 A. This was the number--this was when Mark Quinn
23 asked for all the results -
24 COFFEY, Q.C.:
25 Q. The de-identified -

1 MS. PILGRIM:
2 A. - original and this is the one that Louise
3 finally had to make an executive decision on.
4 COFFEY, Q.C.:
5 Q. Sure.
6 MS. PILGRIM:
7 A. And this was a list of patients who had been
8 negative who had been retested. And our
9 concern within Eastern Health was that this
10 reporter wanted this information because he
11 was going to come up with and report an error
12 rate. And we just wanted to make it, just
13 make it very clear to him that he could not
14 use this information to do that, to come up
15 with an error rate. That was what this was
16 about.
17 COFFEY, Q.C.:
18 Q. Okay.
19 MS. PILGRIM:
20 A. And trying to just make sure that he knew
21 that. Now, whatever he went off and did or
22 whatever, but we just wanted to make that
23 crystal clear to him.
24 COFFEY, Q.C.:
25 Q. Exhibit P-0722? This is an e-mail of August

1 8th, 2007 from Louise Jones to yourself and
2 Dr. Howell and copied to others. She says,
3 "Just met with Robert Thompson, Don MacDonald
4 and Dr. Reza to discuss the development of the
5 ER/PR database and to overview the work that
6 was already under way." And she goes on to
7 say, "We talked about the current process and
8 Robert was particularly interested in
9 completing the work on the 939 and then going
10 back to generate the master list." Now, this
11 master list would be a master list of what?
12 Because it does go on to say, "Master list,
13 this was put on hold by Robert until had the
14 93 list."
15 MS. PILGRIM:
16 A. Initially I think they were going to do the
17 list of all the positives. They were going to
18 have the whole list, everybody that had
19 testing done, that was initially.
20 COFFEY, Q.C.:
21 Q. Have you been told, at any point, by anyone
22 who was knowledgable, methodologist sorts,
23 epidemiology sorts, that for this to be from
24 an epidemiologist's perspective, valuable,
25 that the positives would have to be included?

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1 MS. PILGRIM:
2 A. I've been told many things by methodologists
3 over this time, Mr. Coffey, starting with you
4 never should have done what you did in the
5 first place. But, well, yes, especially if
6 you're trying to get at error rates and things
7 like that, that you should take the whole
8 cohort, you know, everybody. But I've been
9 told different things.
10 COFFEY, Q.C.:
11 Q. Okay. Mr. -
12 MS. PILGRIM:
13 A. I know that they started off to get the
14 numbers.
15 COFFEY, Q.C.:
16 Q. Yeah. And so as of, just so the Commissioner
17 understands it, this was put on hold by Robert
18 because Mr. Thompson and NLCHI were trying to
19 even just verify the 939 list?
20 MS. PILGRIM:
21 A. They were having--yeah, they were going to
22 have to take some time -
23 COFFEY, Q.C.:
24 Q. Go through that?
25 MS. PILGRIM:

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1 A. - to do that.
2 COFFEY, Q.C.:
3 Q. And, in fact, that's still going on?
4 MS. PILGRIM:
5 A. Pretty much now. Not much going on with that.
6 COFFEY, Q.C.:
7 Q. Except for this three full search -
8 MS. PILGRIM:
9 A. Every now and then, you know. But I can never
10 say because with this I never say never. But
11 pretty much now there's not much work going on
12 with this.
13 COFFEY, Q.C.:
14 Q. Except Reza's--the whole idea of looking at
15 the search parameters and going back?
16 MS. PILGRIM:
17 A. Oh, whatever comes out of that, yes, that's
18 definitely a big one that's being talked
19 about.
20 COFFEY, Q.C.:
21 Q. And the idea of including all the positives
22 has not yet been revisited?
23 MS. PILGRIM:
24 A. The idea of reviewing -
25 COFFEY, Q.C.:

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1 Q. No, including all the positives in the
2 database. I apologize. No, that's fine. Had
3 the idea of including all the positives, it's
4 been most recently talked about?
5 MS. PILGRIM:
6 A. It's been talked about, yes.
7 COFFEY, Q.C.:
8 Q. Okay. But it hasn't actually -
9 MS. PILGRIM:
10 A. Well, we're not going to do it.
11 COFFEY, Q.C.:
12 Q. Okay, that's the one, okay.
13 MS. PILGRIM:
14 A. As Eastern Health, yeah.
15 COFFEY, Q.C.:
16 Q. Thank you. If we could, please, Exhibit P-
17 1039? And this is just to give the
18 Commissioner some sense of what, as time
19 evolved, what was going on and the
20 relationships and interaction in them. Here
21 at the bottom of the page is an e-mail from
22 Robert Thompson, October 30th, to Ms. Jones,
23 in effect. She says, he talks about regarding
24 a Thursday meeting on ER/PR. "You'll be
25 coming over here for a 10 a.m. meeting on

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1 'owner board' issues."
2 MS. PILGRIM:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. And there here Louise goes back and says,
6 "I'll have Pat Pilgrim and others with me."
7 So I take it then that at various times from
8 time to time there had been meetings involving
9 the executive of Eastern Health with Mr.
10 Thompson and his people?
11 MS. PILGRIM:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. In terms of deciding who owns what and who's
15 going to -
16 MS. PILGRIM:
17 A. Now, that owner board had nothing to do with
18 ER/PR.
19 COFFEY, Q.C.:
20 Q. Yes, okay.
21 MS. PILGRIM:
22 A. That has to do with a totally different thing.
23 COFFEY, Q.C.:
24 Q. Okay.
25 MS. PILGRIM:

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1 A. He says, "We're meeting about the 'owner
2 board', could we meet before?"
3 COFFEY, Q.C.:
4 Q. In terms of with the whole idea then of who
5 owns what in ER/PR, I'll ask you about that.
6 I take it from time to time that's been
7 discussed?
8 MS. PILGRIM:
9 A. No, what would happen there, Mr. Coffey,
10 usually, would be there would be an issue that
11 needs to be clarified between Heather and
12 Reza, who was working with NLCHI, or Terry.
13 And usually there would be a disagreement
14 about whether a patient should be in the
15 database or not or whether this patient should
16 have been part of the retesting or not. So
17 those were the things that we unusually used
18 to have to get together about and come to some
19 understanding. We didn't always agree on
20 everything.
21 COFFEY, Q.C.:
22 Q. Yes. Exhibit P-3193. Now, this is an e-mail,
23 it's two e-mails, one from yourself to Louise
24 Jones on September 17th, the other from
25 yourself to Dr. Howell, Wayne Miller and

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1 Heather Predham. And the latter three you
2 said, "This is what I sent. Anything major I
3 left out, please advise ASAP?" And then here
4 you're reporting to Ms. Jones, I take it, on
5 the issues involving the database as it was at
6 the time? This would be kind of a summary at
7 the time for Ms. Jones?
8 MS. PILGRIM:
9 A. That's correct.
10 COFFEY, Q.C.:
11 Q. And this relates to getting access, in fact,
12 to the data involving the other authorities?
13 MS. PILGRIM:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. You're requesting that she take that up with
17 Robert, he'd be able to pass it back. He
18 would cause NLCHI to pass it back to--or pass
19 data back to Eastern Health. Exhibit P-0488,
20 page 65. Actually, page 64. Just go back
21 one. This is an executive management meeting
22 of September 19th, '07. You're listed there.
23 I just wanted to ask you about, this is page 4
24 of those minutes, it says, "Deceased patients.
25 There are approximately 21 families of

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1 deceased patients that have not been
2 contacted. There was a conscious decision to
3 wait until the clinical significance component
4 was completed prior to calculating families of
5 the deceased. However, in light of the delay
6 due to the compensation issue for physicians,
7 a decision had to be made to review the 21
8 files in question and how we will proceed."
9 Do you recall what that was about?
10 MS. PILGRIM:
11 A. Well, if we're talking--you know, I really
12 don't. If we're talking about--when was this,
13 in September?
14 COFFEY, Q.C.:
15 Q. September 19th, 2007.
16 MS. PILGRIM:
17 A. Which if we're talking about the contacting
18 deceased, it must have been patients who had
19 become deceased since we did the testing,
20 because we weren't contacting the other, you
21 know, the next of kin. "It was a conscious
22 decision to wait until the clinical
23 significance" -
24 COFFEY, Q.C.:
25 Q. Well, I was--"In light of the delay due to the

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1 compensation issue for physicians," I wanted
2 to ask you about that, if you recall anything
3 about that?
4 MS. PILGRIM:
5 A. There was an issue about compensation for -
6 THE COMMISSIONER:
7 Q. Mr. Simmons (inaudible) are just sitting down,
8 Mr. Simmons.
9 MR. SIMMONS:
10 Q. I think I know what this one is about.
11 COFFEY, Q.C.:
12 Q. Okay, if I -
13 MR. SIMMONS:
14 Q. I don't want to interfere.
15 COFFEY, Q.C.:
16 Q. No, no, no, not at all. I'm just asking -
17 THE COMMISSIONER:
18 Q. Do you -
19 MR. SIMMONS:
20 Q. This relates to Burin radiology.
21 MS. PILGRIM:
22 A. That's what I'm thinking, because -
23 COFFEY, Q.C.:
24 Q. Okay, and it may be.
25 MS. PILGRIM:

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1 A. That is exactly what it is.
2 COFFEY, Q.C.:
3 Q.- it's just that sometimes it's difficult--okay.
4 MS. PILGRIM:
5 A. Because that was the compensation issue.
6 COFFEY, Q.C.:
7 Q. Okay, thank you. Again, sometimes it's
8 difficult to tell from the minutes as to what
9 they relate to. Thank you, Mr. Simmons.
10 THE COMMISSIONER:
11 Q. Okay. So this has nothing to do with ER/PR?
12 COFFEY, Q.C.:
13 Q. No, that's fine.
14 MS. PILGRIM:
15 A. And I should have been able to tell by the
16 action, because my name is not there.
17 COFFEY, Q.C.:
18 Q. Okay.
19 THE COMMISSIONER:
20 Q. Good, I can erase two whole lines.
21 COFFEY, Q.C.:
22 Q. Now, here Exhibit P-1427. This is an e-mail
23 of October 4 from Ms. Predham to a number of
24 individuals, including yourself. It follows
25 up on an October 1 meeting. "Disclosure

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1 options.doc." "Hi, everyone, As promised at
2 the last meeting and for discussion at the
3 meeting on the 15th I am circulating to you
4 two options of a possible letter for
5 communicating the results of the deceased.
6 Thanks, Heather." We go to the next page,
7 that's "dear" and then there's option one and
8 two. And then there's a specific example of
9 option two. See that?
10 MS. PILGRIM:
11 A. I do.
12 COFFEY, Q.C.:
13 Q. Now, I take it at that point consideration was
14 being given to sending a letter?
15 MS. PILGRIM:
16 A. Yes, initially.
17 COFFEY, Q.C.:
18 Q. Initially. Exhibit P-3076? This was despite
19 the fact that that June, 2006 ethics consult
20 had occurred and you would have been aware of
21 it?
22 MS. PILGRIM:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. At this point there's still thought being

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1 given to sending a letter. You, on October
2 4th, came back to Ms. Predham saying, "I also
3 prefer the first option. I'll point out some
4 other people prefer the first option, as well.
5 The question you asked is very interesting. I
6 would consider that we use the same line we
7 always do. You know which one that is. Or we
8 could talk to the cancer centre to have them
9 take over this time. Once we make that
10 decision the decision of who actually sits
11 down with them is one Oscar is still working
12 on." Signed, "Pat." So -
13 MS. PILGRIM:
14 A. That's what we talked about before, right, the
15 -
16 COFFEY, Q.C.:
17 Q. So if we could on that, go back P-1426? Here
18 at the bottom of the page, October 4th, Dr.
19 Howell has weighed in back to Ms. Predham and
20 all of you saying, "I too favour option one."
21 MS. PILGRIM:
22 A. Yeah.
23 COFFEY, Q.C.:
24 Q. And then Ms. Predham had responded to
25 everyone, to him and everyone else saying,

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1 "Thank you for the responses do far, but don't
2 forget to consider options as to who is going
3 to sign this letter and who's going to talk to
4 the patients whose oncologist no longer is
5 practising here. Thanks, Heather." So then
6 if we could go back then to 3076? Because
7 Heather's e-mail out saying, talking about
8 who's going to sign this is at 12:10 p.m.
9 About four and a half minutes later you send
10 an e-mail saying you prefer the first option
11 and you say "The question you asked is very
12 interesting." Which question is that?
13 MS. PILGRIM:
14 A. You'll have to show me which question she
15 asked.
16 COFFEY, Q.C.:
17 Q. Okay. One is--well, there's a couple of
18 different, that's what I wanted to ask you
19 about.
20 MS. PILGRIM:
21 A. You're flipping back and forth there, yeah.
22 COFFEY, Q.C.:
23 Q. Yes. If we could go back to 1426?
24 MS. PILGRIM:
25 A. I know she wanted to know who's going to sit

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1 down with them.
2 COFFEY, Q.C.:
3 Q. Yes.
4 MS. PILGRIM:
5 A. That was one question she asked.
6 COFFEY, Q.C.:
7 Q. And who's going to sign the letter.
8 MS. PILGRIM:
9 A. And who's going to sign it, yes.
10 COFFEY, Q.C.:
11 Q. That's the two questions that are posed there.
12 MS. PILGRIM:
13 A. And I would have probably been responding that
14 we could probably have the letter come from
15 the cancer centre, because I was trying to
16 move things out of quality over to the cancer
17 program. But Oscar was also working on the
18 who's going to sit down with the patient
19 piece.
20 COFFEY, Q.C.:
21 Q. So here if we could go back to 3076? The same
22 line here is, I take it, the same phone line?
23 MS. PILGRIM:
24 A. Yeah, that's what I'm saying, do we use our

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1 patient relations like or do we now set up
2 something over in the cancer centre? And that
3 would have been my preferred option and that's
4 what we did.
5 COFFEY, Q.C.:
6 Q. Okay.
7 MS. PILGRIM:
8 A. Now, you know, the final decision on how to
9 contact the deceased, you do know that we
10 finally brought Robert Thompson into that.
11 COFFEY, Q.C.:
12 Q. Oh, yes. And could you tell the Commissioner
13 about that?
14 MS. PILGRIM:
15 A. Well, we just--I mean, we were back and forth
16 so many times. We knew how we couldn't do it,
17 but we still were, you know, how can we do it.
18 And we thought, well, you know, Robert is
19 pretty wise in these things, maybe we should
20 get him to weigh in on this with us. So he
21 came down and we had a group get together
22 again, I can see us in the room, some of the
23 oncologists, Robert was there, Oscar was
24 there, Louise was there, and we talked out
25 just what we were trying to do and everybody's

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1 ideas about how we should do it. And that's
2 where we just came up with the idea that we
3 would not directly contact anybody. We would
4 get the results back, have them ready, have
5 Sharon Smith's office ready to take the calls
6 and deal with the issues as they came along,
7 knowing that the biggest thing we might have
8 to get into is if we did get a patient's
9 family who called and we couldn't get anybody
10 to talk to them further. And, you know,
11 that's one that we would have had to work on.
12 But as I say, our oncologists, like they
13 always do, they never, ever say totally no to
14 you about anything when it comes to patient
15 care.
16 COFFEY, Q.C.:
17 Q. Exhibit P-2697, please? This is an e-mail of
18 November 2nd, 2007. Well, it's a couple of e-
19 mails. One there at the bottom of the page is
20 from Robert Thompson to Louise Jones, Susan
21 Bonnell. "This draft is also being reviewed
22 by the minister and it incorporates your
23 changes." And this one involving the minister
24 providing a progress report on the work being
25 undertaken by government in collaboration with

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1 the health authorities to prepare for the
2 Commission of Inquiry. And that gets--Mr.
3 Thompson's e-mail is distributed. And then
4 you here at the top of the page wrote to a
5 number of people within Eastern Health saying,
6 "Just to let you know that the minister is
7 going out with the attached information today.
8 We are not in agreement with this and will not
9 be responding to any media inquiries about
10 this. What was that about, why didn't you
11 agree and would not respond to any media
12 inquiries?
13 MS. PILGRIM:
14 A. I think this was--there were several times
15 with the Department that the Minister was
16 preparing to go out with releases and we had
17 just--as you know, throughout this process,
18 there were things uncovered that patients who
19 we thought had been identified had not,
20 etcetera, etcetera. So usually when I'm
21 writing a letter like this, and I remember--I
22 think this would be one, I was trying to get
23 the Department to give us a chance to call the
24 patients who hadn't been notified. It says
25 here "up to today, as a result of the NLCHI,

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1 we have identified nine patients who were
2 never retested."
3 COFFEY, Q.C.:
4 Q. Yes.
5 MS. PILGRIM:
6 A. They were negative, but were all put on
7 Tamoxifen, and we have to notify them that
8 they are being retested.
9 COFFEY, Q.C.:
10 Q. Yes, but there was -
11 MS. PILGRIM:
12 A. So I think I was just saying that we're--you
13 know, like what is the rush with this? Can
14 you give us a little bit of time? It's been
15 since 2005 now. I couldn't understand why we
16 couldn't be given another few days, because we
17 would have sent them all as consults and had
18 them back fairly quickly. So it was just my
19 frustration with the Government that, you
20 know, "why do you have to go out and do that
21 tomorrow?"
22 COFFEY, Q.C.:
23 Q. And did you express that at times?
24 MS. PILGRIM:
25 A. Oh yes, yeah.

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1 COFFEY, Q.C.:
2 Q. To Mr. Thompson?
3 MS. PILGRIM:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. And what was the response?
7 MS. PILGRIM:
8 A. Well, I mean, you know, I guess Mr. Thompson--
9 I don't--he would listen to me and say "I
10 understand your frustration," I guess, and but
11 it didn't change anything.
12 COFFEY, Q.C.:
13 Q. It didn't change anything?
14 MS. PILGRIM:
15 A. No. Well, no, I can't say that. I mean, Mr.
16 Thompson worked with us and when we expressed-
17 -I certainly don't want to leave the
18 impression that Robert Thompson didn't work
19 with us and we had a good relationship working
20 with him, but there were times--when you saw
21 me writing this kind of a letter, it's because
22 I was frustrated that we've had all this time
23 and now we're going to go out to the public
24 and say "well, guess what, there's nine people
25 out there who still haven't been retested,"

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1 and we haven't even had a chance to talk to
2 them. Like I couldn't see the sense in doing
3 that.
4 COFFEY, Q.C.:
5 Q. Did the media press--did the press conference
6 go ahead?
7 MS. PILGRIM:
8 A. I think there--a press conference did go
9 ahead, I think, but I don't know what
10 information was included in it. I mean,
11 obviously if the Minister of Health had a
12 press conference, he would have given all the
13 information that had been given to him.
14 COFFEY, Q.C.:
15 Q. Yes.
16 MS. PILGRIM:
17 A. And I don't know if they delayed it or not.
18 Like we weren't looking for a lot of time. We
19 were looking for a couple of days.
20 COFFEY, Q.C.:
21 Q. And now if we could, Commissioner, look please
22 at Exhibit P-3200? So this would be an
23 exchange between yourself and Ms. Gregory, who
24 works with the--I take it with Mr. Thompson?
25 MS. PILGRIM:

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1 A. She would be, yes.
2 COFFEY, Q.C.:
3 Q. Yes, and here she's saying, the subject is
4 "process of following on newly identified
5 ER/PR patients, November 7th, 2007." She says
6 "can you please confirm if Eastern Health has
7 developed and/or implemented a policy for
8 following up on the newly identified ER/PR
9 cases, identified by NLCHI that have been sent
10 for retesting from the perspective of
11 individual patient care management?" And you
12 went back on November 13th saying "we are
13 still finalizing our plan for this" and you
14 talk about the issue of the deceased patients
15 and how they're going to be handled.
16 Ms. Pilgrim, I wanted to ask you about
17 another instance, if I could, Commissioner, in
18 particular, yes, Exhibit P-3221? Now this is-
19 -these are two e-mails of February 19th, 2008.
20 The first, at the bottom of the page there, is
21 from yourself to Ms. Predham and others saying
22 "we have been informed that the database will
23 be released this Thursday. We are not yet
24 prepared for the communication to the deceased
25 without the Q and A. Sharon, is it possible

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1 to get this from Kara over before tomorrow
2 morning? We have to get it out to the other
3 regions, etcetera. I suppose we will have to
4 go with what we have if we cannot get a
5 response from her. We really have no choice."
6 Signed Pat, and then she responded saying that
7 "Kara will be back in town on Thursday
8 evening."
9 Now Exhibit P-3222, 32-22, referred you
10 to that one because of what I'm about to ask
11 you about now, put it in context. This is an
12 e-mail from, at the bottom of the page here,
13 from Mr. Thompson, February 20th, to yourself.
14 Subject is "today." He writes "Pat, received
15 some feedback from Debbie on yesterday's
16 meeting. Important that we receive further
17 feedback from you today. Can we meet late
18 morning? Will you have additional feedback
19 then? We also need to coordinate on the
20 deceased 'messages' and figure out how
21 tomorrow will unfold. Therefore, perhaps we
22 should include our comm people, so everyone is
23 on the same page. Does 12 noon sound good?
24 In the meantime, I am sending you the slide
25 deck which would form the basis of the media

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1 technical briefing. We also have a draft
2 press release and backgrounder which I will
3 send you in an hour or so, and we have a
4 backgrounder on lessons learned/budget
5 initiatives that will be announced alongside
6 to be sent to you in an hour or so. Lots of
7 detail here. Please advise, Robert."
8 And then you forwarded that on to Ms.
9 Predham and the slide deck is attached here
10 and it's -
11 MS. PILGRIM:
12 A. This is the numbers.
13 COFFEY, Q.C.:
14 Q. The numbers, yes.
15 MS. PILGRIM:
16 A. The technical briefing, yes.
17 COFFEY, Q.C.:
18 Q. Technical briefing, ER/PR database, and then
19 it goes on at some length. In fact, the
20 exhibit itself here runs 25 pages.
21 MS. PILGRIM:
22 A. Um-hm, that's right.
23 COFFEY, Q.C.:
24 Q. Now -
25 MS. PILGRIM:

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1 A. Full of tables. That was the one that was
2 full of all the tables and things.
3 COFFEY, Q.C.:
4 Q. Now here, if we could, please, look at 0246,
5 P-0246? This is an e-mail, if we could just
6 look at the bottom of the page here, that's
7 the one I just looked at with you that Mr.
8 Thompson had sent to you at 9:03 on February
9 20th telling you "here's the slide deck."
10 Here, on the same day at 9:57 a.m., you
11 responded to him saying "Robert, the reality
12 for us this week is we are without some key
13 people who need to be looking at this
14 information. The meeting yesterday was rather
15 disjointed to say the least. The report is
16 being reviewed by people within the
17 organization and we will get feedback to you
18 within a day or so. Our understanding is that
19 this report will not be released tomorrow. We
20 are now working on our key messages for the
21 release, as people are trying to wrap their
22 heads around the information. There are
23 numerous stakeholders here that I have to
24 ensure I have contact with to get their input.
25 They are very busy clinical people and I have

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1 to walk a fine line and not be seen to be
2 pressuring them. We are doing a press release
3 on the peer review documents today at 12, so
4 will not be able to meet at that time. I
5 suggest we meet at 2:30 this afternoon with
6 your communication folks. Our place would be
7 nice, at corporate office. Please advice,
8 Pat."
9 So, I take it that this is an expression
10 of your views to Mr. Thompson concerning this,
11 the release of this database by NLCHI?
12 MS. PILGRIM:
13 A. Yes. There was a lot of information in this
14 report.
15 COFFEY, Q.C.:
16 Q. Yes.
17 MS. PILGRIM:
18 A. And I was just trying to express to him the
19 reality I get of--I thought it was really
20 important that people like Nash Denic and Kara
21 Laing get to read this report, but trying to
22 get them was another thing. So that's what I
23 was expressing there.
24 COFFEY, Q.C.:
25 Q. Now if we could look, please, at Exhibit P-

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1 3225? Here, there's an e-mail, February 20th
2 at 11:34 a.m. from Dianne Smith. She's
3 forwarding it on your behalf to a number of
4 people within Eastern Health saying "please be
5 advised that the joint press release, DOHCS
6 and Eastern Health, on the completed database
7 by NLCHI will not be going tomorrow as
8 scheduled. It will be rescheduled for next
9 week, Monday, February 25th or Tuesday,
10 February 26th. Full details on this release
11 will follow as they are received."
12 MS. PILGRIM:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. And in fact, you had been so notified by Mr.
16 Thompson's office between nine a.m. or
17 between--actually, between ten a.m. and 11:30?
18 MS. PILGRIM:
19 A. Right.
20 COFFEY, Q.C.:
21 Q. You were told--you had understood initially
22 that there was going to be a press conference
23 on the February 21st?
24 MS. PILGRIM:
25 A. Right.

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1 COFFEY, Q.C.:
2 Q. And this was the slide deck?
3 MS. PILGRIM:
4 A. Um-hm.
5 COFFEY, Q.C.:
6 Q. And then Mr. Thompson said--well, you
7 explained to him your concerns?
8 MS. PILGRIM:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. And then it was stood down, you were told?
12 MS. PILGRIM:
13 A. Right.
14 COFFEY, Q.C.:
15 Q. If we could look, please, at P-0247? Now this
16 is the same day, February 20th, 2008 at 5:37
17 p.m., an e-mail from Robert Thompson to
18 yourself and Oscar Howell. The subject is
19 ER/PR media release. He says "I hope things
20 went well today. Although I told you we were
21 delaying the data release until Tuesday, it
22 will now happen tomorrow. Please give me a
23 call ASAP to discuss how we can coordinate
24 tonight and tomorrow morning. This is very
25 urgent, as you can appreciate. I think it is

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1 absolutely essential to have your comm people
2 call Glenda Power to ensure they can go back
3 and forth with drafts tonight. The actual
4 data release will be a 'highly' summarized
5 briefing deck will follow shortly," and you
6 responded at 5:41 to him saying "what? So we
7 have to meet tonight on this?" Signed Pat.
8 So I take it then that--well, actually,
9 just pick up the narrative. P-0248, and then
10 I have a question for you. At 6:16 p.m., the
11 same evening, you send another e-mail to Mr.
12 Thompson saying "Robert, this is really not
13 working for us. We need some people--some
14 time to get our key messages together. We do
15 not even know the role we will play in this
16 release. It is supposed to be joint, but what
17 does that mean? There was supposed to have
18 been a meeting this afternoon which we put on
19 hold because we thought we had time to get our
20 act together on this. What is the great rush
21 with this? What difference will another few
22 days make, other than give us an opportunity
23 to try to be prepared for this? I have
24 already told you that we work with one great
25 limitation here, there are many stakeholders

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1 and they are busy clinical people. I cannot
2 get them. I cannot get anyone right now that
3 I need. I know that Oscar is not available
4 this evening. I would not dare ask Nash Denic
5 to come to anything after his involvement
6 today with the media. He is on call for
7 pathology anyway. This is really not
8 acceptable." Signed Pat.
9 Now just to put this in context for the
10 Commissioner, that was the very day at noon
11 that Eastern Health held a press conference
12 with the media dealing with the issue of the -
13 MS. PILGRIM:
14 A. Peer review.
15 COFFEY, Q.C.:
16 Q. - peer reviews?
17 MS. PILGRIM:
18 A. That's correct.
19 COFFEY, Q.C.:
20 Q. The release of those reports, you had released
21 them that day, that very day, and Dr. Denic
22 was there.
23 MS. PILGRIM:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. How were you--did you go to a meeting that
2 night, Ms. Pilgrim?
3 MS. PILGRIM:
4 A. That night I spent the evening with our
5 communication people. That was the night of
6 the moon eclipse, I remember, and I was in at
7 corporate office with our communication people
8 and we were receiving communiques back and
9 forth from the Government up until 10:30 or
10 11:00 that night, while we tried to work
11 things out.
12 COFFEY, Q.C.:
13 Q. If we could, Exhibit P-0249? This is some
14 more e-mails of the same date. 7:12 p.m. the
15 same day, Mr. Thompson sent you an e-mail, the
16 subject is "urgent." "Pat, here is the one
17 draft data release backgrounder to the draft
18 early lessons learned and budget initiatives
19 backgrounder, and finally received full
20 approval on the budget initiatives. This is
21 good news, but it's slightly different than
22 what Louise submitted. I'd be pleased to walk
23 you through this." He goes on then to talk
24 about that and he says "Glenda is finalizing a
25 draft umbrella news release which will

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1 incorporate key messages from all three
2 backgrounders. Of course, we will need your
3 deceased backgrounder to flesh that out. As
4 for Eastern's role in the technical briefing,
5 we suggest no role. As for Eastern's role in
6 the press conference, we suggest that the
7 Minister take the lead role and in Louise's
8 absence, that you join him on the podium. The
9 Minister's two big messages are related to
10 budget initiatives and the fact that data has
11 been sent to the Commission. Therefore, the
12 key Eastern Health message would be around the
13 data access for families of the deceased. Of
14 course, the media will have many questions and
15 you can anticipate that they may ask you some
16 of them, or one of them (why didn't Eastern
17 know how many people were sent? How come
18 deceased was underestimated, etcetera). We
19 can discuss all those questions tonight."
20 And then you responded at 7:15 saying
21 "Robert, I am getting together with our
22 communication people tonight and trying to
23 bring them up to speed on this. We will call
24 you from there later and provide the
25 backgrounder." So, and in terms of that, if

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1 we could look at Exhibit P-3227? This is the
2 actual news release for the February 21st from
3 Eastern Health on this ER/PR retest results
4 for deceased patients available to family
5 members. That's how it turned out, I take it?
6 Would I be correct on that, Ms. Pilgrim?
7 MS. PILGRIM:
8 A. That's correct, yes.
9 COFFEY, Q.C.:
10 Q. So Ms. Pilgrim, I'm going to ask you then,
11 with all that as the background, can you tell
12 the Commissioner then what you recall and how
13 you felt about it at the time, leading into
14 that evening and what happened and what
15 happened the next day?
16 MS. PILGRIM:
17 A. I was very frustrated at the time. I guess,
18 as I said before, I just couldn't understand
19 why there had to be such a rush on all of
20 this.
21 COFFEY, Q.C.:
22 Q. Were you ever told why?
23 MS. PILGRIM:
24 A. I don't know. I mean, it had something to do,
25 I guess, with the Minister of Health or

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1 whatever. I don't know what happens in the
2 Government side of things, but I was very
3 frustrated with this because we were told it
4 wasn't going to go ahead and then it was going
5 to go ahead, and then my biggest thing, I
6 guess, was my limitation in being able to get
7 the people I needed linked into this, to be
8 available just like that. You just can't get
9 these physicians when you're--one moment
10 you're doing this and the next moment you're
11 doing something else. So that was my
12 frustration. I mean, you know, it was up to
13 Robert and the Minister what they did, as far
14 as their briefing and that went, but it was
15 frustrating for me because I felt I wasn't
16 able to do it on my side the way that I wanted
17 to do it.
18 COFFEY, Q.C.:
19 Q. And what happened then at the press
20 conference?
21 MS. PILGRIM:
22 A. I was there and the Minister of Health was
23 there, and the press was there. They did
24 their technical briefing first. I wasn't at
25 that, but we had some of our communications

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1 people at the technical briefing. So of
2 course, they were e-mailing me every minute
3 about what was being said at the technical
4 briefing, so I would know what was being said
5 there, and I went in and I had to go in and
6 meet with the Minister of Health, I remember,
7 when I went in. He was outside the briefing
8 room in another room, and basically I was told
9 my role there, that he was going to do most of
10 the talking, and that my role was to speak--I
11 mean, he didn't tell me I couldn't talk, but
12 my role there was really to speak about the
13 deceased, what we were doing with
14 communication to the deceased.
15 COFFEY, Q.C.:
16 Q. Now if we could look at P-3238, please? This
17 is an e-mail from yourself at 12:58 on
18 February 22nd to a number of individuals
19 within Eastern Health. Cathy Dornan is there.
20 I take it she worked with Bristol
21 Communications?
22 MS. PILGRIM:
23 A. She was. She was on contract with us at that
24 time.
25 COFFEY, Q.C.:

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1 Q. And below that, on 12:47, just at the same
2 time really, in effect, you'd sent this e-mail
3 to the senior people or is this the--yes,
4 senior people and does this include the Board
5 of Trustees or just senior people?
6 MS. PILGRIM:
7 A. No, that's not the Board of Trustees.
8 COFFEY, Q.C.:
9 Q. That's just the senior people?
10 MS. PILGRIM:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Within Eastern Health?
14 MS. PILGRIM:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. And subject is, "it is over" and you say "and
18 I am still here. It went as well as could be
19 expected. They sent very few questions my
20 way. The Minister of Health got most of them.
21 I got a few key messages across and that was
22 it. I am so relieved. Deborah and Dianne
23 felt the media is finally getting the
24 understanding of how complex this all is. The
25 most questions were related to why we (or the

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1 Government) are not able to give them such
2 information as the false negativity rate, even
3 with all of this. They wanted to know about
4 all the deceased people and how the number had
5 changed, so the headlines will around the
6 number not yet contacted, 44," and you've said
7 "not ours, and the number of deceased, and
8 whatever, who knows." Signed Pat.
9 MS. PILGRIM:
10 A. Well, I probably didn't say "and whatever."
11 You put that on it. I just said "and
12 whatever"
13 COFFEY, Q.C.:
14 Q. And whatever.
15 MS. PILGRIM:
16 A. I didn't--you just put an emphasis on it.
17 COFFEY, Q.C.:
18 Q. I apologize, "who knows" I just said that
19 because you had put the words there "who
20 knows." Ms. Pilgrim, on this point, I wanted
21 to ask you about this, one of the questions
22 that come up at that press conference was how
23 many of the deceased had changed results?
24 MS. PILGRIM:
25 A. That's right.

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1 COFFEY, Q.C.:
2 Q. That was--and it was asked and asked, wasn't
3 it, repeatedly?
4 MS. PILGRIM:
5 A. Yes. My memory of that press conference, I
6 can still see David Corcoran, is it, standing
7 over--he couldn't believe that we still didn't
8 have that information to give them after all
9 this time.
10 COFFEY, Q.C.:
11 Q. Which is the, in particular --well, you knew
12 how many deceased there were.
13 MS. PILGRIM:
14 A. Yeah, but how many of them changed.
15 COFFEY, Q.C.:
16 Q. How many had changed, like just kind of go
17 through the deceased and add up those with
18 changed results.
19 MS. PILGRIM:
20 A. Right.
21 COFFEY, Q.C.:
22 Q. And the media, in particular, him, Mr.
23 Corcoran, was, in effect, he couldn't believe
24 -
25 MS. PILGRIM:

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1 A. Well, they were--you know, they were kind of,
2 you know, "we waited all this time and this
3 is"--it was like "this is what you give us?
4 We're still not getting the answers."
5 COFFEY, Q.C.:
6 Q. Now did you know the answer to that question
7 yourself?
8 MS. PILGRIM:
9 A. How many deceased had changed?
10 COFFEY, Q.C.:
11 Q. Yes, at that time.
12 MS. PILGRIM:
13 A. I guess the information would have been there.
14 I don't know if I had seen it. I don't know
15 if we'd actually sat down and done it. I'm
16 sure somebody did in the organization. I
17 might have known it.
18 COFFEY, Q.C.:
19 Q. But then, if so then, why wasn't it -
20 MS. PILGRIM:
21 A. What they asked me was, you know, because I
22 had a very limited role here. I could only
23 speak to the deceased, and what they asked me
24 was, you know, "why were so many of them
25 missed?"

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1 COFFEY, Q.C.:
2 Q. Missed?
3 MS. PILGRIM:
4 A. Yeah.
5 COFFEY, Q.C.:
6 Q. Missed in the sense of knowing that they had
7 died, and okay, I appreciate that.
8 MS. PILGRIM:
9 A. We only came out with this many and why had we
10 missed so many of them, right?
11 COFFEY, Q.C.:
12 Q. Did anyone--you knew the question was being
13 asked as to how many of the deceased had
14 changed results. Now did you know the answer
15 to that question at that time?
16 MS. PILGRIM:
17 A. Probably not, I don't know if I did or not.
18 Now unless I--I think more the question that
19 was being asked was, you know, what was the
20 error rate. I mean, the numbers that were
21 given because this was the technical briefing
22 and the numbers that had been given at the
23 technical briefing really didn't have any
24 analysis. It was numbers. This many
25 retested, this many the results changed, and I

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1 think that the media was looking for more at
2 this point, having waited all this time. They
3 were looking for some analysis of some of
4 these numbers and they didn't get that because
5 that wasn't what NLCHI was doing. They were
6 just purely replicating what we did and
7 obviously the numbers were changing.
8 COFFEY, Q.C.:
9 Q. Now do you recall Mr. Corcoran asking at that
10 press conference how many of the deceased had
11 changed results?
12 MS. PILGRIM:
13 A. Not specifically. I can see him right there,
14 he was stood up and he wasn't very happy, but
15 I can't remember--it seems to me he was more
16 about, so this is all you have to give us?
17 There's no analysis here.
18 COFFEY, Q.C.:
19 Q. Okay, so you don't recall then that being, I
20 could in effect arrange to have the tape
21 played, I mean -
22 MS. PILGRIM:
23 A. Well I can only tell you what I recall, Mr.
24 Coffey.
25 COFFEY, Q.C.:

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1 Q. What you recall and I appreciate that.
2 MS. PILGRIM:
3 A. And I can recall Mr. Corcoran being upset by
4 that, but I don't recall specifically if he
5 asked for that number or not.
6 COFFEY, Q.C.:
7 Q. In terms of the entire matter -
8 MS. PILGRIM:
9 A. Pardon me?
10 COFFEY, Q.C.:
11 Q. In terms of the entire matter from your
12 perspective when you showed up for the press
13 conference and it started -
14 MS. PILGRIM:
15 A. Uh-hm.
16 COFFEY, Q.C.:
17 Q. You were uncomfortable, very uncomfortable
18 because of the lack of preparation, weren't
19 you?
20 MS. PILGRIM:
21 A. Well I wasn't in a good mood, let's put it
22 that way. I wasn't happy, but I was okay with
23 the role that I had to play, I was only
24 allowed to talk about the deceased and what we
25 were doing, so I was getting the opportunity

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1 to--and I shouldn't say I was only allowed, I
2 knew what my role was and I had the
3 opportunity to at least get that message out
4 about, about we have done all the retesting
5 and this is how you get the answer. So I was
6 pleased to be able to do that on behalf of
7 Eastern Health. I mean, this wasn't anything
8 that I had to be mad about or anything, this
9 was just the way the government was doing this
10 and I had a role to play, but I was frustrated
11 that we had to do it like this and -
12 THE COMMISSIONER:
13 Q. Mr. Coffey, when you can find a spot, we can
14 take the morning break?
15 COFFEY, Q.C.:
16 Q. Yes. If we could, please, Exhibit P2519?
17 This is a series of e-mails involving Louise
18 Jones, Peter Dawe and yourself, April 14th,
19 2008, it's two of them. There's a reference
20 here by Peter Dawe in this e-mail, Ms. Jones
21 saying "Louise, I want to follow up on several
22 issues. We are continuing to meet with CBC
23 concerning the Town Hall meeting." Do you
24 recall the -
25 MS. PILGRIM:

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1 A. I do, yes.
2 COFFEY, Q.C.:
3 Q. - involvement with the activity around this.
4 MS. PILGRIM:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. Did it ever go ahead?
8 MS. PILGRIM:
9 A. No.
10 COFFEY, Q.C.:
11 Q. And why not? This was a plan, I take it, to
12 have some kind of a CBC program produced
13 around ER/PR and the Canadian Cancer Society
14 was involved.
15 MS. PILGRIM:
16 A. I would say the reason that it didn't go ahead
17 was because we couldn't agree on the
18 particulars of who was going to do what.
19 COFFEY, Q.C.:
20 Q. Okay, could you elaborate on that for the
21 Commissioner?
22 MS. PILGRIM:
23 A. Well, this came out of, I think my contacting
24 Peter at some point because at this point now
25 we're still hearing about, certainly from the

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1 Canadian Cancer Society who was probably
2 getting most of the calls and most closely
3 connected with the public about people who
4 still had confusion. There were people out
5 there who were really suffering because of
6 this and I remember I had called Peter and
7 said, you know, is there anything else--I know
8 the public has lost a lot of confidence in us,
9 but even at that time, I thought Peter and
10 them may have had support groups or something
11 going for the public, so I just wanted to have
12 that discussion with him. And to say to him,
13 you know, we can give you some resources, you
14 know, we can help you with some of these
15 things if you think it will help, like is
16 there any way that we can kind of help you and
17 kind of do it behind the CCS, because the
18 public seemed to obviously a better opinion of
19 them than they did of us at that particular
20 time. And out of that he had said to me,
21 well, kind of, you're calling at an
22 interesting time because we are--they were
23 planning some kind of a public function and I
24 think he used the word like a town hall or
25 something, that they were talking about having

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1 where they could have speakers there and give
2 the public an opportunity to ask questions and
3 also give stakeholders an opportunity to get
4 some messages out.
5 So there was a suggestion that perhaps we
6 could get together and talk about that. And
7 that's what we did and we brought--Peter came
8 with Emma Howser and myself, Louise, Cathy
9 Dornan and probably one of our communication's
10 people met once and we kind of talked about
11 how this might go and then we all went off to
12 think about that a little bit more, and then
13 we came back to have some more talking about
14 this. What we were proposing, there would be
15 a panel and the panel would consist of, you
16 know, various stakeholders and there would be
17 members of the public that would be invited
18 and it would be telecast. I think CBC was
19 actually going to do the telecast, which was
20 very good. And so, you know, it seemed to be
21 a good idea until we got into talking about
22 who was going to play what roles and that's
23 where we couldn't agree.
24 COFFEY, Q.C.:
25 Q. And what couldn't be agreed upon?

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1 MS. PILGRIM:
2 A. Well my understanding from--certainly Peter
3 started out the discussions about, you know,
4 even though this sounded like a good idea, he
5 still wasn't really sure how closely
6 affiliated he wanted to be with Eastern
7 Health, you know, publicly, we could
8 understand that. But then when we were
9 talking about this panel, we thought that an
10 administrative person from Eastern Health
11 should be, should have a role to play and
12 Peter did not and I think he was very upfront
13 with us. He said he didn't want this to turn
14 into a PR Op. for Eastern Health. So he had
15 his idea about how this should be and we had
16 our idea, we wanted to have someone from
17 administration and then we talked about, okay,
18 if we had a doctor, a patient and someone from
19 the Canadian Cancer Society be on the panel,
20 maybe someone like Louise Jones could be in
21 the audience and then the moderator of the
22 program could actually throw some questions
23 towards Louise because she was--because she
24 would be there. And those are kind of all the
25 discussions that I had about it. I didn't

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1 have any further discussions. It went on to
2 then discussions between Cathy and our
3 communication people--person and Peter and
4 Emma, I think, and then Cathy had some further
5 discussion with Louise and between the jigs
6 and the reels, we didn't--we agreed to
7 disagree on what that form would look like.
8 COFFEY, Q.C.:
9 Q. And this was all going on at what timeframe?
10 MS. PILGRIM:
11 A. Well it was in the spring.
12 COFFEY, Q.C.:
13 Q. Of 2008?
14 MS. PILGRIM:
15 A. Yeah, this was this year.
16 COFFEY, Q.C.:
17 Q. Thank you, Commissioner, come back, I have two
18 brief topics and I'll finish.
19 THE COMMISSIONER:
20 Q. All right, fifteen minutes.
21 (RECESS)
22 THE COMMISSIONER:
23 Q. Please be seated. Mr. Coffey.
24 COFFEY, Q.C.:
25 Q. Thank you, Commissioner. If we could bring

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1 up, please, Exhibit P-3284? This is an e-mail
2 from yourself, April 28, 2008 to Rick
3 Singleton and others. Subject is "Ethics
4 Review" and you say, "Rick, I'm just getting
5 around to responding to you, re the group of
6 patients who are referring to in the ethics
7 review meeting. You indicated there were four
8 groups of patients and I could not remember
9 who all four were. My memory says that we
10 were asking for--the consult we requested was
11 pertaining to living patients, not the
12 deceased. The four groups of living patients
13 are: those whose results did not change;
14 those whose results changed but did not
15 require a change in treatment; those whose
16 results changed and did require a change in
17 treatment and those patients who should not
18 have been included in the retesting but who,
19 for varying reasons, were included. I am
20 sending this on to Pam, Nancy and Sharon so
21 they can confirm that this was the group we
22 were intending and if we talked about four
23 groups in the meeting, these are the four
24 groups. Would you please confirm, thanks.
25 Pat." Now if we could look, please, at

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1 Exhibit P-3287 because that's the background
2 to--this is an Ethics Consultation
3 Documentation Memo, April 30th, 2008 to
4 yourself from Mr. Singleton. And, Ms.
5 Pilgrim, you would have received this, I take
6 it?
7 MS. PILGRIM:
8 A. I would have, yes, that was to me.
9 COFFEY, Q.C.:
10 Q. Yes. And the consultation had occurred at
11 your request.
12 MS. PILGRIM:
13 A. It had, yes.
14 COFFEY, Q.C.:
15 Q. And could you tell the Commissioner what was
16 done in relation to this?
17 MS. PILGRIM:
18 A. You mean what we did after we got this?
19 COFFEY, Q.C.:
20 Q. Yes.
21 COFFEY, Q.C.:
22 Q. Well obviously we had the consult which I
23 asked for and I asked for an ethics consult,
24 not so much because I was dealing with an
25 ethical dilemma, but there was great--well I

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1 don't want to sound, it wasn't great, but
2 there was disagreement in the organization
3 about doing this and many, many opinions.
4 Some saying we shouldn't send anything out at
5 this time and others saying we should and
6 everything else in between. And sometimes I
7 look towards the ethics group just because
8 they do help you to sit down and put your
9 values lens on, if nothing on, you know, and
10 you can have that kind of a discussion around,
11 well what do we stand for as an organization
12 and what's the right thing to be doing here.
13 So we went and we talked and they agreed that
14 this should be, you know, even though it was
15 late and everything else, it was something
16 that would certainly be what Eastern Health
17 stood for and we should do it. What their
18 suggestion was was not followed.
19 COFFEY, Q.C.:
20 Q. Can I ask you about that because there's an e-
21 mail and I won't take you to it, you
22 subsequently drafted to a number of
23 individuals in which you pointed out that this
24 would involve a significant amount of work.
25 MS. PILGRIM:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. To accomplish this.
4 MS. PILGRIM:
5 A. Now, I can tell you what this finally got down
6 to was an executive decision again by Louise
7 Jones about what this letter was going to look
8 like and what was going to be in it, because
9 there were so many opinions coming her way
10 about whether we should send it, if we sent
11 it, whether, you know, whether an apology
12 should be included in it and finally Louise
13 said, you know, this is my letter and I'm
14 going to send this the way that I want to send
15 it. And basically that's how it ended up.
16 COFFEY, Q.C.:
17 Q. And so the letter--well what letter, if any
18 letters, did go?
19 MS. PILGRIM:
20 A. There was a letter that went to patients who
21 had been retested.
22 COFFEY, Q.C.:
23 Q. Which is the letter that at times is referred
24 to as the apology -
25 MS. PILGRIM:

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1 A. It was called the apology letter. It did
2 actually, you know, it evolved into an apology
3 letter with information in it with
4 attachments, because we were trying--first
5 when we started out, this was really coming
6 from advice we were being given by the
7 Canadian Cancer Society and also we had met
8 with Geri Rogers, one of the patients, about,
9 you know, from a patient perspective what we
10 could be doing or should be doing. And so
11 basically this is--it started off like that
12 and it went through many iterations and
13 finally Mrs. Jones said, "enough is enough,
14 I'm doing it my way and this is what I'm
15 doing."
16 COFFEY, Q.C.:
17 Q. Exhibit P-3307? This is May 13th, 2008 from
18 Dianne Smith, your EA, to Peter Dawe of the
19 Canadian Cancer Society. It says, "Hi Peter,
20 Pat asked me to forward along on her behalf a
21 copy of the patient apology letter and
22 attachments which were sent from Eastern
23 Health for your information. Please find them
24 attached." And then the attachments are
25 described as "Patient apology letter, April

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1 30th, 2008; clarifying approach to hormone
2 receptor tests revised May, 2008; and hormonal
3 therapy information sheet." And if we look
4 here at this exhibit, that's in effect the
5 form letter?
6 MS. PILGRIM:
7 A. Yes, it didn't go out as an individual letter
8 with individual results, it went out as a form
9 letter from the CEO.
10 COFFEY, Q.C.:
11 Q. And this was intended to go to the patients
12 who were still alive, living patients?
13 MS. PILGRIM:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. This document at page 5 is the clarifying our
17 approach to the hormone receptor test and it
18 sets out what Eastern Health was telling their
19 living patients at the time. And actually,
20 I'll go back one, in relation to that, there
21 are headings, "Our review of hormone receptor
22 tests; communications with patients; problems
23 identified with the process Eastern Health
24 used; what we have learned" and then
25 "Improvements to our laboratory. Eastern

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1 Health have made the following improvements."
2 And at page 9 of the exhibit, there is a sheet
3 "Hormonal Therapy Information: what are
4 hormone receptors and what are the benefits of
5 hormone therapy." I take it that that's the
6 document that is otherwise referred to as the
7 apology letter and the attachments?
8 MS. PILGRIM:
9 A. Correct.
10 COFFEY, Q.C.:
11 Q. I take it that this would have gone out to
12 quite a number of, hundreds and hundreds of
13 patients?
14 MS. PILGRIM:
15 A. Yeah, it did.
16 COFFEY, Q.C.:
17 Q. And in the main, what, if any, problems were
18 encountered?
19 MS. PILGRIM:
20 A. Well you heard about a few of them on the
21 news, you know.
22 COFFEY, Q.C.:
23 Q. But I take it in the main what has been the
24 feedback to Eastern Health concerning it?
25 MS. PILGRIM:

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1 A. Louise has gotten e-mails and calls from
2 people thanking her and accepting the apology
3 and we've also had indication that certainly
4 there were patients who thought this was too
5 little too late. So, you know, a myriad of
6 responses, not a lot--not a lot of response
7 actually, directly, but some people phoning in
8 and, you know, I mean, I don't read the blogs
9 and that, but apparently there's been feedback
10 on blogs that are in various media outlets.
11 COFFEY, Q.C.:
12 Q. Okay, if I could please, something I wanted to
13 ask you about, Ms. Pilgrim, you referred to it
14 before, this telling our story, that you told
15 the Commissioner about that, do you recall
16 that?
17 MS. PILGRIM:
18 A. For want of a better title.
19 COFFEY, Q.C.:
20 Q. Yes, and I appreciate that, it's a phrase as
21 opposed to an exact description. Whose--the
22 budgeting from that is coming from whose
23 budget?
24 MS. PILGRIM:
25 A. That would be Eastern Health.

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1 COFFEY, Q.C.:
2 Q. Eastern Health is funding that. And in
3 relation to that because you referred to the
4 idea of there was still a lot of analysis
5 going on and so on within Eastern Health.
6 MS. PILGRIM:
7 A. We had just started the analysis, so we're in
8 to doing some of the analysis now.
9 COFFEY, Q.C.:
10 Q. The person who is--most direct way to ask you
11 this is this: has whatever exists to date,
12 whatever information exists to date, has the
13 Commission of Inquiry been provided with it?
14 MS. PILGRIM:
15 A. I think the first piece of analysis we had
16 done was something that Dr. Nash Denic had
17 asked for. He wanted to see the correlation
18 between, I know one part of it was comments
19 that Dr. Mullen would have made about fixation
20 on a slide and what the actual connection with
21 people who had changed results, so I think
22 you've gotten that one. And -
23 COFFEY, Q.C.:
24 Q. And you're focusing on the analysis, yes, go
25 ahead.

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1 MS. PILGRIM:
2 A. We were--you know, some of the analysis we can
3 do, but the database that we have with NLCHI
4 is very much--we're not going to be able to do
5 what a lot of people want with that database,
6 so then there's going to have to be a question
7 done, what's going to require more research.
8 For example, you know, if oncologists want to
9 now follow these patients, which they probably
10 do, how are we going to set that up for them,
11 et cetera. So that just started because we've
12 just now gotten the database complete that we
13 can really feel fairly, you know, fairly
14 reliable database. So this is the next piece
15 of work that we are doing and hope to have
16 this done, you know, within several months.
17 COFFEY, Q.C.:
18 Q. And, Ms. Pilgrim, the people who are involved
19 in this effort to create, and I'll use your
20 phrase, "create the story" as it were, in
21 terms of to write it.
22 MS. PILGRIM:
23 A. I'm sure we could come up with a better term
24 for that, but -
25 COFFEY, Q.C.:

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1 Q. To write the account.
2 MS. PILGRIM:
3 A. The account, yes.
4 COFFEY, Q.C.:
5 Q. That's probably a better word. Have they been
6 provided with any documentation that the
7 Commission hasn't received?
8 MS. PILGRIM:
9 A. No, they haven't been really provided with any
10 documentation yet. The only thing that has
11 happened is really a sit-down meeting of some
12 of us with an identification of what some of
13 the major themes throughout all of this have
14 been, and then to go from there.
15 COFFEY, Q.C.:
16 Q. Now you, just after the Commission of Inquiry
17 was announced, were appointed point person for
18 this to deal with the Commission itself. In
19 terms of kind of searching for information
20 that was to be provided to the Commission in
21 relation to ER/PR, who was primarily charged
22 with doing that, like setting the search
23 parameters and making sure that they were
24 followed out and complied with?
25 MS. PILGRIM:

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1 A. Well we sat down with Mr. Simmons in the
2 beginning and talked about how it is we needed
3 to set that up and then we talked to people in
4 IM&T and actually, I don't know what the
5 correct term is, but we actually froze
6 people's e-mail accounts from this day forward
7 sort of thing. So we did put a process around
8 it.
9 COFFEY, Q.C.:
10 Q. And now there had been -
11 THE COMMISSIONER:
12 Q. I have a question on this, do you know, for
13 example, things like parameters and searching,
14 how that was done or was somebody else doing
15 that?
16 MS. PILGRIM:
17 A. That would have been somebody else doing that.
18 THE COMMISSIONER:
19 Q. And who would have been doing that?
20 MS. PILGRIM:
21 A. With the IM&T helping people do that.
22 THE COMMISSIONER:
23 Q. But I would assume that somebody instructed
24 them as to -
25 MS. PILGRIM:

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1 A. Well it would have been whatever was in, you
2 know, what people were told was that if you
3 have anything in your paper files, if you have
4 anything in your e-mails and that would be in
5 your sent or your deleted or you in box or any
6 of your personal folders that you have, and if
7 you have books with notes, anything, you know,
8 those would have been the parameters that
9 would have put around it. So we tried to
10 identify every possible source of information
11 that people would have.
12 THE COMMISSIONER:
13 Q. Okay, so then did you instruct each individual
14 that that's what you had to provide?
15 MS. PILGRIM:
16 A. That's what you had to provide.
17 THE COMMISSIONER:
18 Q. And were people given assistance, for example,
19 in searching their computers for relevant
20 documentation in terms of words or methods or
21 things like that?
22 MS. PILGRIM:
23 A. I know that IMT people did meet with people
24 who really didn't--like I would know how to do
25 that, but some people wouldn't. So there was

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1 assistance given through IMT about, you know,
2 if you wonder in this particular file if there
3 was anything, these are the words you can
4 probably put there and see if you can go find
5 it in that file, that's what you mean, through
6 Microsoft.
7 THE COMMISSIONER:
8 Q. Uh-hm.
9 MS. PILGRIM:
10 A. Yeah, that was provided as we went through.
11 THE COMMISSIONER:
12 Q. To those who needed it.
13 MS. PILGRIM:
14 A. Yeah, we identified, Commissioner, the people
15 who we thought would be the sources of
16 information and along the way there were, you
17 know, we missed a couple. There were others
18 we would, as things came up we would say, well
19 you know, that person would have something on
20 that, we forgot to ask him. And then we would
21 notify Dan about that and then we'd get
22 whatever we could from them. That's my
23 understanding of what we did, was the process
24 that we started in the beginning. And I think
25 throughout, I think people understood it, but

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1 I think throughout people kind of had
2 forgotten certain things, like you know, I
3 think Dr. Howell had forgotten one of his
4 notebooks or something, but it's not because
5 it wasn't communicated to people.
6 COFFEY, Q.C.:
7 Q. Were you aware that at times there were
8 delays, I mean, I'll point you to a particular
9 one, a great mass of e-mails came from Heather
10 Predham to the Commission, I believe in the
11 beginning of June of this year.
12 MS. PILGRIM:
13 A. Yes, I was aware of delays, yes.
14 COFFEY, Q.C.:
15 Q. Okay, Ms. Predham will be along, but you were
16 the kind of manager, as it were.
17 MS. PILGRIM:
18 A. Uh-hm.
19 COFFEY, Q.C.:
20 Q. You were aware of delays from time to time.
21 What, if any, steps were taken to address
22 that?
23 MS. PILGRIM:
24 A. From my perspective it would just be working
25 with Dan to try and get the information that

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1 you asked for. I know there's been, you know,
2 regular requests for additional information,
3 et cetera, et cetera, and you know, that would
4 be my only involvement in it, Mr. Coffey,
5 rightfully or wrongfully.
6 COFFEY, Q.C.:
7 Q. One thing in terms of this whole letter issue,
8 Exhibit P-3287? You were actually at this
9 ethics consult, weren't you?
10 MS. PILGRIM:
11 A. I was.
12 COFFEY, Q.C.:
13 Q. See, here and Mr. Singleton has taken the
14 Commissioner through this, but as you pointed
15 out, Ms. Jones eventually went on to make an
16 executive decision in this regard, and it
17 turned into that apology letter we just looked
18 at, with the attachments. Would Ms. Jones
19 have gotten a copy of this?
20 MS. PILGRIM:
21 A. I don't know if--Louise probably didn't see
22 it, but I would have reported what came back.
23 COFFEY, Q.C.:
24 Q. Okay, because here, at the bottom of this page
25 here, it says "it is recommended that letters

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1 be prepared for everyone in the four major
2 categories of patients tested in the time
3 period being reviewed by the Commission of
4 Inquiry and that's the four that you, on April
5 28th, pointed out to him, see. And then it
6 goes on, "The letter should be tailored to the
7 individuals in each category to review the
8 details of their category and the previous
9 contacts and efforts to contact regarding
10 disclosure of their individual cases. The
11 letters should also contain a contact number
12 and an e-mail for further contact." Now the
13 letters that went out certainly have contact
14 information for Eastern Health, don't they?
15 MS. PILGRIM:
16 A. Uh-hm.
17 COFFEY, Q.C.:
18 Q. But the portion of this dealing with the idea
19 of reviewing with the individual patient,
20 tailored to the individual patient
21 circumstances, the details in effect
22 confirming for them, you were retested and you
23 came back as confirmed negative and to have
24 that in writing to a--individualized to a
25 patient.

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1 MS. PILGRIM:
2 A. Uh-hm.
3 COFFEY, Q.C.:
4 Q. That would be done here--if this had been
5 followed.
6 MS. PILGRIM:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. And would confirm that you were contacted,
10 you, the patient, were told about this, the
11 fact that you were being retested in October,
12 for example, '05, October 10th, '05.
13 MS. PILGRIM:
14 A. Uh-hm.
15 COFFEY, Q.C.:
16 Q. And we contacted you in December of 2005,
17 December 15th to tell you the retest results.
18 MS. PILGRIM:
19 A. Uh-hm.
20 COFFEY, Q.C.:
21 Q. And this is to confirm that that's so.
22 MS. PILGRIM:
23 A. That's right. That would have been
24 individualizing the letter.
25 COFFEY, Q.C.:

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1 Q. Yes, and the idea being that coming out of
2 that, if each such patient received such a
3 letter, the patient would be in a position to
4 say, well okay, it's correct, that's my memory
5 of it.
6 MS. PILGRIM:
7 A. Uh-hm.
8 COFFEY, Q.C.:
9 Q. Or it's incorrect and I take issue with your
10 assertion that I was told in December '05 what
11 my results were, back in the -
12 MS. PILGRIM:
13 A. And there is an issue that we could have made
14 a mistake and sent people out the wrong
15 information.
16 COFFEY, Q.C.:
17 Q. Yes.
18 MS. PILGRIM:
19 A. The other issue I would have to tell you is we
20 wanted to get this letter out and we had just
21 started doing a review, two quality reviews
22 and one, for example, of the reviews was DCIS,
23 like we hadn't finished yet, so you know, it
24 made it more and more, I guess, reasonable for
25 us to think that not a specific patient letter

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1 at this time would go out. Now, we still
2 haven't decided, Mr. Coffey, there's still
3 some finishing pieces to all of this. One
4 thing that we are now looking at is how we are
5 going to make sure that disclosure actually
6 ends up on the patient's record because
7 normally they do. Normally a disclosure is
8 written in the chart, and then when we do
9 that, you know, if we write a record of
10 disclosure to go in there, that would be
11 something we would be contacting the patients
12 about and ensuring that they have a copy of
13 that. So there's still going to be more
14 coming from Eastern Health in regards to this
15 and that will really, I think, any concerns
16 that anybody might have about that, we will
17 address that in the next step which we are
18 taking, which is really trying to get
19 disclosure information into--well not trying
20 to get, I mean, we will be putting disclosure
21 information in the patient files.
22 COFFEY, Q.C.:
23 Q. Because and this is why I was--that's where I
24 was going.
25 MS. PILGRIM:

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1 A. Okay.
2 COFFEY, Q.C.:
3 Q. On April 30th, the ethics consult group told
4 you in writing what they thought, their
5 suggestion.
6 MS. PILGRIM:
7 A. Right.
8 COFFEY, Q.C.:
9 Q. Because you had asked for it, you got a
10 response.
11 MS. PILGRIM:
12 A. Right.
13 COFFEY, Q.C.:
14 Q. Here by May 13th, Ms. Jones had made her
15 decisions about--and finalized it in terms of
16 the actual letter that would go out, so it's
17 within two weeks it's decided we're not going
18 to follow, "we" Eastern Health at large, are
19 not going to follow the ethics consult
20 suggestion to tailor the letter to individual
21 circumstances.
22 MS. PILGRIM:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And you're telling the Commissioner then the

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1 idea of sending an individualized letter is
2 still an option?
3 MS. PILGRIM:
4 A. That's another piece of this because we know
5 there are various pieces of this left undone
6 and the one that we--well, like I told you,
7 the one we're working on now, we starting
8 working on is the story and the one right
9 behind that now, which we started talking
10 about, is how are we going to get this
11 information on patient's records.
12 COFFEY, Q.C.:
13 Q. If we could look, please, at Exhibit P-3347--
14 I'm sorry, I'm going to ask, Commissioner, to
15 enter Exhibit P-3347?
16 THE COMMISSIONER:
17 Q. 3347?
18 COFFEY, Q.C.:
19 Q. 3347 please?
20 THE COMMISSIONER:
21 Q. Entered.
22 EXHIBIT ENTERED AND MARKED P-3347
23 COFFEY, Q.C.:
24 Q. And this is an e-mail of April 13th, 2008 from
25 Mr. Thompson to Ms. Jones, it's copied to

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1 yourself and this is one where Mr. Thompson
2 says, "The report I'll be sending you in a
3 little while contains the information on the
4 DCIS review and the physician letter review.
5 The report will be provided to the Commission
6 tonight. My sense is that they will not
7 introduce it into evidence tomorrow, but
8 review it and use it later on; however, I
9 could be wrong. We have not prepared a press
10 release for tomorrow. The Minister will
11 likely be questioned on the extra 15 people
12 who were not contacted with the results. As
13 there are e-mails which talk about this issue
14 just prior to the March 18th press release,
15 which have been disclosed to the Commission
16 and entered into evidence. In response to
17 these questions, he will talk frankly about
18 the work we have each been doing to contact
19 these people. We will assess tomorrow whether
20 a separate news release is necessary. With
21 respect to the alternate search strategies for
22 people who may not have been identified yet,
23 we hold the strong view that this work must be
24 done. My understanding of time and resource
25 commitments is that Wayne Miller's approach is

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1 too large. I suggest using the approach Reza
2 and Terry developed. They have already
3 conducted test runs, so they know it
4 identifies additional files."
5 MS. PILGRIM:
6 A. That's right.
7 COFFEY, Q.C.:
8 Q. And that's the process you were talking about?
9 MS. PILGRIM:
10 A. That was before, yes.
11 COFFEY, Q.C.:
12 Q. And as time went on throughout, after April
13 became May -
14 MS. PILGRIM:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Ms. Jones decided on behalf of Eastern Health
18 that they were not going to do this, at that
19 point, anyway?
20 MS. PILGRIM:
21 A. She had decided that then.
22 COFFEY, Q.C.:
23 Q. By this point.
24 MS. PILGRIM:
25 A. He was still saying to her, he was putting in

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1 writing to her, "we"--I don't know who "we"
2 are, but I guess it's the government, holds a
3 strong view that this must be done. But she
4 had already told him that Eastern Health won't
5 be doing this work.
6 COFFEY, Q.C.:
7 Q. And the other three boards as well.
8 MS. PILGRIM:
9 A. They hadn't weighed in on it up to that time,
10 I don't think, now I don't know -
11 COFFEY, Q.C.:
12 Q. Yes, no, and in fact, yes, you're correct,
13 they had not, because if you look the e-mails,
14 but subsequently is your understanding -
15 MS. PILGRIM:
16 A. Over the summer, in August is when they became
17 a part of the discussion.
18 COFFEY, Q.C.:
19 Q. And said "no".
20 MS. PILGRIM:
21 A. They all unanimously said they're not doing
22 it. No, it would have to become a provincial
23 initiative.
24 COFFEY, Q.C.:
25 Q. In relation to that, is it a matter of money?

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1 MS. PILGRIM:
2 A. It's a matter of--now which search are you
3 talking about now?
4 COFFEY, Q.C.:
5 Q. In terms of the three -
6 MS. PILGRIM:
7 A. The new people?
8 COFFEY, Q.C.:
9 Q. Yeah, to identify people you may have missed
10 to get retested?
11 MS. PILGRIM:
12 A. Yes, okay, so that would be really now having
13 to go in and develop a new database or add to
14 the one that's already there, pick whatever
15 search strategy you're going to use, which is
16 problematic, as we know because we've already
17 tried that. So for the Health Authorities, I
18 guess it's a capacity issue, especially for us
19 because you're still now having to go back to
20 the people that you've seen here at the
21 inquiry who have really been doing this for
22 three years now, in terms of this, and this
23 would be a significant undertaking. So if it
24 could somehow be done outside, you know, if
25 provincially it could be done and really not

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1 require the absolute time commitment because
2 we just don't have the capacity to get
3 involved with that, I mean, that's the simple
4 fact about it. And, you know, somebody could
5 give us five million dollars, it's not money.
6 It's the resources because it's the same kind
7 of people who have to get involved with this,
8 but if it could be done by some research firm
9 or something who could do it differently, I
10 mean, that's fine. And they've said to
11 Robert, you know, if you can find out a way to
12 do this which doesn't involve our same people,
13 well, you know, they have no objection to
14 that.
15 COFFEY, Q.C.:
16 Q. One final topic, Exhibit P-0762. This is a
17 letter from Mr. Thompson, March 6th, 2008, to
18 Louise Jones, "Regarding contact with results
19 to patients with no original test conducted in
20 the province is recorded in ER/PR database",
21 and he says, "I have attached a patient list
22 containing the names of patients that did not
23 have an original ER/PR test conducted in the
24 province, but had a test sent to Mount Sinai
25 as part of ER/PR recall, and for which

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1 documentation of contact with results cannot
2 be confirmed. These patients do not meet the
3 inclusion criteria for the retesting process.
4 Original tests done in the province and
5 retesting completed at Mount Sinai", which I
6 take it is the criteria to get into the
7 database for the retesting process, "and as
8 such are not included in the ER/PR database.
9 Nevertheless, it is my belief that the
10 responsible RHA should follow up with the
11 physicians and/or patients to confirm if the
12 physician ordering the test and/or patient has
13 been contacted regarding the results. NLCHI
14 does not require documentation for each
15 patient, but I would appreciate a written
16 response indicating what action, if any, will
17 be taken on this issue. If you have any
18 questions, please call". If we could look,
19 please, at Exhibit P-0763. Here is a letter
20 of March 8th, 2008, to Mr. Thompson, and here
21 it's from yourself and you write, "The
22 following table of information is in response
23 to correspondence of March 6th, 2008. Please
24 note patients number 1, 4, 5, 6, and 7 did not
25 have "a test sent to Mount Sinai as part of

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1 the ER/PR recall". Four of them had their
2 specimens tested at Mount Sinai as testing as
3 not being conducted at Eastern Health. The
4 disclosure of these results was handled as per
5 any test results ordered by a physician. The
6 other three were done only on a patient and/or
7 family request". So 1, 4, 5, 6 and 7. If you
8 look down here, number 3 is Janet Andrews,
9 okay, and here under disclosure information it
10 says, "She was never tested for ER/PR as she
11 was diagnosed with DCIS. This specimen was
12 tested on her request and was disclosed to the
13 patient in September, 2005". See that?
14 MS. PILGRIM:
15 A. Yes, I do.
16 COFFEY, Q.C.:
17 Q. Could we bring up, please, Exhibit C-0150.
18 This is an exhibit relating to Janet Henley-
19 Andrews. This is a screen capture, and this
20 would be Nancy Parsons' note of November 7th,
21 2005, "This patient had DCIS, but has
22 requested that she be retested. I asked Dr.
23 Cook. He will send her sample for retesting".
24 Could we look, please, at Exhibit C-0151.
25 This is a Mount Sinai Hospital, Pathology and

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1 Laboratory Medicine report. It's for Ms.
2 Andrews, and reports ER is 60, PR is 25, and
3 it's printed off, November 22nd, 2005. This
4 is the report by Brendan Mullen. Finally, C-
5 0152, and this is a chart for physician review
6 panel, Thursday, December 1, 2005. Ms. Janet
7 Henley-Andrews name is on it. It's identified
8 as DCIS here in handwriting. The physician is
9 Dr. Felix, ER 60 percent, PR 25 percent is
10 handwritten under the Mount Sinai Hospital,
11 not the Ventana, Mount Sinai Hospital report.
12 If we could go back then, please, to P-0763.
13 The assertion in your letter of March 7th,
14 2008, to Mr. Thompson, that certainly she was
15 never tested for ER/PR as she was diagnosed
16 with DCIS, fine. This specimen was tested on
17 her request, correct, and was disclosed to the
18 patient in September, 2005. Now you would
19 agree it would be difficult to disclose it
20 because the test didn't occur and wasn't
21 reported until--didn't occur and wasn't
22 reported by Dr. Mullen until November 22nd.
23 So can you tell the Commissioner then--I'm
24 going to ask you this, would you have
25 understood then that NLCHI would have been

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1 relying upon this sort of information to
2 complete their database?
3 MS. PILGRIM:
4 A. Yes. We had--and that's something we found
5 all the way along, there were inaccuracies in
6 the information that we had, and this is a
7 case of it. It's written in our records that
8 the patient had been told results, well,
9 really before the retesting had occurred, but,
10 you know, the date was wrong, and the
11 information was wrong, and we've since found
12 out that this patient wasn't told the results
13 until she went back to see a doctor many
14 months later.
15 COFFEY, Q.C.:
16 Q. In fact, I think she's testified that she was
17 told the results when she came in to be
18 interviewed by -
19 MS. PILGRIM:
20 A. Oh, probably, yes, I know, but -
21 COFFEY, Q.C.:
22 Q. Ourselves, but -
23 MS. PILGRIM:
24 A. Yeah.
25 COFFEY, Q.C.:

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1 Q. But -
2 MS. PILGRIM:
3 A. But that's -
4 COFFEY, Q.C.:
5 Q. She was told that the results existed.
6 MS. PILGRIM:
7 A. Yes, but this is--you know, I mean, there were
8 examples of this. I mean, I've already said
9 we did not do a really good job with this, and
10 this is one example of it.
11 COFFEY, Q.C.:
12 Q. What I want to ask you about is this. I take
13 it that you're understanding was--you would
14 have gotten the information here from whom?
15 Ms. Predham, I take it?
16 MS. PILGRIM:
17 A. I would have gotten information about contact
18 from Heather Predham, and if it was a lab
19 thing, it would have gone to Terry Gulliver if
20 it was lab information. So this would have
21 come directly from the records that Heather
22 would have had.
23 COFFEY, Q.C.:
24 Q. Okay. Has any effort been made to check the
25 validity of those records to kind of cross

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1 reference them with other things?
2 MS. PILGRIM:
3 A. Well -
4 COFFEY, Q.C.:
5 Q. To use Dr. Howell's phrase, if you go this one
6 wrong, how many others are wrong.
7 MS. PILGRIM:
8 A. Well, through the NLCHI exercise we've
9 certainly checked the validity because one
10 thing, for example, is they had to have source
11 documentation of everything, so you couldn't
12 just say we had it, you had to show them that
13 we had it, and then we've also checked the
14 validity of what was in the database--well, we
15 considered if a panel letter had gone to a
16 physician, that that patient would have been
17 considered contacted about their results in
18 the database, but we found out that that
19 didn't necessarily happen, so we've gone back
20 and done a review and we have validated that
21 in that way, and we have actually either
22 validated, like I told you, in one of three
23 ways, and sometimes we would find the
24 information in the chart, other times we could
25 validate it with the physician, and if all

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1 fails, we actually did call the patient and
2 verify with them that they actually got their
3 results. So there's been many processes of
4 validation throughout this.
5 COFFEY, Q.C.:
6 Q. Just a second, please, Commissioner. If we
7 could bring up, please, P-0730. This is a
8 letter of September 19th Ms. Crowley sent to
9 the patients involved in the class action, or
10 she signed it to go out from Eastern Health.
11 Do you know who drafted this letter?
12 MS. PILGRIM:
13 A. I can only tell you what my understanding was,
14 and my understanding was that that letter was
15 drafted through McKelvey--what's the law firm?
16 COFFEY, Q.C.:
17 Q. Stewart McKelvey?
18 MS. PILGRIM:
19 A. Stewart McKelvey.
20 COFFEY, Q.C.:
21 Q. They drafted the letter?
22 MS. PILGRIM:
23 A. That was my understanding. I understood that
24 it was drafted there through Janie Bussey.
25 COFFEY, Q.C.:

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1 Q. Bussey.
2 MS. PILGRIM:
3 A. That was my understanding.
4 COFFEY, Q.C.:
5 Q. When did you have that -
6 MS. PILGRIM:
7 A. And where I got that understanding, I don't--
8 well, at the time, I think I was--well, at the
9 time we were a bit flabbergasted, actually,
10 that we had to send a letter out about this
11 under our letterhead. So there were
12 discussions about that, why did Eastern Health
13 have to send it out, but, anyway, we got over
14 that, we were told we had to do it, and I
15 think it was at that time I said, well, where
16 did the letter come from, surely we didn't
17 have to write the letter, and I was told, no,
18 that the letter had come from the law firm.
19 COFFEY, Q.C.:
20 Q. So, to get this right now, you say you would
21 have learned probably in the summer of 2007?
22 MS. PILGRIM:
23 A. At the time that this was going on, yes.
24 COFFEY, Q.C.:
25 Q. That Eastern Health is going to have to send a

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1 letter on its own letterhead to all the
2 patients, living patients?
3 MS. PILGRIM:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. You also learned and you knew at the time
7 that--understood that the letter, its
8 contents, were being drafted by Stewart
9 McKelvey, the law firm?
10 MS. PILGRIM:
11 A. That's what I--somebody told me that somewhere
12 along the line.
13 COFFEY, Q.C.:
14 Q. Okay.
15 MS. PILGRIM:
16 A. That was my understanding.
17 COFFEY, Q.C.:
18 Q. And the letter, did you have any understanding
19 when the letter showed up in Eastern Health,
20 like, the text for the letter came from
21 Stewart McKelvey?
22 MS. PILGRIM:
23 A. Yes. Well, I don't know where it came from.
24 I mean, it must have come from--we didn't
25 write it.

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1 COFFEY, Q.C.:
2 Q. And the -
3 MS. PILGRIM:
4 A. This would have come into the Quality
5 Department, right.
6 COFFEY, Q.C.:
7 Q. Now at that point in time, the Quality
8 Department was reporting to whom?
9 MS. PILGRIM:
10 A. When was this?
11 COFFEY, Q.C.:
12 Q. This is the summer of '07, August.
13 MS. PILGRIM:
14 A. Me.
15 COFFEY, Q.C.:
16 Q. Yourself, and Ms. Crowley did send the letter,
17 she signed the letter and it went out?
18 MS. PILGRIM:
19 A. She did.
20 COFFEY, Q.C.:
21 Q. And this particular letter we're looking at
22 here now, 730, is the September 19th response.
23 A letter then was received by her from a
24 number of physicians?
25 MS. PILGRIM:

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1 A. That's correct, yes.
2 COFFEY, Q.C.:
3 Q. It's copied to a number of individuals,
4 including yourself, look at the bottom there.
5 MS. PILGRIM:
6 A. Uh-hm.
7 COFFEY, Q.C.:
8 Q. What, if anything, then happened in relation
9 to this? I take it Ms. Crowley did respond?
10 MS. PILGRIM:
11 A. She wrote a letter back to them.
12 COFFEY, Q.C.:
13 Q. Sure.
14 MS. PILGRIM:
15 A. And explained.
16 COFFEY, Q.C.:
17 Q. Explained -
18 MS. PILGRIM:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. That -
22 MS. PILGRIM:
23 A. You know, unfortunately it was the doctors who
24 had to deal with the fallout of this. As with
25 most of this, it's the patient who goes to the

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1 doctor, and then the doctor has to take the
2 time to explain to the patient, the patients
3 are upset, so, you know, this is very
4 unfortunate that this happened, and, you know,
5 it was--it was just human error that nobody
6 saw that screening piece on this letter
7 because that's what this was about, breast
8 screening.
9 COFFEY, Q.C.:
10 Q. Now this did arise here in front of the
11 Commission, Ms. Jones was asked about this in
12 terms of the law firm.
13 MS. PILGRIM:
14 A. Right.
15 COFFEY, Q.C.:
16 Q. Because Ms. Crowley in her response explains
17 to the doctors, look, this is the lawyers
18 caused this.
19 MS. PILGRIM:
20 A. Uh-hm.
21 COFFEY, Q.C.:
22 Q. And I understand--we understand while Ms.
23 Jones was here testifying that day, the day
24 she testified about that, okay, that Eastern
25 Health had to clarify.

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1 MS. PILGRIM:
2 A. I think they wanted to make sure--people
3 thought--they thought that's where it came
4 from. They wanted to get some actual proof
5 that it did come from Stewart McKelvey.
6 COFFEY, Q.C.:
7 Q. So were you involved in that?
8 MS. PILGRIM:
9 A. I was on the periphery of that. I wasn't the
10 person actually doing the e-mailing and that,
11 I don't think.
12 COFFEY, Q.C.:
13 Q. So, anyway, on the day that Ms. Jones
14 testified here, there was--the media was
15 contacted to be told what?
16 MS. PILGRIM:
17 A. The media was contacted?
18 COFFEY, Q.C.:
19 Q. Yes.
20 MS. PILGRIM:
21 A. I don't know--we probably didn't know at that
22 point--like, I don't know if we ever actually
23 100 percent validated where that letter came
24 from. I don't know if they ever found the e-
25 mail or the--I don't know that. I may have

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1 known it, Mr. Coffey, I might have forgotten
2 it. I only know what I thought at the time.
3 COFFEY, Q.C.:
4 Q. Did you speak to the media at the time, for
5 example, Carolyn Stokes?
6 MS. PILGRIM:
7 A. I probably did -
8 COFFEY, Q.C.:
9 Q. To tell her that the letter had come from
10 Eastern Health's own lawyers?
11 MS. PILGRIM:
12 A. I don't think I did.
13 COFFEY, Q.C.:
14 Q. I'm just asking were you aware?
15 MS. PILGRIM:
16 A. I don't know.
17 COFFEY, Q.C.:
18 Q. Okay, you don't.
19 MS. PILGRIM:
20 A. No.
21 COFFEY, Q.C.:
22 Q. Okay. Commissioner, thank you, I've gone a
23 bit longer than I thought. Thank you very
24 much, Ms. Pilgrim.
25 MS. PILGRIM:

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1 A. Mr. Coffey.
2 THE COMMISSIONER:
3 Q. Mr. Pritchard.
4 MS. PATRICIA PILGRIM - EXAMINATION BY MR. ROLF PRITCHARD
5 MR. PRITCHARD:
6 Q. Thank you, Commissioner. Good afternoon, Ms.
7 Pilgrim. My name is Rolf Pritchard.
8 Obviously, we've met before, and I'm a
9 solicitor with the Government of Newfoundland
10 and Labrador. I just briefly wanted to
11 explore two issues with you that arose in your
12 evidence. One of them was Mr. Coffey was
13 taking you through the events around the media
14 briefing on February 21st of this year, and he
15 asked you about whether you had any
16 recollection about being asked by any of the
17 media people present about the conversion
18 rates of the deceased and whether you had
19 information about that, and I think your
20 response was that you didn't have any specific
21 recollection of being asked that?
22 MS. PILGRIM:
23 A. No, I don't have recollection. The only
24 recollection I have is being asked about how
25 come we didn't know about the numbers of

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1 deceased earlier.
2 MR. PRITCHARD:
3 Q. And specifically, just to be clear now, you
4 were asked about the conversion rates of the
5 deceased, at least that's what Mr. Coffey was
6 asking you about?
7 MS. PILGRIM:
8 A. That's what I told him I couldn't remember.
9 MR. PRITCHARD:
10 Q. You couldn't remember that, and would it be
11 fair to say that had you been asked about the
12 conversion rates of the deceased at that time,
13 you wouldn't have been able to answer that?
14 MS. PILGRIM:
15 A. No, I don't think so. I don't think I would
16 have.
17 MR. PRITCHARD:
18 Q. Okay, and would it be fair to say that you
19 lacked that knowledge at that time because
20 those calculations had not been done?
21 MS. PILGRIM:
22 A. Yeah, well, I--it wouldn't have been
23 calculations that I would have done. If
24 somebody else might have done it, but I wasn't
25 aware of them.

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1 MR. PRITCHARD:
2 Q. You weren't aware of them?
3 MS. PILGRIM:
4 A. No.
5 MR. PRITCHARD:
6 Q. All right, fair enough. The other thing that
7 I wanted to ask you about, Ms. Pilgrim, and
8 Mr. Coffey took you to this, I think, on two
9 occasions today. He asked you about the
10 decision making process around the reviewing,
11 what had occurred, he asked you about in April
12 and then subsequently in the summer, and that
13 was around the decision not to go back and
14 review your documents and files, and you had
15 said that what happened was that it became
16 clear that what you would end up doing was
17 going through all the pathology reports, it
18 was a great deal of paperwork and there was a
19 resource issue?
20 MS. PILGRIM:
21 A. Capacity issue for us.
22 MR. PRITCHARD:
23 Q. Capacity issue is the word you used, fair
24 enough.
25 MS. PILGRIM:

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1 A. Uh-hm. I prefer to use the word "capacity"
2 than "resource", because then people think,
3 well, if you throw some money at it, you can
4 fix it, and it's more than that for us.
5 MR. PRITCHARD:
6 Q. Sure, and in terms of that being a capacity
7 issue, when Mr. Coffey asked you about that, I
8 think on two occasions you said that in the
9 end it had become an executive decision that
10 Ms. Jones had decided the capacity wasn't
11 there, it couldn't be done, notwithstanding
12 Mr. Thompson's request, and so he was
13 subsequently advised Eastern Health wasn't
14 able to do it?
15 MS. PILGRIM:
16 A. At that time, yes.
17 MR. PRITCHARD:
18 Q. At that time, okay. The one thing I wanted to
19 ask you about, and I just wanted to take you--
20 in your testimony yesterday, and I don't know
21 if we can call that up, the transcript from
22 yesterday at page 385. Thank you, Registrar.
23 And just looking on page 385, as you move down
24 there, this is--you were also asked about this
25 issue yesterday by Mr. Coffey. And in your

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1 evidence yesterday when you went through that,
2 just towards the bottom of page 385, I'll see
3 if I can scroll down, you were talking, I
4 believe, about the same event again. And
5 there you, right at the bottom, line 23, 24
6 you raised the capacity issue again.
7 MS. PILGRIM:
8 A. Okay.
9 MR. PRITCHARD:
10 Q. And there you say "And at that time between
11 Louise Jones and Robert Thompson a decision
12 was made that we would not do that." And the
13 implication I took reading that was that Mr.
14 Thompson had somehow taken part in that
15 decision and today it became clear to me, when
16 you reiterated this to Mr. Coffey that perhaps
17 you had mis-spoken yesterday. Is that fair to
18 say?
19 MS. PILGRIM:
20 A. Well, obviously if that's how I expressed it.
21 Mr. Thompson didn't stray from his position
22 that we should do this.
23 MR. PRITCHARD:
24 Q. He didn't stray from his position?
25 MS. PILGRIM:

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1 A. No, he did not. It was our decision not to do
2 it.
3 MR. PRITCHARD:
4 Q. Thank you, Ms. Pilgrim. Those are all my
5 questions.
6 THE COMMISSIONER:
7 Q. Mr. Browne?
8 MS. PATRICIA PILGRIM, EXAMINATION BY MR. PETER BROWNE
9 MR. BROWNE:
10 Q. Good afternoon, Ms. Pilgrim?
11 MS. PILGRIM:
12 A. Good afternoon, Mr. Browne.
13 MR. BROWNE:
14 Q. We've met before. Peter Browne, I represent a
15 number of the individual physicians who have
16 been called to testify. I just have one point
17 of clarification. Registrar, could I see
18 Exhibit P-1351? I've made a note yesterday
19 where your--during your testimony, Ms.
20 Pilgrim, about this exhibit. You were shown
21 this exhibit and it shows various numbers, the
22 results back from a summary of the Mount Sinai
23 results. And I made a note that this
24 information was discussed among, I think you
25 referenced the group. And I was unclear as to

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1 what group, we sort of heard about various
2 groups of people meeting throughout this whole
3 process, what group you were referring to? Do
4 you recall?
5 MS. PILGRIM:
6 A. The group?
7 MR. BROWNE:
8 Q. Yeah. Was there a communications group that
9 you -
10 MS. PILGRIM:
11 A. Yeah, there was kind of a core group. But
12 then if you were talking about doing scripts
13 and what people were going to be saying to
14 patients, etcetera, that was really from
15 quality, that group that would be making that
16 decision.
17 MR. BROWNE:
18 Q. Was there a communications group, as well?
19 MS. PILGRIM:
20 A. Yeah, with Susan Bonnell and people like that.
21 MR. BROWNE:
22 Q. And that communications group, did that
23 involve physicians?
24 MS. PILGRIM:
25 A. No.

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1 MR. BROWNE:
2 Q. Okay. Would the communications group be
3 involved with any of this information in terms
4 of disseminating information out to -
5 MS. PILGRIM:
6 A. They'd probably get the information, but, you
7 know, how we were going to go forward and
8 communicate things, really you didn't--the
9 physicians weren't involved in that, no.
10 MR. BROWNE:
11 Q. Okay. If -
12 MS. PILGRIM:
13 A. They were involved in who was going to be
14 panelled and things like that.
15 MR. BROWNE:
16 Q. Thank you for clarifying that.
17 MS. PILGRIM:
18 A. You're welcome.
19 MR. BROWNE:
20 Q. Thank you.
21 THE COMMISSIONER:
22 Q. Mr. Pritchett?
23 MR. PRITCHETT:
24 Q. No questions, Commissioner, thank you.
25 THE COMMISSIONER:

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1 Q. Ms. Newbury?
2 MS. PATRICIA PILGRIM, EXAMINATION BY MS. JENNIFER NEWBURY
3 MS. NEWBURY:
4 Q. Good afternoon, Ms. Pilgrim.
5 MS. PILGRIM:
6 A. Good afternoon.
7 MS. NEWBURY:
8 Q. Jennifer Newbury representing the Canadian
9 Cancer Society. I want to bring you first to
10 a comment that you made, I believe, on your
11 first day of evidence here. You were talking
12 about, I guess, the perception by some that
13 the organized health care system could be seen
14 as paternalistic and I thought that you were
15 agreeing with that concept or the commentary
16 about that viewpoint?
17 MS. PILGRIM:
18 A. Yes.
19 MS. NEWBURY:
20 Q. Okay. And when you were agreeing with that,
21 were you referring to Eastern Health, in
22 particular, or were you including Eastern
23 Health in that or were you talking just as a
24 more general view?
25 MS. PILGRIM:

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1 A. No, I think in general I think that the system
2 is evolving, for sure, but we have a long way
3 to go. And I think as far as Eastern Health
4 goes, I think there's certainly been lessons
5 learned through this process for Eastern
6 Health, just us. But I think it applies to
7 the organized health care system in general.
8 MS. NEWBURY:
9 Q. Sure, okay. But it would also include Eastern
10 Health?
11 MS. PILGRIM:
12 A. Yes.
13 MS. NEWBURY:
14 Q. And you mentioned that we are moving away from
15 that, I guess, the paternalistic -
16 MS. PILGRIM:
17 A. Well, I used paternalistic because that's the
18 term that people used.
19 MS. NEWBURY:
20 Q. Sure.
21 MS. PILGRIM:
22 A. And to me paternalistic is the idea that, you
23 know, doctors and nurses--you sometimes hear,
24 I've heard it said by people that I know who
25 want to be more involved in decision making

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1 that just because you enter a hospital and put
2 on a nightgown, it doesn't make you an idiot.
3 MS. NEWBURY:
4 Q. Um-hm.
5 MS. PILGRIM:
6 A. And that's where that kind of comes from, it's
7 the we know better, we know best from the
8 organized professionals.
9 MS. NEWBURY:
10 Q.
11 MS. PILGRIM:
12 A. So that's what--you know, that's--I think
13 health care has come a long way, but for us to
14 meet the expectations that the public and
15 other stakeholders have of the system, I think
16 there's a lot of dialogue and better
17 understanding that has to go on between the
18 many groups.
19 MS. NEWBURY:
20 Q. Okay. And I understood what you meant, I
21 think, by the use of the phrase
22 "paternalistic" -
23 MS. PILGRIM:
24 A. Yes, I just used that because that's usually
25 what people will say.

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1 MS. NEWBURY:
2 Q. Sure.
3 MS. PILGRIM:
4 A. The paternalistic, you know, system.
5 MS. NEWBURY:
6 Q. And in moving away from that sort of approach,
7 has Eastern Health taken any concrete steps in
8 that regard or is it just more that the mind
9 set of Eastern Health is more amenable to
10 being less or trying to be less paternalistic?
11 MS. PILGRIM:
12 A. I think, you know, again, if I look back over
13 my years in health care, we have come leaps
14 and bounds in terms of what we share with--you
15 know, how we interact with the public, what we
16 share with stakeholders, the way that we do
17 business of health care. I think where the
18 big challenges are going to be now is the
19 whole area of transparency and accountability.
20 Those are the things which, you know, even
21 through this process the whole issue of public
22 disclosure for me is still, I'm still not
23 satisfied with it. Even what we've learned so
24 far, we've had, you know, part one of this
25 Inquiry, the things that I've read, the

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1 disclosure policies, still to me there's got
2 to be a lot more learning on all sides, and I
3 mean, everybody, because they're--the
4 expectations of the health care system and the
5 health care system's capacity to respond to
6 those expectations is going to have to be
7 talked about and debated, as well. But we
8 still have a long way to go in terms of
9 linking with the stakeholders that are in the
10 community in a meaningful way. I know in my
11 career, first when we started with the Health
12 Care Corporation, we were all told we had to
13 have an external advisory committee, you know,
14 so we were told that by Sister Elizabeth and
15 we all went forward and we had one. But what
16 use it was to anybody, I'm not too sure. For
17 me it was a lot of working getting a lot of
18 information that I had to share with all these
19 people on a monthly basis. And for the
20 consumers or patients or representatives of
21 the community that were there, I think it was
22 a frustrating experience for them. And it was
23 really something that we never stopped and
24 said, well, you know, if you're going to do
25 this, we have to really sit down with the

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1 people within the health care system and say,
2 well, this has to be meaningful, so let's talk
3 about why are we doing this and let's talk
4 with these stakeholders and say so what is
5 your expectation of this process and let's
6 probably sit down and decide, well, with this
7 particular forum, we're going to be able to
8 accomplish this, this and this, but not this.
9 So then everybody is pretty clear why we're
10 coming together or why we're not, and we
11 didn't do that.
12 MS. NEWBURY:
13 Q. Okay. So can I take it then from your answer
14 that in moving away from, I guess, a
15 paternalistic approach, for lack of a better
16 term, Eastern Health has learned lessons from
17 this whole process, as well as part to the
18 Inquiry but hasn't yet taken any concrete
19 steps to implement anything? As an example,
20 and I'll throw this out because Peter Dawe has
21 mentioned it, the concept of having a patient
22 right to know, sort of guiding principle or
23 statement?
24 MS. PILGRIM:
25 A. That was--that's the whole issue, for example,

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1 of a patient bill of rights.
2 MS. NEWBURY:
3 Q. Yes.
4 MS. PILGRIM:
5 A. And that's still something which we have on
6 the agenda. Some of our legacy organizations
7 did have that. But again, you know, that's
8 only useful if it's alive and well within your
9 organization. And yeah, those are the things.
10 I would not say, Ms.--that we have not done
11 anything.
12 MS. NEWBURY:
13 Q. Okay.
14 MS. PILGRIM:
15 A. And I look at certain parts of our
16 organization which are further ahead than
17 others. I think that our mental health
18 program probably has some more effective
19 linkages than some of our other programs do
20 because they tend to work with those groups
21 more closely, the community groups. Others
22 have, you know, have been a little bit less--
23 slower to evolve. And I know within Eastern
24 Health now we are going to have a senior
25 position put in which is going to be called a

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1 vice president of, I'll never get the name
2 now, but it's like communications and
3 linkages, and one of the focuses for that
4 group, for that role would be to really work
5 with the organization about, you know, how
6 we're going to work more effectively with the
7 community and with partners in the community.
8 MS. NEWBURY:
9 Q. Okay.
10 MS. PILGRIM:
11 A. So there will be somebody who'll really be
12 focused on that. And the other thing I think
13 that you will see with the boards now, even
14 though it may not be that visible, probably,
15 to the public. But I know with our board,
16 with policy governance, one of the things that
17 they have as their mandate is they have
18 linkages with the communities that they serve.
19 And they have set up, you know, they've been
20 doing needs assessments in these communities
21 and having community based advisory committees
22 like on Bell Island, Burin Peninsula and to me
23 those are positive examples of how the
24 organized health care system is changing to
25 better meet the needs and the expectations

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1 that are there.
2 MS. NEWBURY:
3 Q. So in terms of having, you know, a concrete
4 guiding principle such as a patient right to
5 know, is that something that's still on the
6 agenda still to be considered?
7 MS. PILGRIM:
8 A. Well, I think what you'll see is as we move
9 forward with this, yeah, you're going to have
10 to have something that's going to guide you.
11 MS. NEWBURY:
12 Q. You may not call it that, you might call it
13 something else?
14 MS. PILGRIM:
15 A. No, it might be something else. But you're
16 going to have rules of engagement or terms of
17 reference, whatever you want to call it.
18 MS. NEWBURY:
19 Q. Basically responsibilities or something like
20 that?
21 MS. PILGRIM:
22 A. Yes, yeah. But don't just think because
23 you're bringing in a group of community
24 stakeholders and having a meeting with them
25 once a month that you're actually doing

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1 effective things. Now, in some cases you are.
2 MS. NEWBURY:
3 Q. Yes.
4 MS. PILGRIM:
5 A. But in some cases you're not.
6 MS. NEWBURY:
7 Q. And if it turns out that that process is not
8 going to be effective, I mean will you
9 continue to pursue by implementing another
10 process -
11 MS. PILGRIM:
12 A. Well, I think we have to be committed, but I
13 think it has to be a commitment on all sides
14 that--you know, from where I sit Eastern
15 Health doesn't have all the answer.
16 MS. NEWBURY:
17 Q. Sure.
18 MS. PILGRIM:
19 A. You know, we're not knowledgable about all of
20 this. And there could be other stakeholders
21 that certainly have more knowledge of what we
22 should be doing there and we have to work
23 together. It's got to be an effort that's
24 taken on by all of us and if it's not working,
25 you just don't have people taking up their

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1 bags and leaving and criticizing it or
2 whatever. So we've got to all work at it
3 together.
4 MS. NEWBURY:
5 Q. Has there been any communication with
6 stakeholders to date on that whole issue, for
7 example, The Canadian Cancer Society?
8 MS. PILGRIM:
9 A. No. Since this, the only communication I've
10 had with Peter, I did have a meeting with
11 Peter Dawe about a month ago after he gave his
12 testimony here because I guess I just wanted
13 to talk to Peter about how we're going to move
14 forward and build relationships just between
15 the cancer care program and the Canadian
16 Cancer Society, which is an important linkage.
17 MS. NEWBURY:
18 Q. Um-hm.
19 MS. PILGRIM:
20 A. And we did plan on bringing a group together
21 for that, which we haven't done yet, but
22 certainly I'll be contacting him again. So I
23 think the initial contact has been made there
24 and hope we can build, but I'm talking about
25 something even broader than that -

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1 MS. NEWBURY:
2 Q. Broader than that, right.
3 MS. PILGRIM:
4 A. - as far as Eastern Health goes, yes.
5 MS. NEWBURY:
6 Q. Right, because this sort of principle wouldn't
7 apply only to the cancer -
8 MS. PILGRIM:
9 A. No, no, no, no, no, no. Many, many
10 stakeholders.
11 MS. NEWBURY:
12 Q. Sure. And the position VP communications and
13 linkages, is that--is that a definite position
14 to be implemented?
15 MS. PILGRIM:
16 A. Oh, yes.
17 MS. NEWBURY:
18 Q. Okay.
19 MS. PILGRIM:
20 A. Yeah, I think it's been advertised, probably.
21 MS. NEWBURY:
22 Q. And you just brought up an issue about the
23 board and the fact that there's a policy
24 governance model there and you're hoping that
25 that will be a good method of communicating or

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1 linking with the communities. I believe you'd
2 mentioned in your evidence the other day that
3 you found that the model of policy governance
4 that was being used by this particular board,
5 you found it to be productive, I believe?
6 MS. PILGRIM:
7 A. I was talking about it in terms of comparing
8 how they are approaching their role with
9 quality.
10 MS. NEWBURY:
11 Q. Um-hm.
12 MS. PILGRIM:
13 A. And, you know, boards struggle with that, as
14 you know. What is my role, what should I be
15 involved in.
16 MS. NEWBURY:
17 Q. Sure.
18 MS. PILGRIM:
19 A. I find the approach that they're taking and
20 the work that we're doing with them, to me is
21 much more meaningful than anything I've seen
22 before.
23 MS. NEWBURY:
24 Q. Okay, and that observation, when do you feel
25 that the--that sort of good productive sort of

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1 interaction with the board in terms of the
2 quality, when did you make that observation,
3 was it immediately when the board was formed
4 or was it sometime after, recognizing that
5 this was a new board and they had to, I guess,
6 develop and implement their policies?
7 MS. PILGRIM:
8 A. I think it was evident to me as soon as--now,
9 I had had experience with policy governance
10 before in other boards that I'd been on. And
11 I think as soon as I realized they were going
12 with policy governance, because I was thinking
13 anywhere I'd seen it was small organizations
14 like the Association of Registered Nurses and
15 I was thinking, now, how is this going to work
16 in a billion dollar enterprise with all the
17 things that we have going on. But as soon as
18 I started seeing how it was coming out and we
19 had the first meeting with the board, I could-
20 -you know, I had a bit of hope that this is
21 going to probably work better than anything
22 we've tried before.
23 MS. NEWBURY:
24 Q. Um-hm.
25 MS. PILGRIM:

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1 A. And as it has evolved, I've become more
2 convinced that it is a good way to go.
3 MS. NEWBURY:
4 Q. Ms. Pilgrim, I take it from your evidence that
5 it was your understanding that the plan
6 regarding the physician review panel was that
7 the retest results from Mount Sinai would be
8 panelled, would be referred to the panel
9 before the patient would be advised of his or
10 her results?
11 MS. PILGRIM:
12 A. I don't remember giving any evidence. Did you
13 say I've already spoken about -
14 MS. NEWBURY:
15 Q. That was what I understood from your evidence.
16 That's why I'm asking you to clarify, I wasn't
17 entirely sure.
18 MS. PILGRIM:
19 A. I don't remember saying that.
20 MS. NEWBURY:
21 Q. Okay. Well, what is your understanding of
22 what the plan was at the time?
23 MS. PILGRIM:
24 A. I wasn't directly involved with that at the
25 time.

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1 MS. NEWBURY:
2 Q. Okay.
3 MS. PILGRIM:
4 A. I can tell you what I understood. I
5 understood that all the results would be
6 reviewed and someone like Kara Laing, Nash,
7 they would pull out the ones that had to be
8 panelled. And the only ones that really non-
9 physicians were free to walk away with were
10 the ones who really hadn't changed, the
11 results hadn't changed. The rest would have
12 to be looked at.
13 MS. NEWBURY:
14 Q. And who did the pulling out?
15 MS. PILGRIM:
16 A. I know that Heather would--now, she'd give you
17 a better answer to this because I wasn't
18 directly involved in that panel -
19 MS. NEWBURY:
20 Q. Okay. But just your understanding of who was
21 doing that?
22 MS. PILGRIM:
23 A. It would be Heather would look at it and I
24 think then she would run it by Kara Laing or
25 one of the oncologists.

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1 MS. NEWBURY:
2 Q. And I guess on the second part of that piece,
3 your understanding of whether or not, either
4 simultaneously or whether there was a sequence
5 of events in terms of the Mount Sinai results
6 being communicated to the patient, for
7 example, if a report was revised, pathology
8 report was revised to add an addendum with
9 Mount Sinai's results, would that go to the, I
10 guess, the attending physician or the primary
11 treating physician for the patient before the
12 panel got the case to review -
13 MS. PILGRIM:
14 A. If the results changed, it would have to go to
15 the panel.
16 MS. NEWBURY:
17 Q. Before it went -
18 MS. PILGRIM:
19 A. And my understanding was--now, I might be
20 wrong, because I wasn't directly involved in
21 this -
22 MS. NEWBURY:
23 Q. Okay.
24 MS. PILGRIM:
25 A. - I probably shouldn't be saying anything. I

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1 can only tell you my understanding. But in
2 many cases they didn't put the addendum in
3 there until the patient had been panelled.
4 MS. NEWBURY:
5 Q. Okay.
6 MS. PILGRIM:
7 A. You know, they weren't always--you know, the
8 patient, it was very important that those
9 results be panelled.
10 MS. NEWBURY:
11 Q. Before even -
12 MS. PILGRIM:
13 A. Before anything -
14 MS. NEWBURY:
15 Q. Even the attending physician?
16 MS. PILGRIM:
17 A. Yes.
18 MS. NEWBURY:
19 Q. Even if the attending physician was an
20 oncologist?
21 MS. PILGRIM:
22 A. Once they started to panel, yeah. They even
23 wrote panel letters to themselves.
24 MS. NEWBURY:
25 Q. Okay. And do you know, is it your

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1 understanding or do you have any information
2 whether that approach was consistently
3 applied? Because I think there's been some
4 evidence that -
5 MS. PILGRIM:
6 A. I don't.
7 MS. NEWBURY:
8 Q. - some of the results did reach -
9 MS. PILGRIM:
10 A. You're really asking me things I don't know
11 about now.
12 MS. NEWBURY:
13 Q. And who, I guess among the team, would have
14 been responsible for making that decision?
15 MS. PILGRIM:
16 A. Making what decision?
17 MS. NEWBURY:
18 Q. About the sequence of events, in terms of who-
19 -you know, when the retest results from Mount
20 Sinai were communicated to the physician,
21 whether it was simultaneously with the panel,
22 before or after, who decided how that process
23 would work?
24 MS. PILGRIM:
25 A. Again, the people that would have been

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1 directly involved in that would have been an
2 oncologist, a pathologist and Heather, you
3 know. That's the people -
4 MS. NEWBURY:
5 Q. An oncologist, a pathologist and Heather?
6 MS. PILGRIM:
7 A. Heather Predham.
8 MS. NEWBURY:
9 Q. In deciding how the process would work? I
10 know that, based on what you said -
11 MS. PILGRIM:
12 A. Yes.
13 MS. NEWBURY:
14 Q. - that was your understanding of how it was
15 implemented.
16 MS. PILGRIM:
17 A. Right.
18 MS. NEWBURY:
19 Q. But in terms of deciding "this is our
20 principled approach to dealing with the retest
21 results"?
22 MS. PILGRIM:
23 A. I would have thought they would have discussed
24 that, yeah, and come up with a--but again, I
25 shouldn't be answering your questions because

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1 I wasn't involved -
2 MS. NEWBURY:
3 Q. Okay, so you really don't know?
4 MS. PILGRIM:
5 A. - directly in that at that time, no.
6 MS. NEWBURY:
7 Q. Okay, and I guess you wouldn't be aware then
8 if that plan was ever reconsidered at any
9 point in time, as to how to deal with that?
10 Obviously, if you didn't know the original
11 plan -
12 MS. PILGRIM:
13 A. No, like I don't know the details of that, you
14 know, so I shouldn't even be surmising.
15 MS. NEWBURY:
16 Q. Sure, okay.
17 THE COMMISSIONER:
18 Q. Do I take it from that, Ms. Pilgrim, that you
19 would be surprised to learn that a patient may
20 have been seen had their treatment changed by
21 their oncologist before they were panelled?
22 MS. PILGRIM:
23 A. Oh no, if a patient came into the clinic and,
24 you know, might have said to an oncologist "I
25 wonder what my results are?" and the

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1 oncologist went looking for them, they would
2 deal with that right there, because that was
3 one of the issues. Some of the patients had
4 already been given their results and
5 treatments changed, you know, their treatments
6 changed before they even got to the panel. I
7 know that that happened.
8 THE COMMISSIONER:
9 Q. So the plan could not have been everybody had
10 to go through the panel before their
11 treatments were--decisions were decided.
12 MS. PILGRIM:
13 A. Well, see, I mean, I don't know the details of
14 that.
15 THE COMMISSIONER:
16 Q. Okay.
17 MS. PILGRIM:
18 A. I know that that happened though, that--I know
19 they wrote letters to themselves and I know
20 that there were patients who had already had
21 their treatment changed, and they would
22 probably come up--because I'd hear Heather say
23 that, they--and I read some of the panel
24 meetings. They'd come to the panel, but be
25 put to the side because they were actually

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1 already dealt with.
2 MS. NEWBURY:
3 Q. So there might have been a plan, but those
4 examples would be a deviation from the plan?
5 MS. PILGRIM:
6 A. Yeah, and you'd have to ask somebody other
7 than me, I'm sorry, to give you the details
8 there.
9 MS. NEWBURY:
10 Q. Okay, that's fine, thank you. In terms of the
11 role of the patient relations officer in
12 communication with patients, from your
13 perspective, would it have been appropriate
14 for Ms. Parsons, given her background and her
15 involvement in the whole ER/PR issue, would it
16 have been appropriate for her to advise
17 patients whose results had changed that their
18 results were back, their retest results were
19 back from Mount Sinai, a panel would be
20 reviewing her file to see if any changes of
21 treatment were necessary and that a physician
22 would be in touch with her when that process
23 had been completed?
24 MS. PILGRIM:
25 A. That would be appropriate, yes. It wouldn't

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1 be anything--I guess the only problem with
2 that was that once a patient knows their
3 results are back, they really want to know
4 what those results are, and probably should be
5 given the result so they can go off and ask
6 whomever they want and probably not--you know,
7 I mean, we have learned so much from this and
8 how this was handled that if we had to do this
9 a different way--now some of this is not easy
10 to set up because ideally, patients should get
11 their results as soon as their back and they
12 should be told them by the person who can
13 answer their questions. But with the numbers
14 that we were dealing with and the time lines
15 that we were dealing with, that was not
16 feasible for us to do. So we set up a process
17 whereby we would have someone who would answer
18 the phone. If your results hadn't changed,
19 they could give you those results. But
20 really, if the results had changed, in my
21 mind, they weren't even official until they
22 had been panelled, you know, until the patient
23 had been panelled. So what you're saying is
24 yes, that would have been--there's nothing
25 wrong with that approach, but then I'm sure

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1 the debate and the discussion would have been
2 "but look what that does to the patient" and
3 again, it might be the paternal way of looking
4 at it, "are you going to have these patients--
5 give them that information and then say 'so
6 when the panel is finished, which could be
7 another three weeks time, we'll be in contact
8 with you.'" In hindsight, as I look at it
9 today, I can say well, that would actually
10 give the patients a choice then, if they
11 didn't want to wait those three weeks. But
12 that's not how we were thinking at the time.
13 MS. NEWBURY:
14 Q. It would also give the patient an opportunity
15 to follow up, if she didn't hear -
16 MS. PILGRIM:
17 A. Oh yeah.
18 MS. NEWBURY:
19 Q. - from it in a timely manner.
20 MS. PILGRIM:
21 A. And we know that they would, right. They
22 would call and call. So you know, we made the
23 choices we made.
24 MS. NEWBURY:
25 Q. Sure. Were they actually debated and

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1 discussed prior to Ms. Parsons being given the
2 task?
3 MS. PILGRIM:
4 A. Oh, I would say, yes. I mean, now again, I
5 wasn't in all these meetings, but I know that
6 there were many discussions about the right
7 and the wrong way to do this stuff and how do
8 we do it, and which of these things is going
9 to traumatize the patient less and it seemed
10 like whichever way you went, there was a
11 chance that patients were going to be
12 traumatized by it, and you know, what we're
13 talking about today is how we did it.
14 MS. NEWBURY:
15 Q. Sure.
16 MS. PILGRIM:
17 A. And we don't know what it would have been like
18 if we had done it a different way. It might
19 have been better. It might have been worse.
20 MS. NEWBURY:
21 Q. But in terms of the actual approach taken by
22 Ms. Parsons at the time, if it was debated and
23 discussed, do I take it from that that her
24 approach that she took was actually endorsed
25 by Eastern Health?

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1 MS. PILGRIM:
2 A. Oh, I would say, yes.
3 MS. NEWBURY:
4 Q. Yes, okay, and I guess, the decision
5 ultimately, after these debates and
6 discussions, was that it would not be
7 appropriate for Ms. Parsons--that's what you
8 concluded at the time, to do as I had
9 suggested, which is to advise them that the
10 results are back. There's been a change and
11 they would be -
12 MS. PILGRIM:
13 A. No, and I can only surmise the discussion that
14 would have gone on around that, which would
15 have been on the other side, what are you
16 doing to the patient there, so in terms of the
17 stress that you would be putting on them.
18 MS. NEWBURY:
19 Q. And you don't have any record or you haven't
20 seen any record of any such discussion in your
21 role?
22 MS. PILGRIM:
23 A. No, that probably wouldn't--because most of
24 that discussion would have gone on within
25 Quality, between the people who were actually

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1 doing the calling. I know they got together
2 and did a script and things like that. But,
3 you know, I'm certainly not minimizing the
4 situation that these people were in, in terms
5 of talking to these patients and families, but
6 you know, there was one way we had to go.
7 There was no any way that was--you know, there
8 was issues with whatever way you went, so we
9 picked the one we picked.
10 MS. NEWBURY:
11 Q. Okay. You responded yesterday or you were
12 shown a document about an inquiry raised by a
13 patient through Peter Dawe as to whether or
14 not retesting was being done in alphabetical
15 order.
16 MS. PILGRIM:
17 A. Yes.
18 MS. NEWBURY:
19 Q. And I can bring up the exhibit, if you want to
20 see that again.
21 MS. PILGRIM:
22 A. No, I can remember.
23 MS. NEWBURY:
24 Q. You recall it, okay, and you had advised that
25 that was not in fact the case and the patient-

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1 -that was communicated to the patient
2 accordingly.
3 MS. PILGRIM:
4 A. That was my understanding, yes.
5 MS. NEWBURY:
6 Q. And according to Dr. Laing, she had indicated
7 that the patients were being referred to the
8 panel in accordance with alphabetical order.
9 Basically there would be an alphabetical list
10 of patients and then the patients would be
11 selected from that, starting I guess with the
12 A's and going through to the Z's. Were you
13 aware of that at the time?
14 MS. PILGRIM:
15 A. No. I think the list that went to the panel
16 was alphabetized. So if you had a list of 42
17 that were going today, they would alphabetize
18 that list, but they weren't coming out--
19 because these weren't sent alphabetically.
20 MS. NEWBURY:
21 Q. No, right, so they wouldn't necessarily be
22 coming back -
23 MS. PILGRIM:
24 A. No, like all the A's -
25 MS. NEWBURY:

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1 Q. - so you don't know -
2 MS. PILGRIM:
3 A. - and all the B's. Well, I do know that. I
4 mean, we didn't send them in that way.
5 MS. NEWBURY:
6 Q. Okay.
7 MS. PILGRIM:
8 A. They were sent by year, but the panel would
9 probably organize them alphabetically. Today
10 we've got 44 and here they are, from A to B,
11 yes.
12 MS. NEWBURY:
13 Q. So say if you had these meetings were taking
14 place weekly, roughly, for the most part,
15 starting in about October, and I know on some
16 of those meetings, you might have been waiting
17 for results to come back and you might only
18 have a handful or maybe none at all for
19 scheduling a meeting, but on other occasions,
20 you may have more results back and to be
21 panelled than the panel could deal with in a
22 given evening.
23 MS. PILGRIM:
24 A. Um-hm.
25 MS. NEWBURY:

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1 Q. Were there cases selected for each of those
2 panel meetings chosen by any sort of priority
3 system?
4 MS. PILGRIM:
5 A. I don't know. I wouldn't have been involved
6 in that.
7 MS. NEWBURY:
8 Q. And whose responsibility was that?
9 MS. PILGRIM:
10 A. Well, it would be--Kara was the chair of the
11 panel and Heather was assisting the panel, so
12 you'd have to ask one of them about how that
13 worked. I know they had to put on extra panel
14 meetings. They had to come in on the weekends
15 a few times.
16 MS. NEWBURY:
17 Q. Ms. Pilgrim, you'd indicated the other day
18 that it was always the plan of Eastern Health
19 to determine what the cause of the problem was
20 for the ER/PR testing, and to release that
21 information when you learned what the--
22 whatever you could about your investigation,
23 and by May 2007 when the Inquiry had been
24 called, there had been no steps taken in
25 relation to that particular plan. Is that

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1 correct?
2 MS. PILGRIM:
3 A. When I look back, again you have to put this
4 in the context, and I know it really doesn't
5 matter to you, I guess, but I have to put it
6 in the context of Eastern Health.
7 MS. NEWBURY:
8 Q. Sure.
9 MS. PILGRIM:
10 A. So we were not dealing with an organization
11 that was well established, stabilized and
12 you're just moving from one thing to another.
13 So I would have to say to everybody that the
14 focus--you know, the focus that was given to
15 this, I mean, we went--we did this as fast as
16 we could do it and as well as we could do it
17 with all the other things that were going
18 towards making up and trying to organize and
19 build this organization. So I know that in
20 the fall of 2006, my thoughts were onto now,
21 where are we with ER/PR? Where's the list of
22 patients? Are we going to do some analysis on
23 this? Are we going to start getting some
24 information? So to me, that was when I was--
25 you know, even though there'd been things

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1 going on with ER/PR all along, and that was
2 the time that we kind of dedicated most of
3 Heather Predham's time to--because she had the
4 information--to now clean all this up and get
5 it all together and we'll give you a few
6 months to do this, and then we've got to start
7 talking about how we're going to analyze it,
8 how we're going to get information out of it
9 and what are the next steps with that.
10 MS. NEWBURY:
11 Q. Okay. So there was a plan to do some sort of
12 analysis of the results?
13 MS. PILGRIM:
14 A. Right.
15 MS. NEWBURY:
16 Q. And whatever may come out of your analysis -
17 MS. PILGRIM:
18 A. Plus it might be more reviews. You know, once
19 you start doing the analysis and really the
20 analysis would be very much driven by, well,
21 what are the questions we want answered. If
22 one of the questions is well, what happened
23 here, and we don't have the answer to that
24 question, well then we're going to have to go
25 try to find out the answer to the question.

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1 MS. NEWBURY:
2 Q. But as of May of 2007, I understand you had
3 reasons for not having done anything concrete.
4 I understand that you--you've expressed that,
5 I guess, on more than one occasion.
6 MS. PILGRIM:
7 A. I have, yes.
8 MS. NEWBURY:
9 Q. Had you even gone so far as to say "these are
10 the questions that we would like to have
11 answered, when we embark upon this
12 investigation"?
13 MS. PILGRIM:
14 A. I would say that we certainly had discussions
15 about that, and I know I had Dr. Williams and
16 Dr. Nash Denic come in my office one
17 afternoon. I think Dr. Williams had just
18 retired, I think he retired in 2006, and they
19 had been meeting about the questions they
20 wanted answered, and came in to talk to me
21 about "now when are we going to be able to get
22 this information?" Because I think they were
23 cognizant of the fact that with the
24 information we had, there was going to have to
25 be more work done to get them the answers to

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1 the questions that they had. So I remember
2 that.
3 MS. NEWBURY:
4 Q. And -
5 THE COMMISSIONER:
6 Q. I'm sorry, but it is one, and I'm going to
7 suggest we break for lunch, unless you just
8 want to complete the thought with Ms. Pilgrim.
9 MS. NEWBURY:
10 Q. I guess one little idea, if I could complete
11 that, please?
12 THE COMMISSIONER:
13 Q. Sure, carry on.
14 MS. NEWBURY:
15 Q. After May 2007, there were a couple of things,
16 I think, that you mentioned had been started
17 and one is the Telling our Story and you've
18 engaged someone to prepare that.
19 MS. PILGRIM:
20 A. Um-hm.
21 MS. NEWBURY:
22 Q. You don't consider that to be the
23 investigation, do you?
24 MS. PILGRIM:
25 A. No. No, no, no.

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1 MS. NEWBURY:
2 Q. Okay, and the other project, I guess, that has
3 been started, Dr. Denic has been doing some
4 correlation of the results from Dr. Mullen -
5 MS. PILGRIM:
6 A. That's right.
7 MS. NEWBURY:
8 Q. - to compare whether the issues flagged, in
9 terms of fixation, match up with the actual
10 changed test results?
11 MS. PILGRIM:
12 A. Right.
13 MS. NEWBURY:
14 Q. And also there has been, obviously, some
15 extensive involvement with NLCHI.
16 MS. PILGRIM:
17 A. Right, there has been, yes.
18 MS. NEWBURY:
19 Q. Has there been anything -
20 MS. PILGRIM:
21 A. Any of the analysis that we're doing, by the
22 way, is being done through NLCHI. We're not
23 doing it. They're doing it for us.
24 MS. NEWBURY:
25 Q. Okay. So those are the only three things

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1 since May of 2007 that has been actually
2 started?
3 MS. PILGRIM:
4 A. That sounds so small, those are the only three
5 things since 2007. Well, I guess we spent
6 most of 2007, into 2008, working on the
7 database, and that really wasn't complete
8 until really March/April of this year. So we
9 wanted to have that as clean as we could have
10 it.
11 MS. NEWBURY:
12 Q. Sure.
13 MS. PILGRIM:
14 A. And then we go from there. So I would say,
15 you know, we're on our way now, in terms of
16 the other pieces.
17 MS. NEWBURY:
18 Q. And to date, has there been any sort of plan
19 of action or format for the investigation that
20 you still plan to do?
21 MS. PILGRIM:
22 A. For the investigation?
23 MS. NEWBURY:
24 Q. Yes.
25 MS. PILGRIM:

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1 A. What I have said is we are going to tell our
2 story and a part of the question that needs to
3 be answered with our story is what happened,
4 why were these results. Now how we do that,
5 you know, how we're going to do that -
6 MS. NEWBURY:
7 Q. You don't know?
8 MS. PILGRIM:
9 A. We haven't got that one.
10 MS. NEWBURY:
11 Q. And that was, I guess, the point of my
12 question. I was trying to find out whether
13 there has been any decision made to date -
14 MS. PILGRIM:
15 A. No.
16 MS. NEWBURY:
17 Q. - as to how you will find out what happened
18 and how -
19 MS. PILGRIM:
20 A. Well, and we'll probably get some of it
21 through what Dr. Denic is doing, some of the
22 correlations that he's doing, and then we'll
23 have to do some more work.
24 MS. NEWBURY:
25 Q. Okay, and is there anything in writing

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1 regarding Dr. Denic's correlations?
2 MS. PILGRIM:
3 A. No, other than the request he put in through
4 NLCHI and the results that he got, which I
5 think have been shared with you, the two
6 pieces of information that he started to look
7 at.
8 MS. NEWBURY:
9 Q. Okay.
10 MS. PILGRIM:
11 A. And you should have access to that, I think,
12 through the Commission.
13 MS. NEWBURY:
14 Q. Okay, thank you.
15 THE COMMISSIONER:
16 Q. Before we break, Ms. Newbury, can you--because
17 we have a witness who I think is tentatively
18 scheduled for after lunch--give me some idea?
19 MS. NEWBURY:
20 Q. I expect I'll be about an hour.
21 THE COMMISSIONER:
22 Q. Ms. Brocklehurst, sorry, I can't see you. Do
23 you know whether or not you have any
24 questions?
25 MS. BROCKLEHURST:

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1 Q. Just a few. Won't take very long,
2 Commissioner.
3 THE COMMISSIONER:
4 Q. All right. Do you want to wade in with an
5 estimate, Mr. Simmons?
6 MR. SIMMONS:
7 Q. Probably no more than 15 or 20 minutes.
8 THE COMMISSIONER:
9 Q. All right. So it looks like we're looking at
10 mid afternoon for the next witness. Thank
11 you, 2:15.
12 (LUNCH BREAK)
13 THE COMMISSIONER:
14 Q. Please be seated. Ms. Newbury?
15 MS. NEWBURY:
16 Q. Thank you. Good afternoon, Ms. Pilgrim.
17 MS. PILGRIM:
18 A. Good afternoon.
19 MS. NEWBURY:
20 Q. Ms. Pilgrim, just before the lunch break, you
21 were describing a little bit about the plans
22 to do a--I called it an investigation and I
23 think you thought that wasn't the appropriate
24 word, to look into what happened, what caused
25 the problems, with a view to releasing that to

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1 the public.
2 MS. PILGRIM:
3 A. As a part of telling the story.
4 MS. NEWBURY:
5 Q. Telling the story, okay. But the telling the
6 story part, would that process uncover the
7 problems, the cause of the problems?
8 MS. PILGRIM:
9 A. Well, any analysis that we do would be a part
10 of that.
11 MS. NEWBURY:
12 Q. Okay, so the analysis would do that. The
13 person engaged though to actually write the
14 story -
15 MS. PILGRIM:
16 A. No, no, no. No, no, no.
17 MS. NEWBURY:
18 Q. Okay, just want to be clear on that. So
19 perhaps, I don't know if you'd call it a
20 review or analysis, I'll just call it a review
21 for lack of a better word.
22 MS. PILGRIM:
23 A. Right.
24 MS. NEWBURY:
25 Q. So in terms of the review to try to find out

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1 what caused the problems, I guess, as of
2 February 2008, you have the benefit of the
3 external review reports and perhaps that might
4 be used. I'm not sure if you plan to use the
5 information in that as part of telling the
6 story.
7 MS. PILGRIM:
8 A. Um-hm.
9 MS. NEWBURY:
10 Q. And you're nodding your head, so I -
11 MS. PILGRIM:
12 A. Yes.
13 MS. NEWBURY:
14 Q. - take it that means yes.
15 MS. PILGRIM:
16 A. Yes.
17 MS. NEWBURY:
18 Q. But prior to the decision which required that
19 those reports be released, my understanding is
20 that the intention was that the external
21 review reports of Dr. Banerjee and Ms.
22 Wegrynowski would not be widely distributed,
23 even within Eastern Health, nor would it be
24 used for other than the limited purposes for
25 which they had been initially engaged.

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1 MS. PILGRIM:
2 A. Well, my understanding with peer reviews is
3 that you can use--you know, obviously the
4 recommendations out of a peer review can be
5 shared and used to develop action plans which
6 you can monitor the implementation of.
7 MS. NEWBURY:
8 Q. Okay.
9 MS. PILGRIM:
10 A. And you can also share, you know, facts from
11 peer--I mean, you can't share opinions and
12 things like that, which often peer reviews are
13 people's opinions of this and opinions of
14 that. But certainly the one thing would have
15 been the recommendations and the action plans
16 that came out of those recommendations.
17 MS. NEWBURY:
18 Q. Yes, and those would be more for go-forward
19 basis, how to modify the lab -
20 MS. PILGRIM:
21 A. Right.
22 MS. NEWBURY:
23 Q. - to correct the procedures.
24 MS. PILGRIM:
25 A. But you know, the question is still there

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1 about what happened and that requires some
2 further analysis and correlation of some of
3 the information that we have, which you know,
4 we intend to do as well.
5 MS. NEWBURY:
6 Q. Okay. So even if you were able to rely upon
7 those external review reports for some limited
8 purposes, you certainly weren't intending to
9 rely on them full reign, so that even all
10 members of the executive team would know
11 precisely what's in those reports. That's my
12 understanding.
13 MS. PILGRIM:
14 A. Well, the external review reports give you--
15 identify factors that could have contributed,
16 you know, the fact that there were fixation
17 issues, optimization, all of those things that
18 we've heard about. The question is how much
19 of that actually related to the results, you
20 know, what was the correlation between those
21 things and the results that we got.
22 MS. NEWBURY:
23 Q. Okay, and I'm asking you to, for the purposes
24 of this line of questioning, focus on what was
25 known generally within Eastern Health and all

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1 of the members of the team involved in
2 decisions prior to February 2008 when those
3 external review reports were released without
4 any restrictions upon their use.
5 MS. PILGRIM:
6 A. There wasn't a lot known, other than there was
7 an action plan developed around the
8 recommendations and I think, Ms. Newbury, I
9 had said that certainly Dr. Howell, at one
10 point, he was taking the lead with that to
11 ensure then that that was being monitored and
12 at some point, that would have been shared
13 within the organization, in terms of the
14 action plan.
15 MS. NEWBURY:
16 Q. Okay, but in terms of the underlying causes as
17 to what led to the need for an action plan -
18 MS. PILGRIM:
19 A. Yes.
20 MS. NEWBURY:
21 Q. - that would not necessarily be shared?
22 That's certainly my understanding of the
23 evidence.
24 MS. PILGRIM:
25 A. As a part of the peer review, no, that

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1 information, no.
2 MS. NEWBURY:
3 Q. Okay, and prior to this being released in
4 February of 2008, you've known about the
5 problem since about the spring or summer of
6 2005, I guess as it evolved.
7 MS. PILGRIM:
8 A. Summer of 2005, before it became more widely
9 known.
10 MS. NEWBURY:
11 Q. Okay, and was it from that very moment that
12 there always was a plan by Eastern Health to
13 determine what was the cause of the problem,
14 separate and apart from the peer review
15 process?
16 MS. PILGRIM:
17 A. Certainly from my understanding, there would
18 always have been--at some point, there would
19 have been an effort to make some conclusions
20 and summaries about what actually was the
21 cause of what happened.
22 MS. NEWBURY:
23 Q. Okay, and -
24 MS. PILGRIM:
25 A. Remember, we started off thinking this was a

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1 flawed test, and you know, we had people
2 telling us that the review you're doing is
3 only going to pick out--really going to
4 identify for you your false negatives which
5 are a part of this test. So we've come from
6 there to knowing that there's more to that
7 than just the fact that you have a false
8 positivity rate with this test.
9 MS. NEWBURY:
10 Q. In terms of furthering the investigation, I
11 guess, the non-privileged review, I'll call
12 it, from 2005 onward, was anything done by
13 Eastern Health to preserve evidence, to
14 collect documents, to preserve policies? For
15 example, you were in the process in 2005 of
16 developing new policies because you had a new
17 organization. Was anything done to preserve
18 those types of documents and policies for the
19 purposes of the non-privileged review?
20 MS. PILGRIM:
21 A. I guess the main piece of evidence would be
22 the original blocks and the original slides to
23 lead you to what could have happened in the
24 lab to create this. We all heard that there
25 weren't a lot of policies and procedures in

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1 the lab. They have been developed now, but
2 it's not like they were--you know, mainly what
3 the lab was using, this is my understanding,
4 as far as the procedures, were the manuals
5 that came from the manufacturers. So they're
6 still there.
7 MS. NEWBURY:
8 Q. Yes, and that was learned over time, but at
9 the very beginning, did--was anyone there
10 charged with going out and collecting or
11 preserving, gathering together all of the
12 documentation that would ultimately be
13 required for the non-privileged review?
14 MS. PILGRIM:
15 A. No, not that I can recall. Now again, Dr.
16 Williams or Heather may be able to answer your
17 question better on that, in terms of the very
18 early stages. I know there is information and
19 I know there certainly was a concentration on
20 trying to secure the original slides and
21 blocks and things.
22 MS. NEWBURY:
23 Q. So that part, you're comfortable with that?
24 MS. PILGRIM:
25 A. I'm comfortable with that. I'm not sure about

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1 the rest.
2 MS. NEWBURY:
3 Q. And how about interviewing people who might
4 have information about what had been happening
5 in the lab? Were there any steps taken to
6 find out who has information about this, to
7 talk to someone like Dr. Ejeckam, with a view
8 to recording and having a record of the facts?
9 MS. PILGRIM:
10 A. No, other than what's been done through the
11 Commission of Inquiry.
12 MS. NEWBURY:
13 Q. Okay, and that would have been obviously after
14 2007?
15 MS. PILGRIM:
16 A. Yes.
17 MS. NEWBURY:
18 Q. After May of 2007.
19 MS. PILGRIM:
20 A. Right, because you know, I think I have to
21 reiterate with you that our initial time was
22 taken in doing the retesting and then just as
23 we got into doing anything else with this,
24 then we were into doing the NLCHI database,
25 and the public--and the Inquiry. So we're now

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1 just turning our minds to, okay, what else do
2 we need to be doing here.
3 MS. NEWBURY:
4 Q. Okay. Would it have been difficult to send an
5 e-mail to all pathologists, all oncologists,
6 all lab technologists, the people in the OR,
7 to say "if you have anything relevant, save it
8 or forward it to -
9 MS. PILGRIM:
10 A. Wouldn't have been difficult to do, but we
11 didn't do it.
12 MS. NEWBURY:
13 Q. Okay, and you're aware, I assume, that there
14 has been an ongoing problem with pathologists
15 staying here in the province, that
16 pathologists have been coming and going over
17 the last number of years?
18 MS. PILGRIM:
19 A. Yes, I am, yes.
20 MS. NEWBURY:
21 Q. Were you concerned that pathologists who might
22 have some information about the ER/PR testing
23 might leave without providing their
24 information?
25 MS. PILGRIM:

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1 A. I hadn't really turned my thoughts to that. I
2 don't know what Dr. Denic or Dr. Cook might
3 have done.
4 MS. NEWBURY:
5 Q. And were you concerned that people might, over
6 the period of time between 2005 when you
7 discover the problem until, you know, sometime
8 2007, 2008, may no longer have fresh in their
9 mind -
10 MS. PILGRIM:
11 A. We certainly know we're dealing with that
12 because a part of the process now is
13 identifying people that need to be interviewed
14 and getting their stories, and that will be
15 people in many parts of the organization, in
16 the lab, in the communications area, in the
17 Cancer Centre. So yes, there is certainly the
18 chance that memories are not as sharp as they
19 were, but then some of the people that we will
20 be interviewing, it really hasn't gone out of
21 their minds a lot because they've been
22 interviewed for the Inquiry.
23 MS. NEWBURY:
24 Q. Sure, but of course, over that period of time,
25 you've had new policies, procedures

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1 implemented and they might have moved on and
2 forgotten some of the intricacies of it.
3 MS. PILGRIM:
4 A. Right, yeah.
5 MS. NEWBURY:
6 Q. And in the absence of standard operating
7 procedures, that might be your only source of
8 finding out what happened in particular?
9 MS. PILGRIM:
10 A. Yeah, but most of--there's only a small group
11 and they're still around, you know, the
12 people--for example, the technologists that
13 worked in that lab have been involved with the
14 Commission and they're still around and
15 they're a very small group.
16 MS. NEWBURY:
17 Q. But at the time, prior to the Commission of
18 Inquiry being called -
19 MS. PILGRIM:
20 A. No.
21 MS. NEWBURY:
22 Q. - you had no idea what might happen?
23 MS. PILGRIM:
24 A. No, we did not. You know, I think I have to
25 reiterate with you again that this was not a

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1 focus for us, up until this time. We may have
2 gotten at--I'm sure we would have gotten at
3 this earlier if there hadn't been a Commission
4 of Inquiry, but most of our resources have
5 gone into preparing for and participating in
6 the Commission of Inquiry.
7 MS. NEWBURY:
8 Q. Right.
9 MS. PILGRIM:
10 A. And now we are ready to turn our minds to some
11 other things, other pieces of business that
12 need to be completed.
13 MS. NEWBURY:
14 Q. And of course, since the Inquiry has been
15 called, there's obviously been a lot of data,
16 documents collected, information, interviews,
17 etcetera, but between 2005 and 2007, there was
18 a significant passage of time where
19 information may not have been preserved or
20 information forgotten by those involved.
21 MS. PILGRIM:
22 A. Well, between 2005 and 2007, almost one year
23 of that was spent retesting, testing patients,
24 notifying patients. I mean, we went right
25 into the spring of 2006 with that, and then we

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1 had the summer period and then we got into the
2 fall and then, remember I told you, the first
3 order of business was to try to get the
4 database, a database that we could start with
5 and then we planned to go from there with
6 analysis of that database, but then we came
7 into the Commission of Inquiry. So
8 unfortunately--not unfortunately, obviously
9 this Commission of Inquiry has been very
10 helpful, but you know, what we might have done
11 has really been put off until now.
12 MS. NEWBURY:
13 Q. Okay, and would it have--I understand that
14 resources were at a premium in 2005, 2006, and
15 2007 and probably continues to be an issue, to
16 some extent. Would it have been difficult to
17 communicate with pathologists and oncologists,
18 lab technologists, for an example, and say,
19 you know, "please prepare a brief statement of
20 anything you might have that's relevant to
21 that"?
22 MS. PILGRIM:
23 A. No, it wouldn't have been difficult to do, but
24 we didn't do it.
25 MS. NEWBURY:

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1 Q. Okay, you weren't focused on doing it at the
2 time?
3 MS. PILGRIM:
4 A. No, we were not, no.
5 MS. NEWBURY:
6 Q. Okay. So this was a very tenuous plan?
7 MS. PILGRIM:
8 A. No, no, it was a plan that we had, but we just
9 didn't get to do it. That's all. We had--we
10 were engaged in other things.
11 MS. NEWBURY:
12 Q. If you had been able and turned your mind to
13 it and focused on a non-privileged review in
14 the summer of 2005 or any time in 2006 or
15 2007, what policies or procedures would have
16 applied or governed that type of a review?
17 MS. PILGRIM:
18 A. We probably would have gotten some external
19 help for that ourselves.
20 MS. NEWBURY:
21 Q. Okay.
22 MS. PILGRIM:
23 A. To get--you know, we would have been making, I
24 guess--now I'm only surmising all of this, but
25 we would--you know, normally we would look and

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1 say well, you know, where would you go now to
2 look for what kind of standard you should
3 actually do this review against, etcetera. So
4 we probably would have found ourselves going
5 in the direction of QMPLS and the same people
6 that we ended up going in the direction of
7 anyway.
8 MS. NEWBURY:
9 Q. Okay, now that's the mechanics of it, but I'm
10 wondering are there any guiding policies, for
11 example, and -
12 MS. PILGRIM:
13 A. For doing a quality review?
14 MS. NEWBURY:
15 Q. For doing the review that you're talking
16 about.
17 MS. PILGRIM:
18 A. For doing a quality review, you're talking
19 about doing a review of what happened in the
20 lab?
21 MS. NEWBURY:
22 Q. The review to find out what happened, yes.
23 MS. PILGRIM:
24 A. We would probably have followed the usual
25 process that we follow, which would be any

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1 evidence that you have, you know, trying to
2 keep and protect any evidence. Certainly
3 doing interviews with everybody that was
4 involved, setting up a team around that and
5 usually it would probably be a team with
6 someone who was outside of it, some objective
7 person kind of taking the lead. So we would
8 have used a similar process that we would use
9 for any kind of an internal quality review
10 that we might do.
11 MS. NEWBURY:
12 Q. Would the policies that were in place, I
13 guess, the predecessor organization, Health
14 Care Corporation of St. John's policies that
15 existed between 2005 and up until August 2007
16 when I understand they were replaced, would
17 any of those apply, and they're at Exhibit P-
18 0056, please?
19 THE COMMISSIONER:
20 Q. Sorry, I didn't hear the number you said.
21 MS. NEWBURY:
22 Q. P-0056.
23 THE COMMISSIONER:
24 Q. Thank you.
25 MS. NEWBURY:

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1 Q. And the occurrence reporting that's on page--
2 okay, page 12, the occurrence reporting, and I
3 don't know if you want to take a few moments
4 to look through that. Is that something that
5 would be applicable to that type of a review?
6 MS. PILGRIM:
7 A. Well, the process that we would use would be
8 the kind of an investigation you would do with
9 any occurrence.
10 MS. NEWBURY:
11 Q. Okay.
12 MS. PILGRIM:
13 A. But this would be a bigger one.
14 MS. NEWBURY:
15 Q. Sure.
16 MS. PILGRIM:
17 A. So you would certainly involve--I mean, some
18 occurrences may just take the division manager
19 who does an investigation. Others, there's a
20 team. In this case, there would probably be a
21 team and an external person attached to the
22 team.
23 MS. NEWBURY:
24 Q. So because of the magnitude you would have to
25 tailor -

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1 MS. PILGRIM:
2 A. Yes.
3 MS. NEWBURY:
4 Q. But you still think that the principles -
5 MS. PILGRIM:
6 A. But the steps -
7 MS. NEWBURY:
8 Q. - and the policy would have been -
9 MS. PILGRIM:
10 A. - of the review would be the same, yes.
11 MS. NEWBURY:
12 Q. Okay.
13 MS. PILGRIM:
14 A. Now, we obviously did not fill out an
15 occurrence report on this particular -
16 MS. NEWBURY:
17 Q. I realize that, but just in terms of whether
18 the principles would be applicable?
19 MS. PILGRIM:
20 A. Right.
21 MS. NEWBURY:
22 Q. To that. And I just note there under "Program
23 management department," this is on page 15 of
24 the exhibit, page four of the occurrence
25 reporting policy, item number one says,

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1 "Review the occurrence, initiate an
2 investigation and follow-up process.
3 Assistance of the staff most involved with the
4 occurrence will be required." So that appears
5 to direct that an investigation be initiated.
6 And would that be--would that equate to the
7 review that you're talking about?
8 MS. PILGRIM:
9 A. The principles would be the same. I don't--
10 I'm not too sure that we have anything in
11 writing that would apply to the--a lot of the
12 things that we have would apply to individual,
13 you know, like kind of one patient events or
14 something that's happened in a particular
15 department.
16 MS. NEWBURY:
17 Q. Um-hm.
18 MS. PILGRIM:
19 A. So I'm not sure. You know, we have, certainly
20 have policies about disasters and things like
21 that, and then we have policies which really
22 lend themselves more to individual patient or
23 individual incident things. But I think the
24 principles would be the same.
25 MS. NEWBURY:

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1 Q. Okay. And looking there on page 16 of the
2 exhibit there is a heading, "Loss Control."
3 MS. PILGRIM:
4 A. Yes.
5 MS. NEWBURY:
6 Q. And under that there's a requirement under
7 four, subparagraph (c), it's actually on the
8 next page, 16.
9 MS. PILGRIM:
10 A. Right.
11 MS. NEWBURY:
12 Q. "Secure and physically lock up any records,
13 including notes, test results, monitoring
14 strips, x-rays or other diagnostic films."
15 MS. PILGRIM:
16 A. That's right.
17 MS. NEWBURY:
18 Q. "This ensure that the records are not lost or
19 altered."
20 MS. PILGRIM:
21 A. Um-hm.
22 MS. NEWBURY:
23 Q. And is that the type of principle that would
24 apply?
25 MS. PILGRIM:

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1 A. Yes, yeah.
2 MS. NEWBURY:
3 Q. Okay.
4 MS. PILGRIM:
5 A. It would be the same sorts of things, yeah.
6 MS. NEWBURY:
7 Q. Okay. But that wasn't actually done between
8 2005 and 2007 until the Commission of Inquiry
9 started?
10 MS. PILGRIM:
11 A. Again, you know, you--again, you would have to
12 talk to Heather Predham about that because she
13 would have been the risk management person
14 involved with that at the time. So she or
15 Terry Gulliver--like, the only thing I can
16 remember about was talking about the actual
17 slides and blocks and that evidence.
18 MS. NEWBURY:
19 Q. Okay. And the last sentence of that paragraph
20 says, "Coordinate with program leadership,
21 risk manager and health records." Who would--
22 risk manager, would that be Heather Predham
23 for this -
24 MS. PILGRIM:
25 A. Yes, it would be in Eastern Health, yeah.

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1 MS. NEWBURY:
2 Q. And again, this is the Health Care Corporation
3 predecessor policy?
4 MS. PILGRIM:
5 A. Yes. And this would be, health records would
6 be to secure the patient record.
7 MS. NEWBURY:
8 Q. Okay. And program leadership, who would that
9 -
10 MS. PILGRIM:
11 A. That would be Terry Gulliver and Don Cook, I
12 guess, at the time that this started, because
13 Nash wasn't there.
14 MS. NEWBURY:
15 Q. Okay. And subparagraph (d), "Secure
16 applicable policies and procedures."
17 MS. PILGRIM:
18 A. It gets back to what I just said, you'd have
19 to talk to Heather about that.
20 MS. NEWBURY:
21 Q. Okay. And -
22 MS. PILGRIM:
23 A. I mean, these would be the principles you
24 would apply, whether they were all applied at
25 this time, I don't know because this is such a

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1 massive undertaking. I'm not quite sure.
2 MS. NEWBURY:
3 Q. Okay. And I'm not sure if you're familiar
4 with the evidence of Maria Tracey who was
5 here, I think, on Monday of this week. And
6 she had mentioned that she was trying to
7 gather together operating room procedures and
8 was able to find those for St. Clare's but not
9 for the Health Care--or the Health Sciences
10 Centre.
11 MS. PILGRIM:
12 A. Um-hm.
13 MS. NEWBURY:
14 Q. And perhaps that relates to the fact that they
15 were now operating under Eastern Health and by
16 the time she looked for them maybe they
17 weren't retained. I'm not sure if they would
18 have been available back in the summer of
19 2005, but was that ever thought about at the
20 time, you know, not only do we have to
21 preserve the policies and procedures by virtue
22 of this guideline, if we were to follow it,
23 but we actually have a real possibility here
24 with a new organization, new policies being
25 developed, that someone may decide not to keep

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1 the old policies?
2 MS. PILGRIM:
3 A. Well, there's always that chance. I mean, the
4 staff and managers were instructed very
5 clearly that unless--until you saw an Eastern
6 Health policy, you were to continue to abide
7 by the policies on the site where you worked.
8 MS. NEWBURY:
9 Q. Sure.
10 MS. PILGRIM:
11 A. And from the legacy organization that you came
12 from.
13 MS. NEWBURY:
14 Q. And as the time went on in 2005, 2006, 2007,
15 as new policies were, you know, implemented
16 under the Eastern Health system, there would
17 be a danger that maybe the predecessor
18 policies may not be kept unless someone is
19 specifically told, please provide or retain
20 all policies? And you're not aware that that
21 was done? Perhaps it was, but you're not
22 aware that that was done?
23 MS. PILGRIM:
24 A. I guess there's always a danger that things
25 can be lost or misinterpreted. But I think,

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1 you know, managers in our system certainly
2 understood very clearly what was supposed to
3 be happening with policies and procedures
4 because it's really important that you get
5 that communication out there. Staff have to
6 have something to guide them. So unless there
7 was an Eastern Health one that came to you,
8 you will continue to do what you had always
9 done.
10 MS. NEWBURY:
11 Q. Right. But for the purposes of the review,
12 the non-privileged review process that you had
13 planned, it's not so much what are the new
14 policies but let's keep the old policies
15 because that might have some bearing on what
16 happened?
17 MS. PILGRIM:
18 A. Oh, you're talking about in terms--yes, in--
19 for all of that I can only answer you're
20 asking the wrong person here.
21 MS. NEWBURY:
22 Q. Okay. You have no idea?
23 MS. PILGRIM:
24 A. No.
25 MS. NEWBURY:

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1 Q. Okay. And you're not aware that any such
2 direction had been distributed to -
3 MS. PILGRIM:
4 A. I don't know. Heather may have done that.
5 MS. NEWBURY:
6 Q. And also in this document exhibit is the
7 critical occurrence incident review policy.
8 And would you also look to this document for
9 some guidelines in terms of the non-privileged
10 review if you had conducted it between 2005
11 and 2007?
12 MS. PILGRIM:
13 A. Yeah, well obviously the people who would be
14 very involved probably in leading this, any
15 kind of a review are the people from quality
16 and risk management.
17 MS. NEWBURY:
18 Q. Um-hm.
19 MS. PILGRIM:
20 A. And they are the people who write these
21 policies. So you would expect your risk
22 manager or any of your quality facilitators,
23 they get involved in these reviews so they're
24 very familiar with these guidelines and that's
25 a process that they would put in place.

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1 MS. NEWBURY:
2 Q. Okay. And are you saying that the executive
3 team, for example, might not be as familiar
4 with these policies?
5 MS. PILGRIM:
6 A. You know, we can be reminded from time to time
7 by the quality people about oh, but don't
8 forget to do this and, you know, that's the
9 role that they really play, an important role
10 that they play, actually.
11 MS. NEWBURY:
12 Q. And looking here at page nine of the exhibit,
13 which is page two of the critical occurrence
14 incident review policy, it states that the--
15 item number two, "The program corporate
16 director or clinical leadership team will meet
17 with the risk manager or quality initiatives
18 representative to determine the process for
19 investigation of the occurrence. Normally the
20 program corporate director will initiate and
21 coordinate the investigation and chair all
22 team meetings." Is that the type of thing
23 that you would have done through this non-
24 privilege review?
25 MS. PILGRIM:

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1 A. Well, this kind of happened with what we
2 started with the ER/PR issue. It was very
3 much the--you know, it didn't turn out to be,
4 you know, an intensive internal review, but it
5 was--because they brought in external
6 reviewers fairly early in the game, I think.
7 MS. NEWBURY:
8 Q. Okay.
9 MS. PILGRIM:
10 A. But the team that was put around that, you did
11 have, well, you had the vice president
12 responsible for the service, so because of the
13 magnitude of this, this was really a vice
14 president that took the lead with this.
15 MS. NEWBURY:
16 Q. Um-hm.
17 MS. PILGRIM:
18 A. And you did have involvement of the leadership
19 team and the risk manager.
20 MS. NEWBURY:
21 Q. Okay.
22 MS. PILGRIM:
23 A. So, you know.
24 MS. NEWBURY:
25 Q. But at the end of all of their involvement and

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1 responding and organizing retesting and
2 organizing for the external reviews, whatever
3 their involvement was you're still left in the
4 position, as I understand it, that information
5 cannot yet be relayed to the public, aside
6 from what may have come out through the
7 external review reports, as to what was the
8 cause of the problem, there is yet to be a
9 review, a non-privilege type review that
10 Eastern Health can provide its assessment of
11 what caused the problems?
12 MS. PILGRIM:
13 A. Yes, and as I said before, before you can
14 release any of this, you have to do an
15 analysis of the information that you have.
16 And we have not yet done that analysis. We
17 only now have a database that we feel is
18 complete enough to do that. And database that
19 we have is very limited. We will be able to
20 do some analysis on it. But there is going to
21 have to be--if you're going to get to any more
22 in depth analysis, there's probably going to
23 have to be more work done. This database
24 allows you to do some averages of this and
25 averages of that, but you know, it's still

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1 only a database of numbers and a little bit
2 more information. I think now they have some
3 of Dr. Mullen's work put into that database,
4 so you can do some correlations with the work
5 that he did.
6 MS. NEWBURY:
7 Q. Um-hm.
8 MS. PILGRIM:
9 A. And so that's just the work that's started now
10 in terms of what we're going to be able to get
11 out of that database. But we know that some
12 of the answers that people are going to want
13 are not going to be able to be gotten from the
14 database because it is limited.
15 MS. NEWBURY:
16 Q. Right. And so there might be more work to be
17 done on the part of Eastern Health?
18 MS. PILGRIM:
19 A. Yes.
20 MS. NEWBURY:
21 Q. And in terms of this -
22 THE COMMISSIONER:
23 Q. (Inaudible) the work that you refer to
24 relating to the database is NLCHI doing that
25 for you or is that being done internally?

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1 MS. PILGRIM:
2 A. The analysis?
3 THE COMMISSIONER:
4 Q. Yes.
5 MS. PILGRIM:
6 A. No, NLCHI is doing the--anything we want done,
7 we've agreed that they will do it based on the
8 database that they developed.
9 THE COMMISSIONER:
10 Q. Okay. And you referred this morning to, I
11 believe it was Dr. Denic who was doing some
12 analysis?
13 MS. PILGRIM:
14 A. He asked them for some information and they
15 sent that to him. They did some analysis for
16 him.
17 THE COMMISSIONER:
18 Q. Oh, okay, all right. I had understood that he
19 himself was doing an analysis, but perhaps I
20 misunderstood you.
21 MS. PILGRIM:
22 A. No, no, no. He asked for an analysis to be
23 done, I'm sorry.
24 THE COMMISSIONER:
25 Q. All right.

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1 MS. PILGRIM:
2 A. And they sent him that information last week
3 or the week before.
4 THE COMMISSIONER:
5 Q. So this is what information you have currently
6 is based on the NLCHI database which, of
7 course, comes from your information?
8 MS. PILGRIM:
9 A. That's right.
10 THE COMMISSIONER:
11 Q. But it's based on the NLCHI database and any
12 analysis of that material will be done for you
13 by NLCHI itself?
14 MS. PILGRIM:
15 A. That's correct.
16 THE COMMISSIONER:
17 Q. Okay. Thank you.
18 MS. NEWBURY:
19 Q. So then this non-privilege review which will
20 hopefully put Eastern Health in a position to
21 provide answers it feels are the cause of the
22 problems -
23 MS. PILGRIM:
24 A. Whatever answers we can get, yes.
25 MS. NEWBURY:

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1 Q. Okay. Is that a continuation of whatever
2 process started in the summer of 2005? Is
3 this a new endeavour by Eastern Health when it
4 gets started?
5 MS. PILGRIM:
6 A. No, it's--I mean, you know, there was always
7 the understanding, from all of us, since the
8 beginning, that at some point we would be able
9 to sit down and ask the questions that we want
10 answered and get the answers. Like, that was
11 always the understanding. And where we are
12 now is is one part is telling the story and
13 the other part is now with the clinicians, in
14 particular, identifying what questions they
15 still have that they don't have answers and
16 then trying to get those answers through
17 analysis of the information that we have.
18 MS. NEWBURY:
19 Q. Okay. And you agree that this policy here,
20 the critical occurrence incident review policy
21 would generally govern it, you didn't fill out
22 the forms or what have you, but -
23 MS. PILGRIM:
24 A. No. I mean, we didn't--again, it's similar
25 principles and guidelines, but we didn't

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1 follow this to the T at the time.
2 MS. NEWBURY:
3 Q. Sure. And it would have to be tailored,
4 obviously, to take into account that you're
5 dealing with a large group?
6 MS. PILGRIM:
7 A. And as I said before, if we had to do this
8 over again, we would do this very differently.
9 MS. NEWBURY:
10 Q. Sure.
11 MS. PILGRIM:
12 A. I hope we don't ever have to do it again, but.
13 MS. NEWBURY:
14 Q. Page 10 of the exhibit, which is three of the
15 critical occurrence incident review policy.
16 Under "Documentation" there's the direction
17 that "The program corporate director is
18 responsible for documenting the activities of
19 the team." And at the end, item number two,
20 "At the end of the investigation all notes
21 should be collected and secured in one file.
22 The person to hold the file will be determined
23 by the team."
24 MS. PILGRIM:
25 A. This is the Health Care Corporation of St.

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1 John's policy, right.
2 MS. NEWBURY:
3 Q. Right. But as I understand it, that until a
4 new policy is implemented by Eastern Health,
5 you have no choice but to rely upon this for
6 guidance?
7 MS. PILGRIM:
8 A. Right. But a part of the work that we will do
9 now will be based on many things that we have
10 experienced, we'll be reviewing and this will
11 look even different than that when we come out
12 with the Eastern Health policy. Because one
13 thing, you know, there's many things we've
14 learned and one of them is is that we would
15 resource this team with secretarial support.
16 MS. NEWBURY:
17 Q. Right. Now in this case here it doesn't say
18 that -
19 MS. PILGRIM:
20 A. It says the program -
21 MS. NEWBURY:
22 Q. - the program corporate director -
23 MS. PILGRIM:
24 A. - corporate director is responsible for.
25 MS. NEWBURY:

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1 Q. Right.
2 MS. PILGRIM:
3 A. But we will explicitly have written out that
4 you will provide secretarial support to any
5 meetings that you're having will have a
6 secretary there and minutes will be
7 documented.
8 MS. NEWBURY:
9 Q. Okay. But in terms of documenting the
10 activities of the team, that -
11 MS. PILGRIM:
12 A. Yeah. I mean, it goes to say that. I mean,
13 obviously it's not going to be program
14 directors that's taking the minutes.
15 MS. NEWBURY:
16 Q. Right. And it doesn't necessarily mean that
17 it would have to be minutes. It could be an
18 official report.
19 MS. PILGRIM:
20 A. Note, sure, yes, yeah.
21 MS. NEWBURY:
22 Q. Okay. Something to make it clear that all of
23 the activities of the team are in a record of
24 some sort?
25 MS. PILGRIM:

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1 A. Right. Yes, that's correct.
2 MS. NEWBURY:
3 Q. Okay. And that all notes that are involved at
4 the--during the investigation are kept in a
5 file?
6 MS. PILGRIM:
7 A. Um-hm.
8 MS. NEWBURY:
9 Q. And that wasn't done here?
10 MS. PILGRIM:
11 A. Well, there were many notes here and many e-
12 mails -
13 MS. NEWBURY:
14 Q. I appreciate that.
15 MS. PILGRIM:
16 A. - as I'm sure you've seen.
17 MS. NEWBURY:
18 Q. Yes.
19 MS. PILGRIM:
20 A. So there were a lot of files that were being
21 kept and then that were gathered up for
22 submission and would have been gathered up
23 along the way, as well. But I guess I'm not
24 quite sure. We're just saying at the end of
25 the investigation notes would be collected.

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1 MS. NEWBURY:
2 Q. Um-hm.
3 MS. PILGRIM:
4 A. And secured in one file.
5 MS. NEWBURY:
6 Q. Okay. So you feel then that was essentially
7 accomplished?
8 MS. PILGRIM:
9 A. Pretty much, yeah. I think, you know, we got
10 a lot of notes and information from people.
11 MS. NEWBURY:
12 Q. Yeah. Of course, the work that you're doing
13 is ongoing or you still have -
14 MS. PILGRIM:
15 A. Yes, it is.
16 MS. NEWBURY:
17 Q. - future plans?
18 MS. PILGRIM:
19 A. Still ongoing. It's been going on for three
20 years in regards to this. But obviously, you
21 know, not every situation are you going to end
22 up with a commission of inquiry, things like
23 that.
24 MS. NEWBURY:
25 Q. Now, if an investigation or the non-privilege

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1 review, I'll call it, were commenced after
2 August of 2007 when I believe some new
3 policies were put in place--and that's P-0057,
4 please? I'm just wondering if any of these
5 policies would govern the type of review, the
6 non-privileged review that you were
7 contemplating?
8 MS. PILGRIM:
9 A. This policy would not cover the multi-patient
10 event that we had.
11 MS. NEWBURY:
12 Q. Could you look to it for guidance?
13 MS. PILGRIM:
14 A. Yes. I mean, we kind of - you know, obviously
15 the Quality people would know what was in this
16 policy and most of your program leadership
17 teams would know, but one thing that we are
18 going to have, you know, and have thought
19 about doing, is we're really going to have to
20 sit down and talk about, well, how do you
21 disclose information, and there's things about
22 disclosing information - you know, there's one
23 piece about disclosing it and then there's
24 another piece about how do you actually
25 document in the patient's record that the

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1 disclosure occurred. So this policy is very
2 much related to one patient.
3 MS. NEWBURY:
4 Q. Yes, and that's a little bit of a different
5 issue.
6 MS. PILGRIM:
7 A. Right.
8 MS. NEWBURY:
9 Q. Perhaps I should show you the other policies
10 in this particular document, and feel free to
11 look through the whole thing, but on page 21
12 there's a sentinel event policy.
13 MS. PILGRIM:
14 A. Okay, yes.
15 MS. NEWBURY:
16 Q. And is that something that would apply in the
17 circumstances?
18 MS. PILGRIM:
19 A. A sentinel event policy would be you are
20 putting much more of a structure around this
21 kind of an occurrence. This one would talk
22 about the team and things like that, and - but
23 again, you know, we're looking at all of this
24 now to see if it covers off what would happen
25 in a multiple patient, or do you need

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1 something that's separate to say -
2 MS. NEWBURY:
3 Q. Okay.
4 MS. PILGRIM:
5 A. And one of the first things we're doing is
6 writing down all of our learnings from this,
7 and hopefully we can translate that into a
8 policy.
9 MS. NEWBURY:
10 Q. Okay.
11 MS. PILGRIM:
12 A. Or make changes to existing policies.
13 MS. NEWBURY:
14 Q. So this was in place, I believe, from August
15 of 2007, that's my understanding.
16 MS. PILGRIM:
17 A. Yes.
18 MS. NEWBURY:
19 Q. This is the original approval date, September
20 18th, 2007, and review date, February of 2008.
21 So if the non-privileged review were governed
22 by this particular document, and perhaps it
23 would have to be tailored in the
24 circumstances, but if the governing principles
25 were to apply to your review - I know that the

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1 end of the document, page 23, under the
2 heading "supporting documents", there's a
3 reference there to Newfoundland Evidence Act.
4 Do you know what the purpose of that reference
5 is?
6 MS. PILGRIM:
7 A. Well, I know that it would be there because
8 they use that to guide the development of the
9 policy.
10 MS. NEWBURY:
11 Q. And perhaps it might be useful to show you at
12 the bottom of this document there's another
13 heading "linkages", and then it refers to the
14 occurrence reporting policy, which is at page
15 six of this exhibit.
16 MS. PILGRIM:
17 A. That's right, because they're all
18 interconnected.
19 MS. NEWBURY:
20 Q. Sure, okay, and - I have the wrong page
21 number. So occurrence reporting is page five
22 of the exhibit.
23 MS. PILGRIM:
24 A. Right.
25 MS. NEWBURY:

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1 Q. And on page six, there's a reference there
2 under the fifth bullet at the top of the page,
3 "Under the Evidence Act occurrence reports are
4 protected from legal proceedings". I don't
5 know if that helps you in your interpretation
6 of the reference to Newfoundland Evidence Act
7 in the sentinel event policy.
8 MS. PILGRIM:
9 A. Well, like I said, they would use that - if
10 there was anything that they were applying
11 under the Evidence Act, it would be mentioned
12 in the policy. I mean, the way it sits here
13 now, we do not put occurrence reports on the
14 patient's record. They're considered
15 protected, so they don't go on the record. On
16 the record there is supposed to be a written
17 summary of the occurrence. Now we know in
18 other provinces across Canada this is
19 changing, so we don't know how long that'll
20 stay here as well in this province, but right
21 now they don't go on the file.
22 MS. NEWBURY:
23 Q. So do you know if it was intended when these
24 policies were drafted that activities
25 conducted under either the sentinel events

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1 policy or the occurrence reporting policy
2 would be presumably protected by virtue of the
3 Evidence Act from being disclosed, other than
4 as the brief -
5 MS. PILGRIM:
6 A. Well, occurrence reports would.
7 MS. NEWBURY:
8 Q. Okay.
9 MS. PILGRIM:
10 A. And the other would be if there was mention of
11 a peer review, you know, under our peer review
12 guidelines. Other than that, I can't think of
13 what would be protected.
14 MS. NEWBURY:
15 Q. So you think the sentinel events policy, even
16 though it references the Newfoundland Evidence
17 Act, you don't think that any activity or any
18 documents -
19 MS. PILGRIM:
20 A. Well, sentinel event is just an occurrence.
21 That really is a - what is it, a -
22 MS. NEWBURY:
23 Q. A more serious?
24 MS. PILGRIM:
25 A. A more serious occurrence, yes.

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1 MS. NEWBURY:
2 Q. So wouldn't that -
3 MS. PILGRIM:
4 A. I mean, you know, you wouldn't have anything
5 different. You would have - you don't put the
6 occurrence report on the record, but you are
7 supposed to write up the occurrence on the
8 file, and you are supposed to do the
9 disclosure, and you're supposed to put the
10 disclosure in the file.
11 MS. NEWBURY:
12 Q. I guess the question is this, if you are
13 conducting a review for the purposes of being
14 able to provide information to the public or
15 patients or -
16 MS. PILGRIM:
17 A. Right.
18 MS. NEWBURY:
19 Q. People at Eastern Health who are wondering
20 what's going on -
21 MS. PILGRIM:
22 A. A document that anybody could access, yes.
23 MS. NEWBURY:
24 Q. Exactly, and just so that they can know what
25 caused the problems.

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1 MS. PILGRIM:
2 A. Right.
3 MS. NEWBURY:
4 Q. There's lots of people asking that question.
5 MS. PILGRIM:
6 A. Uh-hm.
7 MS. NEWBURY:
8 Q. If a review is going to be conducted under
9 either of these policies, is there a concern
10 that someone may claim that they are
11 privileged, and, therefore, the results or
12 that aren't to be released and then you end up
13 in the same situation that you did up until
14 February, 2008, that there are answers
15 somewhere in a report, but it can't be
16 released to those who are interested?
17 MS. PILGRIM:
18 A. I think it would be more explicitly filled out
19 in there - more explicitly stated in there
20 this was privileged information we were
21 dealing with, and you don't see that written
22 throughout there other than with the
23 occurrence report.
24 MS. NEWBURY:
25 Q. Okay.

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1 MS. PILGRIM:
2 A. You would see it in a peer review document,
3 and now based on our experience with peer
4 review and quality reviews, based on the court
5 case that we just went through, obviously
6 there's a lot of discussion going on in our
7 organization now reviewing by-laws and all of
8 our policies and procedures to once again look
9 at peer review and how it is that we ensure
10 every step of the way that a peer review is
11 protected.
12 MS. NEWBURY:
13 Q. Right, and I guess for the purposes of this
14 line of questioning, I'm asking you to focus
15 on what the frame of mind was in Eastern
16 Health prior to February, 2008, when that
17 whole interpretation issue, or, I guess,
18 perhaps even December, 2007, when the
19 Application was made about the interpretation
20 about that particular provision of the Act,
21 and focusing on what Eastern Health felt could
22 have been accomplished by conducting a review
23 under these policies if that's what was going
24 to be followed at the time?
25 MS. PILGRIM:

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1 A. I'm not sure what it is you want me to answer,
2 the question.
3 MS. NEWBURY:
4 Q. My concern or my question is whether or not
5 there was a possibility that if what you were
6 intending to be a non-privileged review was
7 conducted under the general guidance of these
8 two policies, whether or not someone might
9 claim that those were privileged and shouldn't
10 be released, thereby you would end up in the
11 same situation that you did with the external
12 review reports of Banerjee and Ms.
13 Wegrynowski?
14 MS. PILGRIM:
15 A. I couldn't answer that question for you -
16 MS. NEWBURY:
17 Q. Okay.
18 MS. PILGRIM:
19 A. About whether that consideration was there.
20 MS. NEWBURY:
21 Q. Okay. Do you know if that had actually been
22 discussed at the time, how can we do this
23 review for the purposes of providing
24 information to the public, what policies do we
25 follow; if we follow either of these two

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1 policies, do we run the risk that someone may
2 claim that, listen, the Newfoundland Evidence
3 Act is referenced there?
4 MS. PILGRIM:
5 A. I wouldn't be able to tell you if that
6 discussion went on.
7 MS. NEWBURY:
8 Q. You didn't participate in any discussion?
9 MS. PILGRIM:
10 A. No, no, no, not with the development of this
11 policy, but the discussion that would go on
12 and has gone on in our organization is, so how
13 is it now then that we ensure peer review is
14 protected.
15 MS. NEWBURY:
16 Q. Okay, and I guess my focus is not on the
17 development of the policies -
18 MS. PILGRIM:
19 A. No, right.
20 MS. NEWBURY:
21 Q. But all along you had it in your mind from
22 back to the summer of 2005 that we're
23 ultimately going to get to a review here so
24 that we can tell people the questions that
25 they want to know?

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1 MS. PILGRIM:
2 A. Right.
3 MS. NEWBURY:
4 Q. Not just the patients, or the public, or
5 reporters?
6 MS. PILGRIM:
7 A. To find out ourselves.
8 MS. NEWBURY:
9 Q. That colleagues within the organization want
10 to know what happened.
11 MS. PILGRIM:
12 A. Right.
13 MS. NEWBURY:
14 Q. So did you ever focus on how can we go about
15 doing that, what policies and procedures must
16 we follow, what policies and procedures or
17 guidelines are available for us to follow to
18 do that?
19 MS. PILGRIM:
20 A. Well, because we - I think that I'm probably
21 confusing you with my answers here. We have
22 just - we knew that we would always get to
23 this point.
24 MS. NEWBURY:
25 Q. Okay.

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1 MS. PILGRIM:
2 A. We are just getting there now with the
3 analysis, so I haven't had any more discussion
4 or thought about that. Now as we get into
5 whatever kind of a report we're going to write
6 up, obviously we will be guided by what we
7 have here if it is considered to be
8 appropriate to what we're doing.
9 MS. NEWBURY:
10 Q. Okay.
11 MS. PILGRIM:
12 A. But I think we all know that since our
13 experience with peer review - because there
14 was a time, and, you know, I remember it in my
15 time, we thought that to have something
16 protected, all you had to do was write
17 "quality review" on the file. If you called
18 it a quality review, it was protected. Well,
19 we've certainly come a long way from that, and
20 now we are within our organization just trying
21 to make sure that when we set something up as
22 a peer review, that we will set it up
23 correctly and we will do our best to ensure
24 that it's protected. Anything else, we would
25 not consider to be protected. We do many

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1 quality reviews that are not protected.
2 MS. NEWBURY:
3 Q. Yes, and I take it then from your answer, that
4 the details and the intricacies about what
5 polices or procedures, practices or guidelines
6 to follow, hadn't even reached that point?
7 MS. PILGRIM:
8 A. No.
9 MS. NEWBURY:
10 Q. Okay, and if you were to start doing your
11 review, like, actually getting down to the
12 details of it tomorrow -
13 MS. PILGRIM:
14 A. Right.
15 MS. NEWBURY:
16 Q. Do you - can you point to any other policies
17 that are currently in place that would apply
18 in addition to what may be here, is there
19 anything that perhaps I'm not aware of?
20 MS. PILGRIM:
21 A. Well, you look to anything they had on how to
22 do a review, and, I mean, what other kind of
23 policies would we have; we have disclosure
24 policies, you talked about that one; consent,
25 policies about doing research in case you were

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1 getting into any kind of things where you
2 might need human - and we have a whole process
3 for that if you were doing research.
4 MS. NEWBURY:
5 Q. Sure, okay.
6 MS. PILGRIM:
7 A. If it became a research part to it. I can't
8 offhand think of anything else. I mean,
9 that's where you would go.
10 MS. NEWBURY:
11 Q. So there's no sort of umbrella policy that
12 pulls together how that investigation review
13 might take place?
14 MS. PILGRIM:
15 A. No.
16 MS. NEWBURY:
17 Q. And making references to any other applicable
18 policies?
19 MS. PILGRIM:
20 A. No.
21 THE COMMISSIONER:
22 Q. Let me just understand at least what I've been
23 taking from this to make sure I've not
24 misinterpreted what you said -
25 MS. PILGRIM:

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1 A. Uh-hm.
2 THE COMMISSIONER:
3 Q. The policies to which Ms. Newbury has referred
4 to do not, in your view, apply?
5 MS. PILGRIM:
6 A. The principles - you know, like, in one of
7 these policies we talk about if you were doing
8 a review, you'd get a team together and you'd
9 take notes and keep - you would follow that.
10 THE COMMISSIONER:
11 Q. Yes, but that would be a matter of choice and
12 commonsense.
13 MS. PILGRIM:
14 A. Right, right.
15 THE COMMISSIONER:
16 Q. I'm understanding you to say that, in fact,
17 these policies do not apply for various
18 reasons because for one thing, this was the
19 large event that went on -
20 MS. PILGRIM:
21 A. Oh, yes.
22 THE COMMISSIONER:
23 Q. And you would not consider yourself to be
24 bound in any way by these policies. In your
25 opinion, the institution always intended to do

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1 a review outside of the peer review process or
2 non-protected review.
3 MS. PILGRIM:
4 A. Uh-hm.
5 THE COMMISSIONER:
6 Q. But as I understand you, you are saying that
7 it's only now that you are in a position to
8 begin to do that review.
9 MS. PILGRIM:
10 A. Uh-hm.
11 THE COMMISSIONER:
12 Q. And while you might use some of the same
13 approaches which are articulated in the
14 particular policies because commonsense tells
15 you that's what you have to do -
16 MS. PILGRIM:
17 A. That's correct.
18 THE COMMISSIONER:
19 Q. It's not because they tell you, but because
20 you're saying, well, this is a good way to go
21 about doing it?
22 MS. PILGRIM:
23 A. Uh-hm.
24 THE COMMISSIONER:
25 Q. Have I got it right?

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1 MS. PILGRIM:
2 A. Yes, but these policies when they were written
3 were not written thinking about multiple
4 patient sentinel events.
5 THE COMMISSIONER:
6 Q. Thank you.
7 MS. NEWBURY:
8 Q. Did you ever consider, or anyone else that
9 you're aware of at Eastern Health consider
10 that it would be essential or beneficial to
11 the various decision makers, and there's a
12 number of different decisions and different
13 groups, I guess, involved in various
14 decisions, did you ever consider whether or
15 not it would be beneficial or essential for
16 those individuals to have access to the
17 results of an investigation into what caused
18 the problems?
19 MS. PILGRIM:
20 A. The individuals who would be doing what?
21 MS. NEWBURY:
22 Q. Involved in any aspect of decision making?
23 MS. PILGRIM:
24 A. Around this?
25 MS. NEWBURY:

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1 Q. Well, one example - okay, there's a decision,
2 I guess, in the summer of 2005, whether or not
3 patients should be advised that retesting was
4 occurring?
5 MS. PILGRIM:
6 A. Uh-hm.
7 MS. NEWBURY:
8 Q. And I believe it was your evidence that you
9 supported Dr. Laing's view that it would be
10 better to wait until the patient could be
11 approached with more complete information.
12 MS. PILGRIM:
13 A. Uh-hm.
14 MS. NEWBURY:
15 Q. About that?
16 MS. PILGRIM:
17 A. Right.
18 MS. NEWBURY:
19 Q. And I also believe it was your understanding
20 at the time that you were not aware of the
21 results of Dr. Carter's quality review that
22 she had started?
23 MS. PILGRIM:
24 A. No, I was not, no.
25 MS. NEWBURY:

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1 Q. Okay, and you were later involved in drafting
2 a letter that would be under the signature of
3 Dr. Gardiner that was to go to physicians, and
4 that was back - that was in, I think, late
5 September?
6 MS. PILGRIM:
7 A. Right.
8 MS. NEWBURY:
9 Q. 2005, and by that time, you still didn't know
10 the results of Dr. Carter's quality review?
11 MS. PILGRIM:
12 A. No.
13 MS. NEWBURY:
14 Q. And the fact that she had uncovered some
15 potential contributing factors -
16 MS. PILGRIM:
17 A. Right.
18 MS. NEWBURY:
19 Q. Fixation, internal controls.
20 MS. PILGRIM:
21 A. Uh-hm.
22 MS. NEWBURY:
23 Q. So obviously you're participating in a couple
24 of decisions there. Your role might have been
25 a bit more minor than others, but you are

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1 participating in these decisions.
2 MS. PILGRIM:
3 A. Right.
4 MS. NEWBURY:
5 Q. Do you think it would have been beneficial for
6 you to have more information, to have all
7 information that was available at that point
8 in time?
9 MS. PILGRIM:
10 A. Well, certainly it wouldn't - it never hurts
11 to have information. I don't know if having
12 that information would have had any impact on
13 how I felt about at that time giving patients
14 - you know, telling them they were being
15 retested without having anything to tell them.
16 I don't think it would have influenced that.
17 MS. NEWBURY:
18 Q. Or whether there might be an obligation to do
19 that?
20 MS. PILGRIM:
21 A. Well, you know, that has more to do with just
22 the whole decision we made about talking to
23 patients regardless of what we would have
24 known about a review that was being done by
25 Bev Carter. So I don't really see that that

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1 would have made a difference to any decision
2 that I would have made there.
3 MS. NEWBURY:
4 Q. But it's possible.
5 MS. PILGRIM:
6 A. Oh, it's possible. I mean, it's possible,
7 anything is possible, but I don't - you know,
8 I wouldn't see that that maybe would have been
9 relevant to that. As far as the letter that
10 we sent out to doctors, that was a letter to
11 tell them, by the way, you're going to be
12 hearing that this retesting is going on,
13 there's an investigation going on within
14 Eastern Health, it was just to bring them into
15 the loop, so to speak, because, you know, we
16 thought that - I mean, they might not even be
17 hearing it on the news what was happening. It
18 might have been helpful there.
19 MS. NEWBURY:
20 Q. But in that letter, I think you were shown a
21 reference to the fact there was a new system
22 in place?
23 MS. PILGRIM:
24 A. We did, we talked about a system being in
25 place.

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1 MS. NEWBURY:
2 Q. And some people might infer from that, that
3 reference, that that might have been a
4 contributing factor.
5 MS. PILGRIM:
6 A. Yeah.
7 MS. NEWBURY:
8 Q. So it's only a partial piece of the puzzle.
9 MS. PILGRIM:
10 A. It is only a partial, yes.
11 MS. NEWBURY:
12 Q. And is it possible that you might have written
13 the letter, at least on the first draft, in a
14 different way, and maybe it would have been
15 changed before it's sent out, but in terms of
16 your own participation of it, if you had known
17 more information about what Dr. Carter had
18 been doing, perhaps you would have changed the
19 content of tone of that letter. Maybe you
20 would have left out the reference to the new
21 equipment so that people won't have the wrong
22 impression about it?
23 MS. PILGRIM:
24 A. I mean, we could have included a lot of things
25 about what might be happening here, or what

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1 might not be happening here. Like I told you
2 - and we didn't, you know, and I don't know if
3 that would have been appropriate to include
4 everything we knew that might be happening
5 when the reason for doing this was to just
6 bring the GPs into the fact that there is this
7 retest going on.
8 MS. NEWBURY:
9 Q. But you might be - would you agree that you
10 might be careful about - if you don't include
11 everything, well, maybe you want to make sure
12 that you're not going to leave the wrong
13 impression?
14 MS. PILGRIM:
15 A. Well, looking back, you know, just having that
16 one little piece about that piece of equipment
17 in there, I mean, obviously, when we did that,
18 we were still thinking that that was - even
19 though there was other information, we were
20 still thinking that was probably going to be a
21 big factor here.
22 MS. NEWBURY:
23 Q. Right.
24 MS. PILGRIM:
25 A. I mean, I can't remember what I was thinking

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1 at any particular point in time.
2 MS. NEWBURY:
3 Q. No, and looking back - I guess, in fairness to
4 you, looking back at it, you don't know what
5 you might have done if you had the
6 information?
7 MS. PILGRIM:
8 A. No, you know, what we know now in hindsight,
9 you would have to ask why did you just put
10 that little piece of information in there, but
11 that's with hindsight, and I don't quite know
12 what the thinking was and how much of that we
13 had put in our minds at the time, and whether
14 we had had more information, maybe we would
15 put nothing in there about that.
16 MS. NEWBURY:
17 Q. Right.
18 MS. PILGRIM:
19 A. Just to say that there's a investigation
20 ongoing, these are the numbers that you call
21 if you have any questions.
22 MS. NEWBURY:
23 Q. Right, and Dr. Gardiner, of course, would not
24 have had access to either the Banerjee nor
25 Wegrynowski's reports?

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1 MS. PILGRIM:
2 A. No, he wouldn't.
3 MS. NEWBURY:
4 Q. Nor did you.
5 MS. PILGRIM:
6 A. He didn't, no.
7 MS. NEWBURY:
8 Q. And you don't have any reason to believe that
9 he would have known the results of Dr.
10 Carter's quality review?
11 MS. PILGRIM:
12 A. I don't.
13 MS. NEWBURY:
14 Q. And Heather Predham, I guess, she was -
15 MS. PILGRIM:
16 A. Heather had the review, but I don't know if
17 she read it. I don't know if Heather--well,
18 you'll find out from Heather, I guess. I
19 don't--and for some reason, I don't think she
20 had read it, but anyway.
21 MS. NEWBURY:
22 Q. But in terms of your own participation in
23 these types of decisions, do you think it
24 might have been more beneficial if an
25 investigation, say, of Dr. Carter's quality

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1 review had continued, or even if it had
2 stopped where she had ended off in July of
3 2005, if what she had completed to date had
4 been incorporated in some sort of an
5 investigation report and distributed to
6 anyone, for whatever purpose, maybe it would
7 be used, maybe it wouldn't, but if it's
8 distributed to the decision makers, at least
9 they have the benefit of that information and
10 can use it as they see fit, or not use it as
11 they see fit, and perhaps if you continued on
12 with an investigation, which is not intended
13 to be privileged or a review that's not
14 intended to be privileged that you might learn
15 other information that might be useful to
16 other decisions that are being made, and
17 perhaps another example of that, there have
18 been--and I'm going to ask you some more
19 detailed questions about it, but -
20 MS. PILGRIM:
21 A. I would just like to make one comment.
22 MS. NEWBURY:
23 Q. Sure.
24 MS. PILGRIM:
25 A. I think if there were a lot of other

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1 information available about factors that might
2 be contributing, I don't think we would have
3 put that in a letter to GPs. So we would have
4 left out the piece about the machine as well.
5 MS. NEWBURY:
6 Q. Right, but perhaps that would be an
7 appropriate route to take at the time.
8 MS. PILGRIM:
9 A. Might have been, yeah.
10 MS. NEWBURY:
11 Q. Maybe it isn't, but -
12 MS. PILGRIM:
13 A. No, it's all -
14 MS. NEWBURY:
15 Q. - I guess the point is that maybe you would
16 have done things differently if you had more
17 information along the lines of a non-peer
18 reviewed investigation had that been completed
19 or at least continued or if you even had a
20 preliminary report about the investigation
21 that had been started.
22 MS. PILGRIM:
23 A. You know, there's one thing that I would like
24 to say about all this, and I think that, you
25 know, it's very hard for me to engage in what

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1 we would have done or what we might have done
2 or what we could have done. What we didn't do
3 was we didn't put a structured process around
4 this at this time and I think that if we had,
5 with an identifiable team of people who were
6 not doing this off the corner of their desk,
7 in an environment where we had just gone into
8 a massive restructuring, I think I can sit
9 down and say to anybody today that this would
10 have turned out very differently.
11 MS. NEWBURY:
12 Q. Sure.
13 MS. PILGRIM:
14 A. But we didn't have any of that, so therefore,
15 for me to say what we would have, could have,
16 should have done, it's really difficult for me
17 to even engage in that.
18 MS. NEWBURY:
19 Q. And I appreciate it's really difficult to say
20 what you might have done in hindsight, if you
21 had the benefit of it, and I guess the point
22 of my question is that an investigation that's
23 not going to be privileged, that the results
24 of which will be available to decision makers
25 would be more valuable if it's done as early

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1 as possible, and I know that you had some
2 limitations on resources, but if you had
3 resources, if Department of Health had handed
4 over resources, if you were able to proceed
5 with an investigation in the summer of 2005
6 and had preliminary reports coming from that,
7 it would be more valuable to have done that
8 earlier in the process because then
9 information can be given to decision makers
10 and they could take that into account as they
11 move along and various decisions have to be
12 made, and perhaps I can give you another
13 example. Throughout the process, there has
14 been discovery of some retro conversions and I
15 will ask you some more detailed questions
16 about that later on, and I know that there
17 might have been some--there's some evidence
18 about Doctor -
19 THE COMMISSIONER:
20 Q. Ms. Newbury, we know the witness disagrees
21 with your proposition because if she doesn't,
22 she doesn't need another example. If she
23 does, then your example is appropriate.
24 MS. PILGRIM:
25 A. Well, I've just given my answer, Commissioner.

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1 I just feel that we could have done this very
2 differently and if we had, things may have
3 been much better than they were. I don't
4 know. It's all supposition on my part, but I
5 know that when I look back and I see what our
6 staff had to do and the things that were done,
7 you know, we didn't have a chance of doing
8 this the way that we would have liked to have
9 done it, f we had done this and if we had done
10 that, so that's why I find this difficult to
11 do. I'm not disagreeing with you that if you
12 had more information, you would have done it.
13 But I can say to you, yes, and if we had been
14 in a stable organization, we would have done
15 it, and yes, if. So you know, I have
16 difficulty just having that kind of a
17 conversation.
18 MS. NEWBURY:
19 Q. Okay. So I take it from your answer that you
20 don't know if the outcome would have been any
21 different or any better if you had information
22 from an investigation at an earlier stage?
23 MS. PILGRIM:
24 A. I can say to you that one would expect that
25 the more information you had, given other

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1 positive factors that you're using, well, yes,
2 it would seem to me that you would have had a
3 better outcome. But everything else would
4 have had to be going with it as well, stable
5 environment, good structure put around this.
6 MS. NEWBURY:
7 Q. Okay.
8 MS. PILGRIM:
9 A. People who are devoted to it, you know, so
10 other things would have to be in place as
11 well.
12 MS. NEWBURY:
13 Q. So you agree that having at an early--having
14 an early investigation, which was not going to
15 be privileged, would be one of the factors
16 that might help Eastern Health have reached a
17 better outcome?
18 MS. PILGRIM:
19 A. Well, yeah, I wouldn't disagree with that, if
20 things had been different.
21 MS. NEWBURY:
22 Q. Right, okay, and I guess the question, reason
23 for the question for that is it's only now at
24 this stage that Eastern Health is going to be
25 embarking on an investigation, and I guess

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1 there's some concerns about whether or not
2 information might have been preserved for
3 that, but secondly, would the result of the
4 investigation have been more valuable earlier
5 on. So that's just why I wanted to raise that
6 with you.
7 MS. PILGRIM:
8 A. Yeah, but I'd just like to point out to you
9 that I don't think it's all bad, because I
10 think there's a lot of information that has
11 been gathered because of this Commission of
12 Inquiry. So I don't think it's all lost,
13 because there's a lot of information that has
14 been put together.
15 MS. NEWBURY:
16 Q. Yes.
17 MS. PILGRIM:
18 A. And because of this, a lot of this is still
19 very fresh in people's minds. So it's not
20 like we've lost three years.
21 MS. NEWBURY:
22 Q. Right.
23 MS. PILGRIM:
24 A. I wouldn't want -
25 MS. NEWBURY:

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1 Q. But just in terms of the general principle.
2 MS. PILGRIM:
3 A. - to leave that impression.
4 MS. NEWBURY:
5 Q. No, I can appreciate that there's been a lot
6 of information gathering and interviews and
7 retention of information and gathering of
8 information since the Inquiry.
9 MS. PILGRIM:
10 A. Correct.
11 MS. NEWBURY:
12 Q. And in terms of the information that was
13 available to you at the time, would it have
14 been beneficial to you to have an official
15 record that you could look to and again, I
16 focus on your involvement in this for a couple
17 of reasons. Number one, you described
18 yourself as being a bit on the periphery, sort
19 of at the earlier stages and you were sort of
20 coming and going, in and out of decision
21 making, I guess as needed or depending on
22 whatever portfolio you have at the time.
23 MS. PILGRIM:
24 A. Mainly because of my having--you know, my
25 different role with having Quality reporting

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1 to me and then not having Quality reporting to
2 me.
3 MS. NEWBURY:
4 Q. Okay.
5 MS. PILGRIM:
6 A. That was the major factor.
7 MS. NEWBURY:
8 Q. And then later on, you've taken a much more
9 significant role, since 2007, when you were
10 appointed as the contact person for NLCHI and
11 also for the Commission of Inquiry.
12 MS. PILGRIM:
13 A. And was given the opportunity to be more
14 involved because I had over half of my
15 portfolio reassigned away from me.
16 MS. NEWBURY:
17 Q. Okay, and so that's freed up some time for you
18 to devote to this?
19 MS. PILGRIM:
20 A. Yes.
21 MS. NEWBURY:
22 Q. And do you think that, in light of those two,
23 I guess, aspects of your involvement in this
24 matter, that an official record outlining
25 everything that had been done would have been

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1 useful for you as you got involved in this?
2 Just so that you had access to, for example,
3 in the fall of 2005, the fact that Dr. Carter
4 had done a review. You weren't able to go, at
5 that point in time, I take it, to some binder
6 to say "here's the information before I start
7 to get myself involved in this again, I'm
8 going to have a review to see what else has
9 happened."
10 MS. PILGRIM:
11 A. No, it wasn't all together in a binder, and
12 you did have to speak, but you know, it didn't
13 take you too long to kind of get yourself up
14 to scratch with what had gone on, but it
15 wasn't written or documented in any particular
16 place. We had to start doing that, you know,
17 building the binders and building the
18 chronology of events.
19 MS. NEWBURY:
20 Q. Right, and in terms of, you know, whether or
21 not you might miss some information, for
22 example, about Dr. Carter's quality review,
23 that was obviously possible in the absence of
24 that?
25 MS. PILGRIM:

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1 A. Yes.
2 MS. NEWBURY:
3 Q. Okay, and even, I guess, to this day, even
4 though you're significantly involved in this
5 matter, to this day, you still don't seem to
6 know how the panelling process was taking
7 place, and is it because that type of
8 information isn't in a binder or that you just
9 haven't had a chance to review that?
10 MS. PILGRIM:
11 A. That's probably not something that I've asked
12 very specific questions about. I knew that
13 the panelling and I knew what types of
14 patients went to the panel, but exactly who
15 the two or three people were, I wasn't into
16 the nitty gritty of that. My job, on a go-
17 forward basis, since I've been, is to really
18 prepare the organization for the Commission.
19 So there are still things, like that detail
20 that I would not know.
21 MS. NEWBURY:
22 Q. Okay, and I guess my question is does that
23 type of a record actually exist or do you--
24 every time you have a question about some
25 aspect of this, do you have to go to two or

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1 three people and try to find what the
2 consensus is as to how the retesting results
3 were handled, in terms of whether they get
4 channelled through the panel first or whether
5 they can go to the physicians at the same
6 time?
7 MS. PILGRIM:
8 A. Well, the panelling on a go-forward basis that
9 I've been involved in, I know how that worked.
10 MS. NEWBURY:
11 Q. Right, but in terms of what happened before
12 that.
13 MS. PILGRIM:
14 A. Before that, well no, I mean, that's a part of
15 telling the story, isn't it? There's parts of
16 that now that we have to sit down and document
17 how all that worked, and if I were--I don't
18 have to go to three or four people. If I had
19 a question about how the panelling worked, I
20 would go to Heather Predham about it. She was
21 the one who was most involved.
22 MS. NEWBURY:
23 Q. And she would have all that information?
24 MS. PILGRIM:
25 A. Well, she was most involved with it. She was

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1 coordinating the panel.
2 MS. NEWBURY:
3 Q. And do you know if everyone who had
4 interaction with the panel would also have
5 that information? Dr. Laing was the chair of
6 the panel.
7 MS. PILGRIM:
8 A. Dr. Laing was the chair and I think you've
9 heard evidence from the physicians that most
10 of them would get a list and they would come
11 and the charts would be there for them to
12 review and that's kind of how the panel
13 worked. Well, how the list got there, you
14 know, how patients got on the list and the
15 charts got pulled for the panel, that would be
16 the detail about well, who was helping Heather
17 do that, you know, was that Heather and the
18 chair of the panel, which would be my
19 understanding of it.
20 MS. NEWBURY:
21 Q. So Dr. Laing would not necessarily know how
22 that was done, how the -
23 MS. PILGRIM:
24 A. I'd say Dr. Laing, as the chair of the panel,
25 was involved with that.

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1 MS. NEWBURY:
2 Q. Okay.
3 MS. PILGRIM:
4 A. But she didn't actually get the charts pulled
5 or anything. Heather would have Quality doing
6 that, and someone in Quality probably typed up
7 the list and sent it out. You know, Quality
8 was providing a secretarial function to that
9 panelling as well.
10 MS. NEWBURY:
11 Q. So whether or not Dr. Laing and Heather
12 Predham are on the same page as to how that
13 process is to work and of course, we haven't
14 heard from Ms. Predham yet, you could only
15 find that out if you went to both of them and
16 asked them what is their understanding of it?
17 MS. PILGRIM:
18 A. Well -
19 MS. NEWBURY:
20 Q. You can't go to an official record to say here
21 is the -
22 MS. PILGRIM:
23 A. No.
24 MS. NEWBURY:

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1 Q. - decision about how we're going to handle it?
2 MS. PILGRIM:
3 A. No, I can't.
4 MS. NEWBURY:
5 Q. Okay.
6 MS. PILGRIM:
7 A. No.
8 MS. NEWBURY:
9 Q. And my question is would that have been
10 helpful?
11 MS. PILGRIM:
12 A. Sure, yes. But I will also answer you that if
13 we had--and I have to keep going back to this,
14 that I have to make it very clear that how
15 Eastern Health dealt with this was not in a
16 normal way, well really in a correct way in a
17 normal environment, and you know, it has to be
18 said that that did affect our ability to
19 respond to this massive undertaking which we
20 took on, which we had never had any experience
21 with.
22 MS. NEWBURY:
23 Q. So you're saying that perhaps if this happened
24 three years into the formation of Eastern
25 Health as an organization, even if you had an

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1 ad hoc procedure adopted and you didn't have
2 all sorts of formal policies, you think you
3 might have handled it more efficiently?
4 MS. PILGRIM:
5 A. You would have been in--you know, when I think
6 back at what the executive team was doing
7 during the summer of 2005, into the fall of
8 2005, I mean, we came together as a group that
9 didn't know each other. We had this
10 organization that we didn't know and every
11 time we got together, I mean, our focus was on
12 integration issues. So you know, we were
13 really jeopardized in our ability--we weren't
14 a stable organization at that time, and
15 anybody that knows--I mean, you would
16 understand or anybody else that that's really
17 going to affect the way that you can take on
18 any kind of an endeavour, especially something
19 that is as big as this one.
20 MS. NEWBURY:
21 Q. Okay, I was going to ask you some questions
22 now about the retro conversions and if I could
23 have Exhibit P-0103 please? And this is your
24 e-mail to Sharon Smith and Heather Predham and
25 I believe it's page two of that document.

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1 MS. PILGRIM:
2 A. What date is on this one?
3 MS. NEWBURY:
4 Q. Sorry, I'll show you beginning again, that's
5 August 8th, 2006. And you're sending it--
6 actually that's from you to Patricia Pilgrim--
7 sorry, from Heather Predham to you and Sharon
8 Smith.
9 MS. PILGRIM:
10 A. Okay.
11 MS. NEWBURY:
12 Q. But you have embedded in that your original
13 message which is from you to Sharon Smith and
14 Heather Predham, copied to Ms. Bonnell,
15 Barrington and Smith and that's dated August
16 7th, 2006?
17 MS. PILGRIM:
18 A. Yes.
19 MS. NEWBURY:
20 Q. And you were shown this yesterday, I believe,
21 and the bullet there "Notification of retro
22 converters", you state that "We know there are
23 four cases who are living and have not been
24 notified and one case who is deceased whose
25 husband has been calling requesting

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1 information." And I'm just wondering if you
2 had been involved at any point in time in
3 setting criteria as to what would be
4 considered a retro converter?
5 MS. PILGRIM:
6 A. No. And that came from the list of--I mean,
7 that name came to me from the people who were
8 most directly involved in this, you know, the
9 core group kind of thing who were doing most
10 of the review of this.
11 MS. NEWBURY:
12 Q. Okay, and do you even know what would
13 constitute a retro converter, the precise
14 definition of that?
15 MS. PILGRIM:
16 A. That's a good question, I mean what my
17 understanding of it would have been that that
18 would be a patient who was considered
19 clinically positive and had been retested and
20 came back clinically negative with results
21 that were like zero, zero.
22 MS. NEWBURY:
23 Q. Okay.
24 MS. PILGRIM:
25 A. And I know that some of them, well I don't

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1 know actually, but I know that--you know, so
2 you could have been 90/90 and came back zero
3 zero or you could have been 30/20 and came
4 back zero zero.
5 MS. NEWBURY:
6 Q. And would the issues of cutoffs play a role in
7 that?
8 MS. PILGRIM:
9 A. I think there were some of these cases that
10 actually, it was more their positivity rather
11 than they met any cutoff point, they had
12 positive results, were considered to be
13 positive clinically and came back negative.
14 MS. NEWBURY:
15 Q. If a patient had been considered clinically
16 positive because they were 50/60, for example,
17 but they haven't treated--they weren't offered
18 or recommended Tamoxifen or a comparable drug
19 because of some risk factor, would that have
20 fallen into the category of a retro converter
21 based on your understanding?
22 MS. PILGRIM:
23 A. Oh sure, yeah, if the numbers changed--if the
24 numbers were what made up a retro converter,
25 it wasn't based on whether they were treated

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1 or not.
2 MS. NEWBURY:
3 Q. It was based on whatever the clinical
4 standards were at the time.
5 MS. PILGRIM:
6 A. Whatever the numbers were.
7 MS. NEWBURY:
8 Q. So whether they would broach the topic can we
9 consider this person for Tamoxifen or hormonal
10 therapy and then looked to see if there's any
11 -
12 MS. PILGRIM:
13 A. Well there's a lot of patients that they did
14 panel that when they looked, the patients had
15 already been on Tamoxifen. But they still
16 went to the panel, you know, with the patient-
17 -some of the patients were considered
18 clinically negative and because of that they
19 were retested. They came back positive--oh
20 no, we're talking about retro converters here,
21 sorry. So your question was? I'm finding it
22 very warm here now.
23 MS. NEWBURY:
24 Q. I'm just wondering and I think you answered
25 the question and I'll just repeat it just to

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1 make sure I understood it correctly, that you
2 would have understood that if a patient had
3 been considered clinically positive, but not
4 offered or recommended Tamoxifen or other
5 hormonal therapy because of a contraindication
6 -
7 MS. PILGRIM:
8 A. Yes.
9 MS. NEWBURY:
10 Q. That you would still categorize that as a
11 retro converter, even though it may not have
12 any implications for treatment?
13 MS. PILGRIM:
14 A. Yes, because of the numbers, yeah.
15 MS. NEWBURY:
16 Q. And I take it from your evidence -
17 MS. PILGRIM:
18 A. But, you know, you're not asking somebody who
19 was making those decisions.
20 MS. NEWBURY:
21 Q. I just wanted to know what your understanding
22 was at the time.
23 MS. PILGRIM:
24 A. That was my understanding, yes.
25 MS. NEWBURY:

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1 Q. And I take it that you weren't involved in
2 reviewing the data, the retest results to see
3 which of those specimens fell in that
4 category?
5 MS. PILGRIM:
6 A. No, I was not, no.
7 MS. NEWBURY:
8 Q. And are you aware of a situation or how a case
9 might be handled where the original result was
10 ER negative and PR positive, a PR positivity
11 rate of, you know, 50 or 60 or something above
12 whatever the cutoffs were at the time.
13 MS. PILGRIM:
14 A. Right.
15 MS. NEWBURY:
16 Q. Would that have been considered, and again, if
17 those were retested and came back negative,
18 negative or zero zero, how--would that have
19 been considered a retro conversion?
20 MS. PILGRIM:
21 A. A patient who was--let me see now, some of the
22 patients who were ER positive, if you were ER
23 positive, you would have been retested. If
24 you were PR positive, you still would have
25 been retested because you were ER negative.

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1 MS. NEWBURY:
2 Q. Right.
3 MS. PILGRIM:
4 A. Right? And then the question is?
5 MS. NEWBURY:
6 Q. And if those--if that select group of people
7 who were ER negative, PR positive originally
8 were retested and determined to be zero zero,
9 would they be considered retro conversions
10 based on your understanding at the time?
11 MS. PILGRIM:
12 A. I don't know the answer to that.
13 MS. NEWBURY:
14 Q. Okay, you hadn't focused on that at the time
15 and no one ever brought that issue to your
16 attention?
17 MS. PILGRIM:
18 A. Well I'm sure it was discussed by the people
19 who were doing the categorizing of the
20 patients. I mean, my understanding of that
21 would be, I know that if you were PR positive,
22 you would have been considered by--we were
23 told by the oncologist they considered those
24 patients to be positive. So if you came back
25 negative, I mean, one would think that they

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1 would consider you as a retro converter, but
2 I'm not sure about that.
3 MS. NEWBURY:
4 Q. Okay. And in this case, there is evidence
5 from oncologists and also Dr. Kwan in
6 September that in fact PR positive patients
7 were generally treated as the same as ER
8 positive.
9 MS. PILGRIM:
10 A. They considered them clinically as positive,
11 yes.
12 MS. NEWBURY:
13 Q. Right, okay. But you said, you're sure that--
14 I think you said you were sure that people
15 would have considered that at the time, but
16 you don't know? I was asking you if anyone
17 had brought that to your attention?
18 MS. PILGRIM:
19 A. Well I don't know because I wouldn't have been
20 in those kind of discussions, those were the
21 discussions that would have been going on
22 between, when the--you know, the pathologist
23 and the oncologist about which patients were
24 which and the retro converter group, I mean,
25 they were--I can remember Dr. Nash Denic was

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1 very much into what that group were, defining
2 who they were.
3 MS. NEWBURY:
4 Q. Dr. Denic, okay.
5 MS. PILGRIM:
6 A. Yes.
7 MS. NEWBURY:
8 Q. I want to show you two documents and see if
9 you can add any explanation. The first is P-
10 2642 please? And this is an e-mail from
11 Heather Predham to Dr. Denic and it has an
12 attachment, it's dated May 17th, 2006. So
13 just for a reference, that was before the
14 document I just showed you the e-mail dated
15 August 7th, 2006 that you wrote.
16 MS. PILGRIM:
17 A. Yes, uh-hm.
18 MS. NEWBURY:
19 Q. And just showing the list there, I don't know
20 if we could have that turned. I don't know if
21 you can read that there, the print is a little
22 small. Are you familiar with this list here?
23 MS. PILGRIM:
24 A. No.
25 MS. NEWBURY:

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1 Q. And there's a second list at P-1373 please?
2 And this is another document, Heather Predham
3 to Dr. Denic, May 18th. It's also copied to
4 Dr. Williams, Dr. Cook and Debbie Parsons with
5 another attachment and on the next page, this
6 is a slightly shorter list. And are you
7 familiar with this particular document?
8 MS. PILGRIM:
9 A. No.
10 MS. NEWBURY:
11 Q. And when you were -
12 MS. PILGRIM:
13 A. That doesn't mean I haven't seen that
14 document. I can't say I've never seen it, but
15 it doesn't jump out at me as something I've,
16 you know, I can say oh yes, that's what that
17 is.
18 MS. NEWBURY:
19 Q. So you wouldn't be able to say whether either
20 one of those is considered to be a list of
21 retro converters?
22 MS. PILGRIM:
23 A. No.
24 MS. NEWBURY:
25 Q. And can you say whether or not you would have

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1 had access to this information or relied on
2 this information when you drafted your memo in
3 August of 2006?
4 MS. PILGRIM:
5 A. When I drafted the memo to go back, that was
6 when we had to put it on the table? I would
7 have relied on any information that I would
8 have given to go back to NLCHI would have
9 either come from Terry Gulliver in the lab -
10 MS. NEWBURY:
11 Q. Now this is long before NLCHI's involvement,
12 this is 2006.
13 MS. PILGRIM:
14 A. Okay.
15 MS. NEWBURY:
16 Q. And the exhibit I'm referring to, just to show
17 it to you again, is P-0103, that's the August
18 7th e-mail that you sent to Heather Predham
19 and you're indicating here the notification of
20 retro converters -
21 MS. PILGRIM:
22 A. Now this is in August, right?
23 MS. NEWBURY:
24 Q. Yeah, three months later.
25 MS. PILGRIM:

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1 A. August, 2006 when Dr. Williams is on annual
2 leave and Mrs. Pilgrim is getting drawn into
3 some of the conversations around this, and I
4 would say what you see before you there is my
5 attempt to summarize what I heard and to make
6 sure we all heard the same thing, because I
7 would have been--I remember when Bob was on
8 holiday at that time, because I was the
9 executive person there, I was getting drawn in
10 to making decisions and it was really
11 important to me that I made sure I was getting
12 it right.
13 MS. NEWBURY:
14 Q. Uh-hm.
15 MS. PILGRIM:
16 A. And if I remember correctly, I think what you
17 see there is my attempt--we had had a
18 conversation, there was some decisions that
19 had to be made and I was reflecting back to
20 them what I understood from what we had just
21 talked about.
22 MS. NEWBURY:
23 Q. Okay. And discussions were with whom?
24 MS. PILGRIM:
25 A. Well obviously Heather would have been there,

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1 I would think because if it was something to
2 do with--if you go down to what I said, if you
3 just flick it, I think I can flick down too
4 here. Yeah, this is what this was, it was me
5 trying to make sure I got it all right and
6 then there were questions, there were things
7 that we were awaiting and I kind of put that
8 in bold to make sure that whatever action we
9 were going to do, I put that there. So it was
10 just kind of capture at that point in time so
11 I was on the same wave length as everybody
12 else.
13 MS. NEWBURY:
14 Q. So you think then that the information here--
15 and in particular, I guess my focus is on the
16 four cases of living retro converters and the
17 one who is known to be deceased, that would
18 have come more from discussions, as opposed to
19 perhaps -
20 MS. PILGRIM:
21 A. Yes, that would have been what we were talking
22 about, yeah. And me just trying to capture it
23 and throw it back at them and say, now tell
24 me--and then I think on the top, Heather
25 probably made some clarification to what I had

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1 written.
2 MS. NEWBURY:
3 Q. Right, okay and I don't see any changes there
4 about the numbers of retro converters?
5 MS. PILGRIM:
6 A. No.
7 MS. NEWBURY:
8 Q. Okay. And whether or not she was referring to
9 those lists, you had no idea, there was no
10 discussion about that?
11 MS. PILGRIM:
12 A. No. No, no, no. It was just something, they
13 would have been asking me for advice on
14 something. There would have been decisions or
15 a need to let's sit down now and make sure
16 that we're all on the same wave length here.
17 MS. NEWBURY:
18 Q. Do you know if there exists currently an up-
19 to-date list outlining all of the retro
20 converters, whatever Eastern Health considers
21 to be or defines to be retro converters and
22 how those cases were handled?
23 MS. PILGRIM:
24 A. You can go into the NLCHI database and do a
25 search for the retro converters.

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1 MS. NEWBURY:
2 Q. Had that been done by anyone?
3 MS. PILGRIM:
4 A. Yeah, I think it was done there awhile ago by
5 Dr. Nash Denic because I think he wanted to
6 review the original slides.
7 MS. NEWBURY:
8 Q. And do you know when he did that?
9 MS. PILGRIM:
10 A. He--I think there was some evidence given here
11 too, wasn't there -
12 MS. NEWBURY:
13 Q. Yes, I was asking Dr. Denic -
14 MS. PILGRIM:
15 A. I think the last time that that would have
16 been done, like anything like that, within the
17 database there are certain categories of
18 patients that have been categorized, so you
19 can search them. So you can go in and search
20 the deceased, you can go in and search another
21 group that came back from Mount Sinai with no
22 tumour, you can search DCIS. So retro
23 converter is a group that you can--now, as you
24 know, that number has changed. You started
25 off with a number and they've been reviewed

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1 and now there's a finite list of what's left
2 in there after everybody's had their say and
3 agreed upon that would be called a retro
4 converter list in there.
5 MS. NEWBURY:
6 Q. So does such a list exist?
7 MS. PILGRIM:
8 A. In that database you can search it, yes, I
9 would say.
10 MS. NEWBURY:
11 Q. Do you think Dr. Denic did it after he
12 testified or before he testified?
13 MS. PILGRIM:
14 A. I think if I remember correctly, he gave some
15 testimony because somebody said--somebody had
16 asked him, some of the pathologists had done a
17 review and I think he said, "Oh yes, I think I
18 was the one who did it. It wasn't some of
19 them, it was me."
20 MS. NEWBURY:
21 Q. Okay, and he referenced, I think, four retro
22 converters.
23 MS. PILGRIM:
24 A. Four, yes, that he had looked at.
25 THE COMMISSIONER:

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1 Q. Ms. Newbury, it's about the time for the
2 afternoon break, so wherever it is convenient,
3 we'll break.
4 MS. NEWBURY:
5 Q. This is a good place.
6 THE COMMISSIONER:
7 Q. Okay, we'll take a break.
8 (RECESS)
9 THE COMMISSIONER:
10 Q. Please be seated. Ms. Newbury.
11 MS. NEWBURY:
12 Q. Thank you. Exhibit P-0720 please? Ms.
13 Pilgrim, this is a document prepared by Marion
14 Crowley, sent to Louise Jones and copied to
15 Joyce Penney and Pam Elliott with the results
16 to be provided to Mark Quinn. This was
17 following an access to information request,
18 and attached to that are 20 odd pages with
19 data, the original ER and PR results and the
20 Mount Sinai ER and PR results. Are you
21 familiar with this document?
22 MS. PILGRIM:
23 A. Yes, I am.
24 MS. NEWBURY:
25 Q. And there are a few entries in this report

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1 that I want to refer you to and they involve
2 what appear to be negative ERs, positive PRs
3 on initial testing, original testing and then
4 negative results on retesting for both ER and
5 PR. Line 20 here on the first page. There's
6 actually two entries there for line 20, and
7 that actually happens several times throughout
8 the document. And I'll--and perhaps I can
9 actually take this opportunity to ask you
10 about that. Would that--what would that
11 represent, having two entries for line 20?
12 MS. PILGRIM:
13 A. That there were two specimens, probably, that
14 were tested.
15 MS. NEWBURY:
16 Q. Okay. Because I notice that there's nothing
17 here over that column indicating what those
18 numbers mean?
19 MS. PILGRIM:
20 A. No.
21 MS. NEWBURY:
22 Q. So it's your assumption or belief that that
23 would be one patient and two samples?
24 MS. PILGRIM:
25 A. Yes, every number represents a different

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1 patient, so if there's any more than one of
2 one number, it would be same patient,
3 different specimen.
4 MS. NEWBURY:
5 Q. Okay. And just going to the very end of this
6 document just to get a sense of the numbers
7 that are involved. There are 887 numbers.
8 And again, there are multiples for some, so
9 876, for example, on this page has two
10 different entries?
11 MS. PILGRIM:
12 A. Um-hm.
13 MS. NEWBURY:
14 Q. And have you counted up how many total entries
15 are there, taking into account -
16 MS. PILGRIM:
17 A. No.
18 MS. NEWBURY:
19 Q. Okay.
20 MS. PILGRIM:
21 A. I didn't prepare this.
22 MS. NEWBURY:
23 Q. You didn't, okay.
24 MS. PILGRIM:
25 A. This was prepared through quality.

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1 MS. NEWBURY:
2 Q. So there were 887 here in total. And I've
3 actually done my own calculation, I guess, a
4 rough calculation and I've come up with95
5 additional entries there. So if you look at
6 all the multiple entries there, so if you look
7 at all the multiple entries, there would be an
8 additional 95 and the total of 887 and 95
9 would be 982. And I don't ask you to accept
10 that, I'm just putting it to you as, I guess,
11 a possible conclusion here. But there
12 certainly are multiple entries here for many
13 of the different line numbers there. And
14 again, this is August of 2007. And back to
15 the first page, so line 20 there's a negative
16 75 and then on retesting it's two and a zero.
17 I'm going to just show you a few of these just
18 so you can speak to it as a group. And line
19 61, and again, there are multiple entries
20 here, but the third one we have zero for ER,
21 50, 60, for PR, zero and zero from Mount Sinai
22 testing. And if you look at the other two
23 entries from both the original and the Mount
24 Sinai results are all negatives?
25 MS. PILGRIM:

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1 A. Um-hm.
2 MS. NEWBURY:
3 Q. Well, actually, or the original says negative
4 whereas Mount Sinai says zero?
5 MS. PILGRIM:
6 A. Zero, yes.
7 MS. NEWBURY:
8 Q. Looking at line 142, original results, less
9 than five for ER, less than 25 for PR and
10 retesting it's zero, zero. Line 436, less
11 than ten for ER, 60 for PR, zero and zero.
12 Getting to the end here. Line 767, again,
13 this is a situation where there are a couple
14 of entries there. Negative--on the second
15 entry for 767, negative ER, 40 to 50 PR and
16 zero and zero for Mount Sinai. And above that
17 the other entry has just Xs for the original
18 and then zero, zero from Mount Sinai. And
19 then one more to show you for now.
20 MS. PILGRIM:
21 A. So you're just picking out the ones with the
22 positive PR and a negative ER originally?
23 MS. NEWBURY:
24 Q. Yes. And then here, 827, negative ER, 67 PR,
25 zero, zero?

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1 MS. PILGRIM:
2 A. Um-hm.
3 MS. NEWBURY:
4 Q. On retesting. Do you know if those cases were
5 reviewed by the physician review panel?
6 MS. PILGRIM:
7 A. Well, what you would have here would be
8 there's many deceased patients results in this
9 group.
10 MS. NEWBURY:
11 Q. Okay.
12 MS. PILGRIM:
13 A. And the deceased patients' results were not
14 reviewed by the panel.
15 MS. NEWBURY:
16 Q. Okay.
17 MS. PILGRIM:
18 A. So I don't--you know, obviously I don't know,
19 but what you have here is a mixture of living
20 patients and deceased.
21 MS. NEWBURY:
22 Q. Okay.
23 MS. PILGRIM:
24 A. And if they're deceased, what you're showing
25 me, none of them would have been reviewed by

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1 the panel.
2 MS. NEWBURY:
3 Q. Okay. So if they're all deceased, none of
4 them would be reviewed by the panel?
5 MS. PILGRIM:
6 A. That's right.
7 MS. NEWBURY:
8 Q. Okay. So whether or not there -
9 MS. PILGRIM:
10 A. There was no panelling -
11 MS. NEWBURY:
12 Q. - would have been treatment, anything -
13 MS. PILGRIM:
14 A. Yeah. And it's hard to tell her because
15 there's no designation as to whether they were
16 living or deceased.
17 MS. NEWBURY:
18 Q. And can you say for sure that none of them
19 were living?
20 MS. PILGRIM:
21 A. Oh, no, I can't.
22 MS. NEWBURY:
23 Q. Okay.
24 MS. PILGRIM:
25 A. But I can't tell you whether they weren't,

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1 either, because there's nothing to say--what I
2 can say to you, if you have deceased results
3 in here, which you do, according to the
4 numbers, that none of them were reviewed by a
5 panel.
6 MS. NEWBURY:
7 Q. Okay. Now, if any of those happen to be
8 living, was there any other process in place
9 aside from panelling to review appropriateness
10 of treatment?
11 MS. PILGRIM:
12 A. No, other than results going back to an
13 individual physician about his or her patient
14 that they might--I mean, the process that we
15 set up for review and, as you know, this was
16 all about giving someone a chance at a
17 treatment, that would have been done through
18 the panelling process.
19 MS. NEWBURY:
20 Q. Um-hm.
21 MS. PILGRIM:
22 A. And you do know that there were some
23 differences. Sometimes a particular
24 oncologist would just--especially early in the
25 game they were changing treatments without

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1 panelling them, the first groups that were
2 being retested.
3 MS. NEWBURY:
4 Q. Right, okay. So in your mind it's possible
5 that there might have been a physician
6 addressing changes in treatment and these
7 living cases, if there are any, may not have
8 gone to the panel?
9 MS. PILGRIM:
10 A. If anybody was addressing treatments before
11 that, it would have been the first cases
12 before they even set up the retesting.
13 MS. NEWBURY:
14 Q. Okay.
15 MS. PILGRIM:
16 A. The original cases that were coming in and
17 they were making decisions on them as they
18 were getting them.
19 MS. NEWBURY:
20 Q. Okay.
21 MS. PILGRIM:
22 A. Because individual physicians were ordering
23 them on their own patients.
24 MS. NEWBURY:
25 Q. Right. And so that would have been pre the

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1 physician review panel process?
2 MS. PILGRIM:
3 A. Yes. And even those really were reviewed,
4 because I think Joy McCarthy actually did a
5 list of those at some point.
6 MS. NEWBURY:
7 Q. Right. And there was some evidence that they
8 may have had a more limited review, but -
9 MS. PILGRIM:
10 A. But they were reviewed.
11 MS. NEWBURY:
12 Q. - there is evidence that some of those, at
13 least, were referred to the panel?
14 MS. PILGRIM:
15 A. Yeah, they were summarized, yes.
16 MS. NEWBURY:
17 Q. Okay. If I could have Exhibit P-3057, please?
18 And this is a document that you were shown
19 yesterday, I believe. It has the--sorry, the
20 date of that is November 30th, 2006. And that
21 has some numbers there. And in terms of this
22 breakdown of numbers and assuming that some of
23 those entries that I just showed you on the
24 exhibit, the Mark Quinn data from August of
25 2007, now that's a few months later. But do

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1 you know if--where those would have been
2 categorized here or based on your earlier
3 information can you even do that?
4 MS. PILGRIM:
5 A. No, I can't, no.
6 MS. NEWBURY:
7 Q. Okay. And this case here, it appears, looking
8 through the document, that there are--we're
9 dealing with 12 confirmed positives?
10 MS. PILGRIM:
11 A. Um-hm.
12 MS. NEWBURY:
13 Q. And down here under "Change in Results"
14 there's a heading, "Originally had a degree of
15 ER positivity, but on retesting was negative."
16 So in terms of the living patients' results,
17 which would be the first four headings here,
18 it seems that all the positive results would
19 be the four here on the bottom where there was
20 some degree of ER positivity but converted or
21 on retesting was considered negative. And up
22 above there are confirmed positive results of
23 12. So that's a total of 16. Do you see any
24 other categories -
25 MS. PILGRIM:

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1 A. That's what that says.
2 MS. NEWBURY:
3 Q. - if those entries that I showed you were,
4 actually, any of them were living patients, do
5 you see any other categories here that those
6 entries could fit into?
7 MS. PILGRIM:
8 A. No, I don't.
9 MS. NEWBURY:
10 Q. Okay. And again, this list is a little bit--
11 this breakdown of numbers is somewhat earlier
12 than Mark Quinn's data that was provided to
13 him in August of 2007, so perhaps some came
14 after the fact. But you don't know that?
15 MS. PILGRIM:
16 A. I don't, no.
17 MS. NEWBURY:
18 Q. Now, you'd mentioned--you've referenced in
19 your own e-mail of August of 2006 four
20 retroconverters. And Dr. Denic referred to
21 four retroconverters in his evidence. And
22 that would be consistent with here. Now, he
23 also--sorry, you also reference in your e-mail
24 a retroconverter for a deceased patient, so
25 that would actually be five. So that, I guess

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1 the -
2 MS. PILGRIM:
3 A. There were different numbers at different
4 times until they were all reviewed.
5 MS. NEWBURY:
6 Q. Right.
7 MS. PILGRIM:
8 A. My understanding now, forgetting about the
9 deceased, but in the living, there are
10 actually four official that are actually
11 officially considered to be retroconverters.
12 MS. NEWBURY:
13 Q. Retroconversions, okay.
14 MS. PILGRIM:
15 A. In the database now.
16 MS. NEWBURY:
17 Q. Yeah. So while you may have initially, as of
18 the time of your e-mail you were starting to
19 track--you, for some reason, had some
20 information about a deceased patient -
21 MS. PILGRIM:
22 A. But that happened a lot of times you'd have
23 and then when you'd look at it, it wasn't the
24 right information or whatever. So I know that
25 they've all been reviewed, Dr. Denic has

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1 looked at them all, because I think he
2 actually looked at seven at one time or
3 something. But officially now in the database
4 there's four living.
5 MS. NEWBURY:
6 Q. Four living, okay. And is it that the
7 reference to the deceased patient who was a
8 retroconverter, is it that something about
9 that changed, maybe the opinion as to whether
10 it was a retroconversion changed or did you
11 just stop keeping track of it?
12 MS. PILGRIM:
13 A. Well, it's probably just that then we put the
14 deceased one over with the deceased group
15 because they weren't being panelled.
16 MS. NEWBURY:
17 Q. And perhaps I can bring up Exhibit P-3222,
18 please? And I believe it's page 8. This is
19 the draft technical briefing, so this is what
20 NLCHI had provided in February of 2008,
21 earlier this year. And here they have
22 information which, I guess, originated from
23 Eastern Health. Eastern Health reports 12
24 were confirmed positive, which means a total
25 of--I guess they're saying that there were a

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1 smaller number of negative, ER negative
2 patients there. But it does say that 12
3 people were confirmed positive. And it also
4 confirmed that 18 people were originally
5 positive, which means that the number of ER
6 negative patients retested was 995. So that
7 would seem to suggest that there are 18 people
8 who were originally positive and 12 of those
9 were confirmed positive and the difference
10 would be six. Does that mean six were not
11 confirmed positive?
12 MS. PILGRIM:
13 A. I'd have to know if they were alive or dead. I
14 don't know if he's--he's talking about all
15 patients here, because this is the total
16 database he's talking about, the 995, right.
17 MS. NEWBURY:
18 Q. He's talking about the total database, yes.
19 MS. PILGRIM:
20 A. So this is living and dead? Yeah, it is, this
21 is all of the database. So if your question
22 is how come we've now got six here instead of
23 four, I don't know the answer to that. I can
24 only tell you that if you went into the
25 database now, there would be four confirmed

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1 retroconverters alive, living.
2 MS. NEWBURY:
3 Q. Living, four confirmed retroconverters living?
4 MS. PILGRIM:
5 A. Yes.
6 MS. NEWBURY:
7 Q. Okay. And do you know whether that includes
8 ER negatives originally, PR positives for--
9 because you're focusing only on the living? I
10 mean, has that analysis actually been done?
11 MS. PILGRIM:
12 A. No. That's probably something, a question now
13 that Wayne Miller is having done through the
14 analysis that's being done. Because there's
15 very little analysis has been done on this
16 database.
17 MS. NEWBURY:
18 Q. Right, okay. So you can't answer then whether
19 or not -
20 MS. PILGRIM:
21 A. No, I can't.
22 MS. NEWBURY:
23 Q. Okay. Whether or not ER negatives, PR
24 positives converting to zero, zero -
25 MS. PILGRIM:

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1 A. No, no.
2 MS. NEWBURY:
3 Q. Okay.
4 MS. PILGRIM:
5 A. No, I cannot, I'm sorry.
6 MS. NEWBURY:
7 Q. Now, Dr. Laing, as I recall her evidence,
8 couldn't recall panelling any retroconverters
9 cases after May of 2006 when a couple of
10 retroconverter lists were prepared, the first
11 two I showed you earlier today that went from
12 Heather Predham to Dr. Denic.
13 MS. PILGRIM:
14 A. Um-hm.
15 MS. NEWBURY:
16 Q. And remember those two lists, you weren't
17 familiar with them?
18 MS. PILGRIM:
19 A. No.
20 MS. NEWBURY:
21 Q. You don't think you relied upon them?
22 MS. PILGRIM:
23 A. No.
24 MS. NEWBURY:
25 Q. You may have seen them, but you weren't

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1 specifically familiar with them?
2 MS. PILGRIM:
3 A. No, no, no.
4 MS. NEWBURY:
5 Q. And Dr. Laing couldn't recall panelling any
6 retroconverters after May of 2006.
7 MS. PILGRIM:
8 A. Um-hm.
9 MS. NEWBURY:
10 Q. Okay. I'm just pointing out that the numbers
11 don't seem to necessarily add up. You've got-
12 -in terms of the PR retroconverters, looking
13 at zero ER and -
14 MS. PILGRIM:
15 A. Positive -
16 MS. NEWBURY:
17 Q. - positive PR going to zero, zero, you've got
18 seven that fall into that category. Now,
19 perhaps the answer is that they are all
20 deceased.
21 MS. PILGRIM:
22 A. Yeah, I think unless you knew if you--that's
23 the problem here with even answering these
24 questions, because when we talk about
25 retroconverters, we're talking about, you

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1 know, the ones that have actually been
2 categorized are the living, you know.
3 MS. NEWBURY:
4 Q. Okay.
5 MS. PILGRIM:
6 A. Because they haven't panelled or really
7 discussed the--now, sometimes a deceased have
8 been discussed with families, but we're
9 talking about amongst the living patients that
10 were retested.
11 MS. NEWBURY:
12 Q. Why hasn't an analysis of this been done to
13 date?
14 MS. PILGRIM:
15 A. Because there hasn't been an analysis--there
16 really has not been a completed database to
17 start. We wanted to make sure that it was as
18 complete as it could be.
19 MS. NEWBURY:
20 Q. Um-hm.
21 MS. PILGRIM:
22 A. And we're pretty much there, even though we're
23 still making a few changes to the database.
24 But now you can actually start doing some
25 analysis and feel fairly confident that not

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1 much of this is going to change once you start
2 doing your analysis. So there will be all
3 kinds of tables and percentages and things
4 like that that will come out of this that we
5 haven't seen yet.
6 MS. NEWBURY:
7 Q. And looking at, I guess, a more immediate
8 issue as to how these cases were handled from
9 a treatment perspective, shouldn't an analysis
10 of that aspect of it have been done earlier?
11 MS. PILGRIM:
12 A. Well, they would have been reviewed, the cases
13 would have been reviewed -
14 MS. NEWBURY:
15 Q. How would they have been reviewed?
16 MS. PILGRIM:
17 A. - living patients. Well, if living patients
18 had a change in their results, they would have
19 been reviewed.
20 MS. NEWBURY:
21 Q. Okay. So do I take it from your answer then
22 that if these cases were properly reviewed in
23 terms of making sure that the right treatment
24 was given, then these that I've identified
25 here would likely all be cases of deceased

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1 patients?
2 MS. PILGRIM:
3 A. Um-hm, yeah.
4 MS. NEWBURY:
5 Q. But you don't know?
6 MS. PILGRIM:
7 A. I can't answer that question, no.
8 MS. NEWBURY:
9 Q. And who can answer that question?
10 MS. PILGRIM:
11 A. We could probably answer it for you when we
12 get it analyzed or we could go back and have a
13 look at it and see if we could get you the
14 answer to it. But, you know, like I said, I
15 wouldn't be able to answer that question right
16 now.
17 MS. NEWBURY:
18 Q. Okay, and do you need--I mean, with specific
19 information, not looking at the stats or any
20 sort of epidemiological study from that, would
21 you not have easy access to this just to be
22 able to verify that, yes, this has been
23 reviewed by either the physician review panel
24 or it's been otherwise reviewed by a physician
25 to confirm whether or not these patients are

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1 living or if they are living, that they have
2 been treated or their treatment has been
3 reviewed?
4 MS. PILGRIM:
5 A. Well, what I can tell you is there are four
6 official retroconverters in the database and
7 all of those patients have been reviewed. I
8 know that much.
9 MS. NEWBURY:
10 Q. Okay.
11 MS. PILGRIM:
12 A. But as far as, you know, if the rest are
13 deceased, well, then they haven't been
14 reviewed.
15 MS. NEWBURY:
16 Q. Okay. But in terms of, I guess, the more
17 immediate issue, which is verifying whether or
18 not -
19 MS. PILGRIM:
20 A. The four official -
21 MS. NEWBURY:
22 Q. - these people have had their treatment
23 reviewed -
24 MS. PILGRIM:
25 A. The four official have been reviewed.

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1 MS. NEWBURY:
2 Q. Right.
3 MS. PILGRIM:
4 A. I can tell you that.
5 MS. NEWBURY:
6 Q. Okay. By the panel?
7 MS. PILGRIM:
8 A. Yes.
9 MS. NEWBURY:
10 Q. Okay, and anyone that's not official, if they
11 happen to be living, you don't know that?
12 MS. PILGRIM:
13 A. Well, there's only four official in the
14 database. Because they've been very carefully
15 put in the database and they have been
16 categorized as retroconverters. So, you know,
17 anybody who's in there as a retroconverter,
18 and there are four, they have had their case
19 reviewed, living patients.
20 MS. NEWBURY:
21 Q. Okay, and so the four retroconverters, are
22 they defined to be people who had a positive
23 result, however that was clinically
24 determined, and converted to negative,
25 regardless of whether or not they were

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1 initially treated as clinically positive?
2 MS. PILGRIM:
3 A. Yes.
4 MS. NEWBURY:
5 Q. That's your understanding?
6 MS. PILGRIM:
7 A. That's my understanding.
8 MS. NEWBURY:
9 Q. Okay. Is it possible that anyone who was
10 reviewing the list of retest results to
11 determine which one should be referred to the
12 physician review panel might have incorrectly
13 assumed that an ER negative, PR positive was
14 considered negative and then looking at the
15 Mount Sinai retest results saw zero, zero,
16 negative results and made an assumption that
17 this is a confirmed negative case?
18 MS. PILGRIM:
19 A. But there wouldn't have only been one person
20 who would have reviewed the results of
21 anybody's whose results changed. There wasn't
22 any one person who reviewed that. And even
23 that, there's been so many reviews done on
24 this now with NLCHI and the care that they
25 took with that database, patients there who

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1 had changed results, there should be something
2 there talking about a panel, you know, that
3 these patients were panelled. And many, many
4 times we would get lists from NLCHI as they
5 were doing their review to say these patients
6 had changed results, where's the panel letter,
7 you know, where is the evidence of panelling.
8 MS. NEWBURY:
9 Q. Okay. Would NLCHI have known that a ER
10 negative, PR positive is considered to be a
11 positive result?
12 MS. PILGRIM:
13 A. Yes. The oncologists told us that, they
14 considered them to be positive.
15 MS. NEWBURY:
16 Q. Did NLCHI know that?
17 MS. PILGRIM:
18 A. They knew that as they went through their
19 retesting, yes, it was said to them.
20 MS. NEWBURY:
21 Q. So in addition to the, I guess, the clinical
22 issue as to whether or not any
23 retroconversions who are still living have had
24 their treatment reviewed and addressed and
25 determined to be appropriate or changed, if

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1 necessary, would you agree that there is
2 another issue there in that an analysis of
3 that might have some bearing on the
4 reliability of your positive test results
5 generally?
6 MS. PILGRIM:
7 A. I'm not quite sure what the question is, an
8 analysis of the four retroconverters or are
9 you asking me because we did have people who
10 changed from positive to negative, that that
11 had some impact on our positive patients?
12 MS. NEWBURY:
13 Q. Could it? Has anyone done an analysis?
14 MS. PILGRIM:
15 A. Well, the way that you would have to do that
16 would be you would have to do a review of all
17 your positive patients.
18 MS. NEWBURY:
19 Q. Regardless of whether their--well, just
20 starting at looking at what you actually have
21 already, you've got a number of results in
22 your possession?
23 MS. PILGRIM:
24 A. We do.
25 MS. NEWBURY:

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1 Q. You've indicated that Dr. Denic has only
2 reviewed four that were living,
3 retroconversions?
4 MS. PILGRIM:
5 A. He reviewed four of the, you know -
6 MS. NEWBURY:
7 Q. Of the slides?
8 MS. PILGRIM:
9 A. The bona fide retroconverter group.
10 MS. NEWBURY:
11 Q. Um-hm.
12 MS. PILGRIM:
13 A. That are in the database.
14 MS. NEWBURY:
15 Q. Right.
16 MS. PILGRIM:
17 A. And -
18 MS. NEWBURY:
19 Q. And was he doing that with a view to making
20 sure that any of those people might have been
21 treated properly or just to make sure that -
22 MS. PILGRIM:
23 A. No, I think he was, he was wanting to see were
24 they really retroconverters or were they
25 misinterpretations or what were they.

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1 MS. NEWBURY:
2 Q. But why did he want to do that?
3 MS. PILGRIM:
4 A. I don't know. You'd have -
5 MS. NEWBURY:
6 Q. Was it to make sure that if we take them off
7 Tamoxifen, that we're doing it based on a
8 valid result from Mount Sinai?
9 MS. PILGRIM:
10 A. No, no, no, I don't think so. He didn't do
11 that in consultation with the oncologists.
12 This was just his own, for his--he was looking
13 at them himself. You'd have to ask him why he
14 did it, but I think he was doing it to see if
15 it was a true retroconversion or if there was
16 a mistaken with the original interpretation of
17 the slide.
18 MS. NEWBURY:
19 Q. Okay, and if that was the purpose for looking
20 at those four, I guess the bona fide
21 retroconverters, why not expand that and look
22 at the other retroconverters, the PR
23 retroconverters who may be deceased?
24 MS. PILGRIM:
25 A. I don't know that. He hasn't--we haven't done

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1 any analysis with the deceased. You know,
2 whether they'll want to when they get into
3 their questions or not, I don't know.
4 MS. NEWBURY:
5 Q. Did you have any understanding as to a concern
6 or a possible concern about false positives
7 and what literature might say about that or
8 what sort of the general views are on that as
9 a possibility?
10 MS. PILGRIM:
11 A. Well, the things that, I guess, have guided us
12 through this is that first when we started
13 this, the reason we did this review in the
14 first place was because there was a known
15 false negativity with this test.
16 MS. NEWBURY:
17 Q. Um-hm.
18 MS. PILGRIM:
19 A. And there weren't too many people talking
20 about the known false positivity tests. Now,
21 we also know that any test has variability in
22 it, so there'll be false negatives and false
23 positives and if you reviewed any test, you're
24 going to get those types of results. But that
25 wouldn't be a reason for us to do that. We

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1 have had no concerns expressed at all from
2 physicians that they're concerned about this,
3 that they think this is something that we
4 should be doing. And, you know, based on that
5 we've just--we have not done the review of all
6 the positives, and we have really made a
7 decision that we're not going to do a review
8 of all the positives. We've only recently
9 made a decision that we're going to do
10 something now as far as the weak positives go
11 and you know, and we've been working on that
12 one for quite awhile. But, you know, for the
13 reasons that I just said, and I guess
14 predominantly, like, there are, you know, the
15 oncologists, there's nobody expressing any
16 concern about this particular group of
17 patients because we know that you get
18 variability in any test that you have and
19 that's not normally how--and my understanding,
20 that's not normally how they practice is going
21 back and doing these checks when they know
22 there's variability in a test anyway, you
23 know, any test.
24 MS. NEWBURY:
25 Q. Okay. But presumably in this case when the

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1 decision was made to do retest results, what
2 you were dealing with when the first set of
3 results came back from retesting, you had 16
4 out of 25 that came back with different
5 results?
6 MS. PILGRIM:
7 A. Right.
8 MS. NEWBURY:
9 Q. I mean, it wasn't, that certainly wasn't
10 within the realm of what you thought would be
11 happening based on literature?
12 MS. PILGRIM:
13 A. Well, depending on who you talk to. I think
14 I've already said here that depending on who I
15 talk to within Eastern Health, some people,
16 you know, some of the--like Dr. Patrick
17 Parfrey, some of those people, they weren't
18 all that surprised with the results that we
19 got based on the science of that test. So,
20 you know, and I mean, I'm way out of my league
21 with this now. I didn't know what to expect
22 because I didn't even know what an ER/PR was
23 when we started out here. I can only tell you
24 kind of how we gauged this. And we still to
25 this day are not having any oncologists say to

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1 us that we should retest the positives.
2 MS. NEWBURY:
3 Q. Okay. And do you know if the oncologists have
4 all the data that exist to date about how
5 many--the fact that you've got eight, 18
6 people, according to the NLCHI technical
7 briefing draft?
8 MS. PILGRIM:
9 A. Well, I would say that certain Kara Laing
10 would probably know that, yes, if there--
11 because there were people, they know that
12 there's people who were--who were retested,
13 they know the majority of the people that were
14 retested, their results didn't change, they
15 were positive. And most of them were retested
16 because they asked to be retested. You know,
17 most of the ones that came back positive, came
18 back positive. And then I think we now have
19 on record four living who came back with
20 results changed. And -
21 MS. NEWBURY:
22 Q. Right, but--sorry.
23 MS. PILGRIM:
24 A. And then there are people within the negative
25 group. But I haven't seen anybody actually

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1 categorize which ones of those they would
2 consider to be official retroconverters or
3 not. I can't tell by just that list that you
4 showed me from Mark Quinn.
5 MS. NEWBURY:
6 Q. Now, I showed Dr. Laing those entries, as
7 well.
8 MS. PILGRIM:
9 A. Um-hm.
10 MS. NEWBURY:
11 Q. And she didn't seem to have any sort of
12 particular knowledge about that?
13 MS. PILGRIM:
14 A. No, but she also didn't say to you, because I
15 was here when you questioned her about that,
16 she didn't say, you know, well, a lot of those
17 patients in there are deceased, either. She--
18 you know, but she--for example, she knows
19 there's four retroconverters in there, in the
20 living group, and she knows, because some of
21 her patients are the ones who have been
22 retested, some of the positives, and she knows
23 that the results have come back positive. So,
24 you know, the only thing that I can say to
25 you, Ms. Newbury, is we are guided by,

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1 usually, a request that comes from oncologists
2 or, you know, that they are saying we really
3 should be doing this, we need to be doing
4 this. And again, I would have to go back to
5 even if somebody said, yeah, this is a good
6 thing to do, we would have to go back to the
7 capacity of Eastern Health to do this, as
8 well, and that would have to be a very big
9 factor in this, as well. Because you would
10 have to start off and develop another database
11 and go right from scratch in terms of
12 retesting the positives.
13 MS. NEWBURY:
14 Q. But is it really all or nothing in terms of
15 how to handle the positives, is there
16 something -
17 MS. PILGRIM:
18 A. Well, we're going to do the weak positives.
19 MS. NEWBURY:
20 Q. Yeah.
21 MS. PILGRIM:
22 A. We're going to look at that group, because we
23 have some evidence before us that a lady
24 actually made a decision about treatment
25 because of her level of positivity.

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1 MS. NEWBURY:
2 Q. How about looking at all of the
3 retroconversions, whether they are deceased or
4 not, whether they were treated appropriately
5 or not from the beginning, so that would
6 include the ER negatives, PR positives
7 converting to zero, zero, as well as the--and
8 maybe some of those overlap with the four
9 official retroconverters.
10 MS. PILGRIM:
11 A. Um-hm.
12 MS. NEWBURY:
13 Q. How about analysing each and every one of
14 those to determine what is the source of the
15 problem for those results?
16 MS. PILGRIM:
17 A. Um-hm.
18 MS. NEWBURY:
19 Q. False results, whether it's interpretation or
20 pre-analytical or analytical or whatever, and
21 then make an informed decision about if any
22 additional search should be done?
23 MS. PILGRIM:
24 A. And that may be something that the oncologists
25 or the pathologists will want to do now that

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1 they're getting to the point where they can
2 get some information out of this database.
3 MS. NEWBURY:
4 Q. Okay. And there are a number of other, and I
5 won't bring you to it, but there are a number
6 of other conversions. And perhaps if you were
7 here, that document also identifies the Mark
8 Quinn data conversions from 10, 10 to zero,
9 zero. And there were, I think, four examples
10 of that situation. And depending, I guess, on
11 when the cutoff was, they may have been
12 treated as positive or not.
13 MS. PILGRIM:
14 A. Whether they would be considered or not, yes.
15 MS. NEWBURY:
16 Q. But in any event, from a technical standpoint
17 you still have something that would today be
18 considered a positive result converting to a
19 negative result?
20 MS. PILGRIM:
21 A. And I guess you could keep going with this,
22 because you could say, well, you know, we
23 started out with this and there was a 30 and a
24 ten and now it's all ten and where do you stop
25 with this. You know, it's--and I have to be

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1 certainly guided by the clinicians within
2 Eastern Health as to what concerns they have
3 and what they think we should be doing in
4 terms of to, just to remember that we started
5 out to try to give people an opportunity for
6 hormonal treatment.
7 MS. NEWBURY:
8 Q. Yeah. And what about the possibility that
9 some might be on treatment that shouldn't
10 really be taking hormonal therapy?
11 MS. PILGRIM:
12 A. And you know, again, we have said to patients,
13 if you have any concerns, call us, we will get
14 you retested. We also have, you know, would
15 say to patients that if you have any concerns
16 about any of this, talk to your doctors. And
17 we know that our oncologists are certainly,
18 patients that are under their care, and the
19 majority of these patients are still with our
20 oncologists, I mean, those discussions are
21 being had with those patients.
22 MS. NEWBURY:
23 Q. Okay. But in terms of the, again, you know,
24 the concern that you have with resources and
25 whether you can embark upon a similar

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1 retesting program with all of the positive
2 test results from '97 to 2005, no doubt that
3 would be a very significant task. But when
4 first confronted with the index case, what
5 Eastern Health did, from observation, is they
6 took a targeted approach, first of all
7 selecting types of cancer that might cause
8 concern, then focusing on a year?
9 MS. PILGRIM:
10 A. Right.
11 MS. NEWBURY:
12 Q. And then expanding that search on an, I guess,
13 on an as needed basis?
14 MS. PILGRIM:
15 A. Right.
16 MS. NEWBURY:
17 Q. And expanding the search as they thought,
18 well, we can't limit it to this?
19 MS. PILGRIM:
20 A. Um-hm.
21 MS. NEWBURY:
22 Q. Couldn't a similar approach be taken with the
23 retroconversions that you have now, look at
24 it, see well, perhaps these are all cases
25 where it's a problem with interpretation and

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1 then maybe limit a review of positive cases to
2 interpretation only as opposed to retesting,
3 or perhaps look to see if these are all from
4 one particular hospital or from one particular
5 year?
6 MS. PILGRIM:
7 A. That might be something that some of the
8 doctors would like analyzed, but I would also
9 just like to remind you that when we first
10 started out in 2005, there was another piece
11 of information that we knew about this test,
12 and that it was known to have false positives.
13 You know, that was known in the literature
14 and known through experience. So that was
15 another thing why we took, you know, a
16 particular route was because of the false
17 positivity rate of this test.
18 MS. NEWBURY:
19 Q. Uh-hm.
20 MS. PILGRIM:
21 A. And there was a concern about that right from
22 the beginning. Again we would be very much
23 guided by the clinicians within Eastern Health
24 if they wanted to do any more of these
25 reviews, but I would also have to say that our

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1 capacity to do them would also be a factor
2 that have to be taken into consideration.
3 THE COMMISSIONER:
4 Q. You're saying false positivity or false
5 negativity?
6 MS. PILGRIM:
7 A. I'm saying if anybody wanted to embark upon
8 this now -
9 THE COMMISSIONER:
10 Q. No, you were saying when you started out -
11 MS. PILGRIM:
12 A. Oh, sorry, false negativity, I meant. It was
13 a characteristic--I'm sorry, I said false
14 positivity. I'm getting my negatives and
15 positives mixed up now.
16 MS. NEWBURY:
17 Q. Exhibit P-1402, please. This is an e-mail on
18 page two from Heather Predham to a group, and
19 you're included in the group, and that's
20 involving a patient who was originally ER/PR
21 30 and 40, converting to 0 and 0, and she is
22 among the four here at the--Heather Predham
23 says at the end, "She was one of the four
24 patients that we classified as
25 retroconvertors".

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1 MS. PILGRIM:
2 A. Uh-hm, yes.
3 MS. NEWBURY:
4 Q. And she also states here, "That the original
5 slides were assessed by pathology, and it was
6 found that the original interpretation was
7 accurate".
8 MS. PILGRIM:
9 A. I mean, the only thing--I don't know this
10 particular case, so I can't speak to it.
11 MS. NEWBURY:
12 Q. So you don't know who might have been involved
13 in that?
14 MS. PILGRIM:
15 A. No, I don't know what particular case we're
16 talking about there.
17 MS. NEWBURY:
18 Q. And Dr. Denic had given evidence that he had
19 reviewed the four slides that were considered
20 to be retroconvertors, and I believe it was
21 his evidence that all four would have involved
22 situations of over calling a slide due to
23 background staining, and which I understand to
24 be an issue of Dr. Denic disagreeing with the
25 original interpretation.

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1 MS. PILGRIM:
2 A. See I don't even know if we're talking about
3 the same four here. You're going back to 2006
4 now, and, you know, there's been different
5 numbers of retroconvertors as we went through.
6 I can remember hearing one time that there
7 were seven, but then when they were reviewed,
8 they weren't all retroconvertors. So the
9 thing that we have now is we have four, and I
10 don't know if this one she's talking about is
11 a part of the four that we now know that have
12 been validated as retroconvertors, might not
13 be.
14 MS. NEWBURY:
15 Q. How could they not be validated as
16 retroconvertors?
17 MS. PILGRIM:
18 A. I don't--what I'm saying to you is as we went
19 through this review, we would get tables with
20 patients and they would be called certain
21 things, but then when we, you know, did a
22 review of them, you could end up with "no
23 they're not, the seven of them aren't
24 retroconvertors, somebody made a mistake with
25 this or that, and this is what you have, you

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1 have four", and all I'm saying is I can tell
2 as we sit today, we have four. I don't know
3 if this person is one of those four. I don't
4 know that because they had to be verified as
5 retroconvertors.
6 MS. NEWBURY:
7 Q. And I guess my understanding was that by
8 August of 2006 when you were drafting your e-
9 mail to Heather Predham summarizing the four,
10 and when Heather did her numbers--this is e-
11 mails in between, and Heather Predham did
12 numbers again in November, 2006. Again it
13 seems to refer to four that are
14 retroconvertors?
15 MS. PILGRIM:
16 A. Yes, but now don't go by what I was saying
17 because I was only going back to them, what
18 they were saying in that e-mail. I was just
19 getting it down as I understood it. It's not
20 that I was the source of that information.
21 MS. NEWBURY:
22 Q. Okay, so Ms. Predham is the one who will
23 answer that?
24 MS. PILGRIM:
25 A. She's the one who could answer this for you,

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1 yes.
2 MS. NEWBURY:
3 Q. And there's no official repot or summary of
4 analysis, even like a small analysis of the
5 retroconvertors that can summarize what's been
6 done?
7 MS. PILGRIM:
8 A. There's no analysis of that database done yet.
9 There's just a list of numbers -
10 MS. NEWBURY:
11 Q. Even a small portion?
12 MS. PILGRIM:
13 A. No. Now there might be if one of the
14 oncologists or pathologists has asked for
15 something in the past week or so that Wayne
16 was able to give them.
17 MS. NEWBURY:
18 Q. Okay.
19 MS. PILGRIM:
20 A. But we're just starting the analysis now.
21 MS. NEWBURY:
22 Q. In this continuation of this e-mail from Ms.
23 Predham to the group, the second last
24 paragraph, and you were shown this reference
25 yesterday, Ms. Predham states, "I can only

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1 assume that Mr. Crosbie will now have another
2 story. I anticipate that he will call for a
3 total retest of all ER/PR results. We did
4 discuss that at the panel level, but there is
5 a documented false positive rate with this
6 test, and 5 out of 962 falls well within that
7 range. Of course, we can revisit this
8 decision". Do you know where Ms. Predham
9 obtained the figures, 5 out of 962?
10 MS. PILGRIM:
11 A. I do not.
12 MS. NEWBURY:
13 Q. Was there any discussion of this among any
14 members of that group, the recipients of this
15 e-mail?
16 MS. PILGRIM:
17 A. There probably was. I can't remember if there
18 was or not. Somebody probably asked her where
19 she got that number.
20 MS. NEWBURY:
21 Q. Probably, but you don't have any knowledge of
22 that?
23 MS. PILGRIM:
24 A. I have no recollection of me having a
25 conversation with her about that, no, I don't.

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1 MS. NEWBURY:
2 Q. When assessing the false positive rate to
3 compare it to what is being stated as
4 appropriate in the literature, as an example,
5 would you look at the number of positive
6 results that are converting to negative and
7 divide that by or see what percentage that is
8 of all the positive results that were
9 retested? I'm just looking at what fraction
10 would you look at, what numerator or what
11 denominator would you use?
12 MS. PILGRIM:
13 A. I have no idea. I don't know where she got
14 that number. Obviously, it came out of the
15 literature somewhere that somebody said in a
16 batch of, you'd get 5 out of 962 that would be
17 false positive.
18 MS. NEWBURY:
19 Q. I think she's referring to--that 5 out of 962,
20 I'm assuming that's data from Eastern Health?
21 MS. PILGRIM:
22 A. Yes, but she's applying a percentage from
23 somewhere to that.
24 MS. NEWBURY:
25 Q. Right, and she doesn't state what that is.

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1 MS. PILGRIM:
2 A. To come up with that number, but she didn't
3 say what it was.
4 MS. NEWBURY:
5 Q. But do you agree that whatever the sources of
6 the information, do you think the methodology,
7 if she's taking 962 cases, which is about the
8 total number of cases retested -
9 MS. PILGRIM:
10 A. Yeah.
11 MS. NEWBURY:
12 Q. And if 5--if you look at the four living, plus
13 one retroconvertor that was deceased, if
14 that's where the five is coming from, would
15 you take five and divide that into 962 to find
16 out what the false positive rate is?
17 MS. PILGRIM:
18 A. No, I mean, that's applying your statistical
19 analysis very loosely there with that. I
20 don't--I would have to know the source, and
21 what kind of numbers you'd have to be using to
22 come up with how many you would expect out of
23 that number. I can't--you know, I can't
24 answer that question. I didn't do that. She
25 came up with that somewhere.

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1 MS. NEWBURY:
2 Q. But you received it and this didn't alarm you
3 or cause you to inquire about it?
4 MS. PILGRIM:
5 A. No, I wouldn't have been alarmed at that point
6 about that. Again, I guess, I have to go back
7 to if we did any test and retested patients,
8 we would find changed results because none of
9 them are 100 percent. We know this particular
10 one was characterized by a false negative
11 rate; others ones are characterized by
12 something else, but they're not 100 percent,
13 so you would get changed results. We know
14 that.
15 MS. NEWBURY:
16 Q. And do you know what the literature says for
17 the expectation for false positives?
18 MS. PILGRIM:
19 A. For false positive, no, other than what we
20 would have heard here. I heard Dr. Dabbs the
21 other day talking about it. I have to confess
22 that I don't understand a lot of what he was
23 saying, it was beyond me, in terms of biotins
24 and whatever he was saying.
25 MS. NEWBURY:

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1 Q. Sure.
2 MS. PILGRIM:
3 A. And--no, you know, I don't know. I know that
4 the biggest thing with this test is false
5 negative. With any test you're going to get
6 false positives and false negatives. So I
7 don't know if this is any worse from the false
8 positive point of view than any other test. I
9 don't know that.
10 MS. NEWBURY:
11 Q. Okay.
12 MS. PILGRIM:
13 A. I can't answer that.
14 MS. NEWBURY:
15 Q. And if you--you're the Chief Operating
16 Officer?
17 MS. PILGRIM:
18 A. I am.
19 MS. NEWBURY:
20 Q. And presumably involved in decision making?
21 MS. PILGRIM:
22 A. I am.
23 MS. NEWBURY:
24 Q. In terms of positivity -
25 MS. PILGRIM:

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1 A. Uh-hm.
2 MS. NEWBURY:
3 Q. The fact that you have, based on, I guess, the
4 rough data from NLCHI from February of 2008, 6
5 out of 18 that appear to be converting, does
6 that figure alarm you? Do you know whether or
7 not that's consistent with the literature?
8 MS. PILGRIM:
9 A. Or 4 out of 16?
10 MS. NEWBURY:
11 Q. Or 4 out of 16.
12 MS. PILGRIM:
13 A. Uh-hm, again I would have to say to you that I
14 would be guided by the people who care for
15 patients and know about these results. So I
16 might have a discussion and say, you know,
17 what does that mean now, we've retested this
18 many people and we've got four of them that
19 have changed. I really matters not to me, I
20 guess, the fact that Nash has looked at them
21 and said they were a misinterpretation because
22 then that leads you to another question; well,
23 how many more misinterpretations do you have
24 in there.
25 MS. NEWBURY:

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1 Q. Sure.
2 MS. PILGRIM:
3 A. And, you know, I would have to be guided by--
4 if people who are looking after patients are
5 concerned about this, they're going to have to
6 express their concern and put forward a
7 proposal if that's what they want if they want
8 something more done, and Eastern Health will
9 have to make a decision. We know that we
10 would not have the capacity to engage in a
11 huge review, and it would certainly have to be
12 done outside of Eastern Health, and it would
13 take a long time because it would probably
14 become a research project, and then one would
15 have to ask, well, are you doing this now for
16 research or are you doing it to help patients,
17 you know, and we have to plead with patients
18 that if you have concerns, please go and talk
19 to your doctors about--you know, if you're a
20 positive patient, any concerns, call us, we'll
21 retest you, or go talk to your doctors about
22 this.
23 MS. NEWBURY:
24 Q. Ms. Pilgrim, what can you advise with regard
25 to the Cancer Registry and any deficiencies

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1 that you're aware of that have existed in the
2 Cancer Registry prior to and including 2005,
3 and what has been done since then?
4 MS. PILGRIM:
5 A. Well, I know that there are deficiencies in
6 the Cancer Registry.
7 MS. NEWBURY:
8 Q. And can you explain what those are?
9 MS. PILGRIM:
10 A. Well, in terms of our ability to get some
11 information, we weren't doing death clearance
12 with our registry. Our registry is not as, I
13 guess, comprehensive as many in terms of some
14 of the things that we capture there, and we
15 know that in other provinces, their registries
16 -- because, you know, these registries really
17 start off as administrative registries that
18 capture certain data which is required, and
19 this is reported off to national entities or
20 whatever on a regular basis, but a lot of
21 people then take that and they further develop
22 it and expand it so it really becomes a cancer
23 database, and that is certainly where we would
24 like to see ourselves going, that we would be
25 developing a comprehensive cancer database,

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1 and I know that a part of the discussion that
2 was held this week as far as looking at what
3 we might do with the weak positives would be--
4 there would be a requirement, if we're going
5 to start doing that, that now we really start
6 to look at--if we're going to do this
7 exercise, we are going to start now to develop
8 and enhance the cancer database in this
9 province. So what we have done--like, we
10 know, for example, that we do not have an
11 epidemiologist associated with our cancer
12 registry. You know, that's kind of a given in
13 most areas that you would have
14 epidemiological support if you're going to be
15 really using your database to enhance your
16 knowledge of what's going on in your province,
17 and what we've done is we've been able to
18 enlist the support of the epidemiologist in
19 Nova Scotia because they do have them attached
20 to their database, and we will be putting that
21 into our budget submission for the upcoming
22 year. Now again that will have to be
23 prioritized with everything else. That doesn't
24 mean we're going to get that this year, but we
25 do know we've got--Sharon Smith is very linked

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1 now with an Atlantic group, and we know that
2 the Cancer Centre, the NCTRF, prior to Eastern
3 Health, they did have a lot of work that they
4 did with the database. They were getting it
5 off the ground, but they were having
6 difficulty getting resources to make that
7 database into what it needed to be. So, you
8 know, I could say to you that within the
9 cancer care program, there would definitely be
10 a plan to enhance what we now have and to
11 continue to improve that.
12 MS. NEWBURY:
13 Q. You indicated that it wasn't as comprehensive
14 as in some other places. Are you referring to
15 the types of data that is provided to the
16 Cancer Registry or to the completeness of it?
17 MS. PILGRIM:
18 A. The completeness of it. We know that in some
19 provinces, for example, if you wanted to look
20 at the weak positives and you said, well, we
21 won't define them, but how we'll find them is
22 we'll go in and do a list of every patient
23 that's not on Tamoxifen. In some provinces
24 have very comprehensive databases. I'm going
25 to go out on a limb now and say maybe BC, but

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1 they might be able to go and get a report of
2 that fairly quickly, or in Ontario in some of
3 the cancer centres. We don't have that in our
4 database. We don't have the capacity to do
5 that. So that's what I mean, we will enrich
6 the database by putting more and more
7 information in there.
8 MS. NEWBURY:
9 Q. Okay, and there's two issues there. Number
10 one, is having, I guess, a computer system or
11 technology in place?
12 MS. PILGRIM:
13 A. Yes.
14 MS. NEWBURY:
15 Q. So that you have somewhere to put the
16 information.
17 MS. PILGRIM:
18 A. Right.
19 MS. NEWBURY:
20 Q. And the second aspect of it is making sure
21 that all of the information is gathered so
22 that if you have a report for a particular
23 patient that all of the different fields of
24 information would be inserted in that?
25 MS. PILGRIM:

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1 A. That's right.
2 MS. NEWBURY:
3 Q. There's a third issue -
4 MS. PILGRIM:
5 A. And we really need epidemiological support. I
6 mean, that's a big gap with the database.
7 MS. NEWBURY:
8 Q. And would you agree there's a third issue in
9 making sure that all tumours that are
10 diagnosed in the province are actually
11 referred or provided to the Cancer Registry?
12 MS. PILGRIM:
13 A. Yes, and we have an e-path system in this
14 province which some provinces don't have. So
15 we do have the ability to, you know,
16 electronically get this information into our
17 registry, which makes us ahead of many other
18 provinces actually, but we have one region
19 that doesn't--and that is something that we
20 have plans to go through the Department of
21 Health and Community Services and try to
22 address the issues of that particular region.
23 The issues around confidentiality, I think, is
24 what the issue is, so they don't report.
25 MS. NEWBURY:

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1 Q. Which region is that?
2 MS. PILGRIM:
3 A. It's Labrador.
4 MS. NEWBURY:
5 Q. Is that the issue that Dr. Dankwa raised?
6 MS. PILGRIM:
7 A. Dankwa talked about, yes.
8 MS. NEWBURY:
9 Q. The absence of legislation.
10 MS. PILGRIM:
11 A. Yes, and I think, you know, that's going to
12 have to be something that the provincial
13 government does.
14 MS. NEWBURY:
15 Q. Obviously, Eastern Health can't do that.
16 MS. PILGRIM:
17 A. No.
18 MS. NEWBURY:
19 Q. But Eastern Health has made a request to try
20 and address that?
21 MS. PILGRIM:
22 A. I don't know--my understanding is that had
23 gone to the government level before, I think,
24 when Bertha Paulse was there maybe. I don't
25 know, I'm kind of surmising. I shouldn't be

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1 saying that now.
2 MS. NEWBURY:
3 Q. Okay.
4 MS. PILGRIM:
5 A. But that certainly would be a part of our plan
6 now as we move into the fall.
7 MS. NEWBURY:
8 Q. And in terms of--I think Dr. Laing was talking
9 about trying to develop, and she did refer to
10 BC as well, a more comprehensive breast cancer
11 dataset, and I don't know if she was able to
12 clarify for us as to how that would work, the
13 details, or the mechanics, how integrated that
14 might be with the actual main Cancer Registry
15 there. Are you able to shed any light on that?
16 MS. PILGRIM:
17 A. Well there's different ways, I think, you can
18 do it. You can set it up as a separate
19 database that's linked with your registry, or
20 you can set it up--I don't know. Now that I
21 don't know. You'd have to be asking Sharon
22 Smith or somebody that because I'm not into
23 that level of deal with it.
24 MS. NEWBURY:
25 Q. Ms. Pilgrim, one final question. Regarding

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1 the deceased patients and communication with
2 the families, would there be anything wrong
3 with writing the next of kin to advise them
4 that retest results were available, wrong, or
5 inappropriate, or undesirable, I guess? Not
6 to impose the information on them. I
7 understand that there is a concern about that,
8 and there was an ethics consultation about
9 that, but to ensure that all families are
10 actually specifically alerted to the
11 possibility that they can avail of retest
12 results, if they so choose, would there be
13 anything wrong with writing to the next of kin
14 to advise them that results are available?
15 MS. PILGRIM:
16 A. There would be nothing wrong with it, but we
17 chose not to do it because we felt that it
18 would be--the decision that we made,
19 rightfully or wrongfully, was that we did not
20 want to impose even the fact that we had
21 retested, that this is available, we'll send--
22 oh, I see what you mean, to send it out to the
23 families and say we have done the retesting
24 rather than the way we did it.
25 MS. NEWBURY:

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1 Q. The same information that you would put in
2 your press release, put it in a letter and
3 direct it to the next of kin, just so they
4 know, and it would be no more imposing, I
5 would suggest, upon them, the information that
6 they may not want, than if they heard it on
7 the radio?
8 MS. PILGRIM:
9 A. It probably would be nothing wrong with it,
10 but when we looked at what we did, we felt
11 that we did due diligence with what we did in
12 terms of trying to get the message out with
13 our public service announcements and our
14 newspaper ads, and, you know, we did meet and
15 talk about that to see how many responses we
16 had--how many requests we had actually gotten,
17 and for the present, we just feel that we have
18 done due diligence with that.
19 MS. NEWBURY:
20 Q. But based on your experience with all of the
21 difficulties in trying to reach the patients
22 who were living and had changes in the retest
23 results, did you feel comfortable that press
24 releases would help to identify all of those?
25 MS. PILGRIM:

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1 A. I think that, with all of the--you know,
2 there's certainly been a lot of media coverage
3 and this is a very public issue which is going
4 on here, so again when we looked and when we
5 reviewed, and we did stop and ponder this, we
6 felt that what we had done was sufficient for
7 the present time. We were happy with that.
8 We felt we had done due diligence there.
9 MS. NEWBURY:
10 Q. But to this very day, there's still a lack of
11 comfort among--certainly Robert Thompson seems
12 to be pressing to look more into whether or
13 not you've completed--you've actually
14 identified all of the people who might have a
15 change in test?
16 MS. PILGRIM:
17 A. He's not talking about notifying the deceased.
18 MS. NEWBURY:
19 Q. No, I'm just saying -
20 MS. PILGRIM:
21 A. He was part of that decision.
22 MS. NEWBURY:
23 Q. Right, I realize that, but just extrapolating
24 from your experience as an organization in
25 trying to identify whether it's through the

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1 self-identification process or looking through
2 databases to make sure that you communicate
3 with any families of a deceased patient who
4 could be affected and might want results, how
5 reliable would the press release process be?
6 MS. PILGRIM:
7 A. You know, it's like I just said, it hasn't
8 been just a press release. There have been
9 public service announcements, there has been
10 much, much exposure of this ER/PR--I mean, you
11 know, a lot of people have heard about this,
12 and again we have made a decision that we have
13 done due diligence with this.
14 MS. NEWBURY:
15 Q. Thank you, Ms. Pilgrim, those are all the
16 questions I have.
17 MS. PILGRIM:
18 A. You're welcome.
19 THE COMMISSIONER:
20 Q. Ms. Brocklehurst.
21 MS. PATRICIA PILGRIM - EXAMINATION BY MS. LAURA
22 BROCKLEHURST
23 MS. BROCKLEHURST:
24 Q. Thank you, Commissioner. Good afternoon, Ms.
25 Pilgrim.

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1 MS. PILGRIM:
2 A. Good afternoon.
3 MS. BROCKLEHURST:
4 Q. Ms. Laura Brocklehurst, I'm here on behalf of
5 the class members.
6 MS. PILGRIM:
7 A. Yes.
8 MS. BROCKLEHURST:
9 Q. I just have a couple of quick questions. I
10 know it's been a long day and it's very warm
11 now. First I'd like to talk to you about the
12 number of patients that were harmed. You
13 mentioned probably two days ago now when Mr.
14 Coffey asked you if the Board of Trustees
15 every inquired into how many patients were
16 harmed by the ER/PR matter, you said that the
17 Board had been given numbers. What I'm
18 wondering is were there any documents drafted
19 expressly for the Board with respect to the
20 numbers of patients affected by this issue?
21 MS. PILGRIM:
22 A. No, there were just briefing notes and
23 presentations for the Board.
24 MS. BROCKLEHURST:
25 Q. Okay.

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1 MS. PILGRIM:
2 A. I can just remember at one of the
3 presentations, my memory is that there were
4 numbers shared with the Board, and I think
5 you've got copies of any briefing notes that
6 went to them.
7 MS. BROCKLEHURST:
8 Q. Okay, so anything that was given to the Board
9 is before the Commission?
10 MS. PILGRIM:
11 A. I think you do, yes.
12 MS. BROCKLEHURST:
13 Q. You said you think. Is there any way to
14 verify that aspect?
15 MS. PILGRIM:
16 A. Well, anything that we had, I would hope has
17 come to the Commission. Any briefing notes,
18 anything that you asked for and we gave it to
19 you. So what I was saying--I can't remember
20 what I said a couple of days ago now, but my
21 memory about the Board is that there were
22 numbers shared with them at one presentation
23 that I saw Dr. Williams doing, you know,
24 numbers in terms of how many people were
25 retested and what the changes were.

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1 MS. BROCKLEHURST:
2 Q. Okay, and to your knowledge, that's before the
3 Commission?
4 MS. PILGRIM:
5 A. Yes.
6 MS. BROCKLEHURST:
7 Q. You also said that when this Commission was
8 established back in 2007, that Mr. Tilley
9 asked you to take the lead preparing Eastern
10 Health for the Commission. Is there anything
11 else on the topic of the number of patients
12 affected that is not before the Commission now
13 simply because it's just more recent? Is
14 there anything that came up last week in a
15 meeting, yesterday that you missed, anything
16 else that you know of that might not be before
17 the Commission?
18 MS. PILGRIM:
19 A. The only thing that probably wouldn't be
20 before the Commission now, which we're just
21 completing is the review that we did--we did a
22 review of patients that were supposed to be
23 contacted by their physician, were they? And
24 we found out that they were not, some of them
25 and the other thing--so you know, that will be

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1 kind of summarized as a report, that review
2 that we did. And the other thing would be the
3 DCIS patients, so we did two quality reviews
4 that we have completed, but we haven't
5 summarized. But as we went through those
6 quality reviews, we did find that there were
7 patients who--the process that was supposed to
8 have happened within the boards had not
9 happened in some instances.
10 MS. BROCKLEHURST:
11 Q. All right, can I ask you to get those reviews
12 to the Commission, maybe through Mr. Simmons
13 when they are formalized?
14 MS. PILGRIM:
15 A. Sure, we can do that.
16 MS. BROCKLEHURST:
17 Q. Perfect. So do you know what the Board is
18 being told now about the numbers of patients
19 affected overall? Do you have any idea what
20 numbers would be floating around before the
21 Board or any of its committees?
22 MS. PILGRIM:
23 A. I know the Board is being given updates now
24 about the Commission. Like they had kind of--
25 when the NLCHI did their, well Robert

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1 Thompson, I mean, NLCHI did the database for
2 Robert Thompson and then there was a press
3 release about--which really brought numbers,
4 that's when, you know, you heard things like
5 Eastern Health said there were 939 patients
6 and it ended up to be 1013 and then last week
7 there were ten more, so now it's 1023. They
8 probably don't have that latest information,
9 but they have been given updates as we go
10 through and would have certainly heard
11 information when Robert came out last March
12 with the numbers. But remember, there's no
13 analysis of these numbers.
14 MS. BROCKLEHURST:
15 Q. Right.
16 MS. PILGRIM:
17 A. Because NLCHI did no analysis as well, it's
18 just numbers.
19 MS. BROCKLEHURST:
20 Q. Okay, fair enough. The other thing I wanted
21 to ask you about this afternoon, from your
22 knowledge, as a quality and risk management
23 person, is there any generally accepted
24 percentage or maybe range of percentages for a
25 budget that should be spent on quality

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1 analysis in order to ensure that there is an
2 adequate level of quality control in either in
3 Eastern Health as a whole or in any of its
4 divisions, specifically here the lab?
5 MS. PILGRIM:
6 A. To my knowledge there isn't and if you
7 travelled around the country, you would be
8 blown away what you would see in Calgary, for
9 example. It's hard to put a dollar figure on
10 it because you cannot consider--the resources
11 that you have in your quality department are
12 not the only resources that you have which
13 have a quality focus. You know, for example,
14 if you said, well how much money does Eastern
15 Health spend on quality and you just went and
16 got the budget that Pam Elliott has in her
17 department, that would be an underestimation
18 of that. We consider that, for example, our
19 whole infectious control and management
20 service to be a quality--they have a quality
21 function, so you would have to add them in.
22 We have many project people, you know,
23 specialists of all types who have quality foci
24 (phonetic) as well to their jobs. So no, to
25 answer your question, which I should do and

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1 not ramble on, is that no, you wouldn't come
2 up with a particular percentage of your
3 budget. But you can get figures maybe that
4 could compare, you know, you can sometimes get
5 figures, for example, of how much of your
6 budget goes to this as compared to other
7 hospitals across the country. But you never
8 know if you're comparing apples with apples.
9 They're not really that meaningful to you
10 because you don't know what's included in
11 them.
12 MS. BROCKLEHURST:
13 Q. Okay, but any comparisons that there are--do
14 you know how Eastern Health compares to any
15 other health boards, whether in this province
16 or outside?
17 MS. PILGRIM:
18 A. Well I know how we compare with Calgary, but
19 you know we've stopped trying to compare
20 ourselves with them.
21 MS. BROCKLEHURST:
22 Q. And how is that?
23 MS. PILGRIM:
24 A. Again, you don't know, you see, because
25 Calgary might have put all their eggs in their

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1 quality department; whereas we have resources
2 spread out, for example, if you heard Dr.
3 Oscar Howell, he now has two, really two
4 quality people in the lab and if we were to
5 give you an estimate of how much money we
6 spend and we only went with our quality
7 department, they wouldn't be in there. So
8 you'd have to really be comparing apples with
9 apples. We know that we need more people in
10 quality and we--Ms. Jones really approved
11 three more positions this year, but they're
12 going to be, you know, doing some very diverse
13 jobs for us. So it's really hard to--there's
14 no, like, cook book or recipe that you can
15 get. You just have to know your organization
16 and the context in which you work and be able
17 to identify the gaps that you feel you have.
18 MS. BROCKLEHURST:
19 Q. Okay, so there's no one standard that, you
20 know, Eastern Health can say we should be
21 spending "X" percentage on quality assurance -
22 MS. PILGRIM:
23 A. No.
24 MS. BROCKLEHURST:
25 Q. And we're here.

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1 MS. PILGRIM:
2 A. No.
3 MS. BROCKLEHURST:
4 Q. Okay, those are all my questions. Thank you,
5 Commissioner.
6 THE COMMISSIONER:
7 Q. Thank you. Mr. Pike?
8 MR. PIKE:
9 Q. No questions, thank you.
10 THE COMMISSIONER:
11 Q. Mr. Simmons?
12 MS. PATRICIA PILGRIM, EXAMINATION BY MR. DAN SIMMONS
13 MR. SIMMONS:
14 Q. Good afternoon, Ms. Pilgrim.
15 MS. PILGRIM:
16 A. You have five minutes, Mr. Simmons.
17 MR. SIMMONS:
18 Q. I know that, so I'm going to be as quick as I
19 can and there's only a very few things,
20 there's a couple of factual things I wanted to
21 clarify with you and a couple of other topics
22 that I wanted to give you an opportunity just
23 to say a little bit more on.
24 MS. PILGRIM:
25 A. Okay.

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1 MR. SIMMONS:
2 Q. And the first of those is that you've told us
3 before about your involvement in the creation
4 of the Health Care Corporation of St. John's
5 and the transition from four separate acute
6 care hospitals in St. John's into Health Care
7 Corporation and that we know that you're also
8 involved in, in the transition from there into
9 Eastern Health, which was an even broader
10 organization. Can you maybe tell me a little
11 bit more about what you know about how long
12 the planning process was for the transition
13 into the Health Care Corporation and whether
14 people were put in positions where they were
15 dedicated to that without other
16 responsibilities, and then maybe compare that
17 to the process for the transition into Eastern
18 Health?
19 MS. PILGRIM:
20 A. Well in my humble opinion there was no
21 transition into Eastern Health, it's just one
22 day it wasn't there and the next day it was
23 there and, you know, Mr. Tilley started off
24 and then he put in a senior team and away we
25 go with this big organization. And I think

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1 that that was certainly a poor way to bring
2 that--in my opinion, that type of an
3 organization into being. When we had the--it
4 was a bit different with the Health Care Corp.
5 because that was merging hospitals with the
6 plan to close some of those major hospitals,
7 but there was a team that was put in place who
8 really had the responsibility to do all the
9 planning for them and that's all they had to
10 do. The original plan would be that there
11 would be a three-year period that they were
12 doing that, if I remember correctly. I took
13 it about seven years, actually, I mean, they
14 were there for a very long time behind the
15 scenes still making these things happen.
16 MR. SIMMONS:
17 Q. How long was the preparation process before
18 Health Care Corporation was actually created?
19 How long before that did people begin
20 preparing for it?
21 MS. PILGRIM:
22 A. Sister Elizabeth and the corporate team, if I
23 remember, they were in place for a much longer
24 period of time, able to be meeting and
25 planning and because they went out and did all

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1 the consultation about the type of clinical
2 structure we were going to put in place. So
3 there was, you know, more planning time put
4 into the Health Care Corporation and more time
5 set aside for that then there was with Eastern
6 Health.
7 MR. SIMMONS:
8 Q. Now the two amalgamations were different
9 things -
10 MS. PILGRIM:
11 A. They were.
12 MR. SIMMONS:
13 Q. - because in the Health Care Corporation case
14 you were bringing together institutions that
15 perform similar functions, largely.
16 MS. PILGRIM:
17 A. Right.
18 MR. SIMMONS:
19 Q. And in the Eastern Health case it was bringing
20 together a broader range of services that
21 hadn't fit together before. Can you give me
22 any idea of whether the magnitude of the task
23 of accomplishing those amalgamations was
24 really any different or if one was a larger
25 task to take on than the other?

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1 MS. PILGRIM:
2 A. Well, I mean, we thought the Health Care Corp
3 was pretty big, but Eastern Health was much
4 bigger and like you say, you had a rural urban
5 mix that you had to deal with, you had--the
6 whole issue of integrating now across the
7 region and so you're integrating services,
8 starting with administrative services which
9 tend to be the easier ones to do, like your
10 financial systems and things like that from
11 Port Blandford right into St. John's and on
12 top of that, you had what we call the
13 continuum of care. So everything that could
14 possibly relate to Health and Community
15 Services was now a part of this organization,
16 as well as services that the government
17 devolved into the region that would
18 traditionally have been managed through the
19 Department of Health centrally. They were all
20 devolved out into the regions, so it was a
21 humungous task.
22 MR. SIMMONS:
23 Q. You've told us a couple a days ago now a
24 little bit about the Hay review of the Health
25 Care Corporation and the role that you then

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1 took on as the clinical efficiency person and
2 can you tell me, if you can, what effect that
3 time period in those events had on the, on the
4 priority objectives for the Health Care
5 Corporation in the years following the Hay
6 report and whether that changed over time?
7 MS. PILGRIM:
8 A. Well certainly post Hay, we like to call it,
9 that became a very time of great constraint.
10 The Hay Group came in and purely did a
11 financial review and, you know, their
12 objective was to find ways that we could save
13 money and they found them and they reported
14 them. And we had to agree or disagree. Some
15 of the things we found we agreed with, some we
16 disagreed with and then we had to very quickly
17 put a plan in place to implement and come up
18 with the savings.
19 MR. SIMMONS:
20 Q. Uh-hm.
21 MS. PILGRIM:
22 A. So it was a time of very much more focus on
23 efficiency effectiveness and not as much focus
24 in my mind on quality and the other, you know,
25 quality of work life and things like that. It

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1 was very focused to save this money and try to
2 get these numbers that we're showing you,
3 which should be your benchmark.
4 MR. SIMMONS:
5 Q. Right. Did the focus begin to change back
6 more to quality initiatives at any point?
7 MS. PILGRIM:
8 A. Oh yes, I think -
9 MR. SIMMONS:
10 Q. And by when?
11 MS. PILGRIM:
12 A. There was a point at which we were starting to
13 feel fairly good about the Health Care
14 Corporation. It was probably in, as we went
15 into 2004, 2005 we felt we'd weathered most of
16 the storms that we had, we felt that we were
17 beginning to have a culture, an identity as
18 the Health Care Corp. and we were starting to
19 do things which we were proud of, we were
20 starting to make a name on the national scene
21 with things that we were doing. So the focus
22 did shift, but we had a period which we all
23 called post Hay which was no fun. It was very
24 constraint oriented.
25 MR. SIMMONS:

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1 Q. Okay. A couple of specific things now I want
2 to ask you about. Can I have Exhibit P-0486,
3 page 39 please? This is a set of executive
4 minutes from September 28th, 2005, which would
5 have been four days before the story in the
6 Independent newspaper which was the first
7 public information about the retesting of the
8 ER/PR results. And you were asked about this
9 last line at the bottom here, which said "We
10 are positioned to move with a communication's
11 strategy when required." And when you were
12 questioned about that before, I wasn't clear
13 what you understood that communication
14 strategy to be? And what was that
15 communication strategy meant to address?
16 MS. PILGRIM:
17 A. Well when the story broke, obviously we had to
18 quickly respond in the public.
19 MR. SIMMONS:
20 Q. Uh-hm.
21 MS. PILGRIM:
22 A. Up to that point we had a communication
23 strategy and a plan to notify patients, you
24 know, it was going to be a letter or whatever,
25 but the communication strategy we had wasn't,

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1 oh, we're going to have this just in case this
2 breaks in the media. That wasn't the aim of
3 that communication strategy.
4 MR. SIMMONS:
5 Q. So this wasn't a communication strategy, that
6 was a contingency plan in case it became
7 public?
8 MS. PILGRIM:
9 A. No, no. It was a part of--the bigger strategy
10 of we're going to talk to the patients and
11 we're going to communicate to the public.
12 THE COMMISSIONER:
13 Q. So that was the plan if nobody found out?
14 MS. PILGRIM:
15 A. That's right, you know, it wasn't--we weren't
16 sitting there with the plan, now we had better
17 have this just in case the media gets this.
18 THE COMMISSIONER:
19 Q. Sorry, but now that Ms. Pilgrim has raised
20 this, was there a plan--was there anything
21 going on to plan for getting in touch with--
22 preparation for getting in touch with
23 patients? Were you doing a strategy for when
24 all these things get bad, were you already
25 starting to pull together the names and the

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1 contact numbers and all that kind of stuff.
2 MS. PILGRIM:
3 A. Oh yeah, there were lists being prepared and
4 addresses and--because remember at one point
5 we were going to send a letter.
6 THE COMMISSIONER:
7 Q. Uh-hm.
8 MS. PILGRIM:
9 A. So we were getting prepared to send that.
10 THE COMMISSIONER:
11 Q. You did have that list, did you?
12 MS. PILGRIM:
13 A. We did, yes.
14 MR. SIMMONS:
15 Q. P-1496 please? And I'm going to scroll down
16 on this one. You were taken through a whole
17 series of e-mails, beginning with the
18 Independent story on the 2nd of October, up to
19 this point on the 18th of October, 2005 and
20 this, in this particular e-mail there's
21 discussion of the letter and this is some
22 views expressed from Mr. Boone directed
23 towards Ms. Predham. And you were asked
24 questions concerning whether that had any
25 impact on the decision that was made to

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1 contact patients by telephone, rather than by
2 letter. And what I wanted to do was refer you
3 to P-1183 please? And these are some notes
4 from a--I'll try P-0925 I think is the typed
5 written version. These are some notes of the
6 meeting that you attended, according to Dr.
7 Williams' notes on October 18th, 2006. And
8 present were Dr. Laing, George Tilley, Heather
9 Predham, Susan Bonnell, Dr. Cook, Dr. Williams
10 and yourself. And if you note on the
11 decisions there, item three is "Phone patients
12 who have been retested and are not
13 converters."
14 MS. PILGRIM:
15 A. Uh-hm.
16 MR. SIMMONS:
17 Q. And my question is at the time that you
18 attended this meeting and this decision was
19 made, was the views expressed by Mr. Boone in
20 that e-mail known to the group or were those
21 circulated afterwards?
22 MS. PILGRIM:
23 A. Yes.
24 MR. SIMMONS:
25 Q. Okay, did those views play any part at all in

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1 the decision that was made here to your
2 knowledge?
3 MS. PILGRIM:
4 A. In my opinion they did not.
5 THE COMMISSIONER:
6 Q. To call all patients who had not converted, is
7 this--that's the phrase you're talking about
8 Mr. Simmons, is it?
9 MR. SIMMONS:
10 Q. Phone patients who have been retested and
11 they're not converters, that's number three.
12 And above that, two, it says "Phone patients
13 who are retested."
14 MS. PILGRIM:
15 A. And, you know, this is--I don't think this is
16 the meeting, but you know, I can very clearly
17 remember Dr. Williams making that decision at
18 some point.
19 MR. SIMMONS:
20 Q. Okay, and the other thing I was going to ask
21 you concerning that is you did say at times
22 there was advice received from Mr. Boone that
23 at times in other circumstances was followed
24 and at times it wasn't, it wasn't followed.
25 MS. PILGRIM:

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1 A. That's correct.
2 MR. SIMMONS:
3 Q. Can you recall there ever being any suggestion
4 that there were any consequences for the
5 organization in not following his advice?
6 MS. PILGRIM:
7 A. No.
8 MR. SIMMONS:
9 Q. Can you recall there ever being any
10 consequences of not following advice that came
11 from either legal counsel or from the insurer?
12 MS. PILGRIM:
13 A. No.
14 MR. SIMMONS:
15 Q. And there were times you can recall when that
16 advice was ignored and not followed?
17 MS. PILGRIM:
18 A. Oh yes, many times.
19 MR. SIMMONS:
20 Q. I'm going to leave it at that and I understand
21 that you do have a few things that you wanted
22 to say.
23 MS. PILGRIM:
24 A. Yes.
25 MR. SIMMONS:

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1 Q. And it's almost five o'clock, so it's probably
2 an appropriate time.
3 MS. PILGRIM:
4 A. Thank you. First of all I would like to thank
5 the Commissioner and co-counsel for the
6 opportunity to speak at these public hearings
7 and to emphasize what an important process
8 this has been for all of us. We have learned
9 a lot from this and, Commissioner, we look
10 forward to your recommendations when this is
11 all over, and it will be over at some point.
12 I would like to echo the sentiments of
13 many of my colleagues within Eastern Health
14 and express my sincere apologies to the
15 patients and families that have been affected
16 by this retesting process. I still firmly
17 believe that we, within Eastern Health, did
18 make the right decision back in 2005, a
19 decision that was made in the best interests
20 of our patients and their families to commence
21 this retesting process. It has become
22 apparent that though we made a right decision,
23 we did not execute the process in the right
24 way, so I express my deep regrets for our
25 failure in this regard and the stress and

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1 anxiety caused to patients and their families
2 as a result of this. We set out to help, not
3 to create further trauma for those who had
4 experienced this diagnosis and treatment.
5 I also regret as a long-time person
6 within the health care system and someone who
7 really believes that we have a good health
8 care system in this province, I regret that
9 the impact this has had and how it has shaken
10 patients' faith and also the public's faith in
11 our health care system. And I said I wasn't
12 going to get emotional.
13 Thirdly, I wish to ensure patients and
14 the public that the system has improved
15 because of this in many ways. We do not go
16 through this experience without many lessons
17 learned along the way. These lessons have
18 come about as a result of quality issues in
19 the lab, of our need for better information
20 management systems, improve ways to
21 communicate with the public and improve ways
22 to disclose. We have also learned a lot about
23 peer review and things that we took for
24 granted with peer review, we know that we now
25 have to go back and rethink this in terms of

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1 our obligation to the public and also our
2 obligation to professional practitioners
3 within the system. In my opinion, it is
4 imperative that this learning be used to
5 improve the system and I would like to assure
6 our patients that this has and continues to
7 happen within Eastern Health.
8 Fourthly, I would like to express, I
9 guess my concern or my concern that we need to
10 stabilize the system in this province, the
11 health care system that has been negatively
12 affected by this whole experience.
13 COMMISSIONER:
14 Q. Take your time.
15 MS. PILGRIM:
16 A. I didn't think I was going to do this, but
17 anyway.
18 Staff administrators and physicians have
19 been gravely affected by this. You have
20 already hear from many of them who have had to
21 continue to provide a service on a go forward
22 basis, while at the same time responding to
23 the demands of this testing process and review
24 that has really been active for over three
25 years. Through this process there have been

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1 some happenings that will require further
2 effort on all of our parts to move forward in
3 a positive manner. I refer specifically to
4 our relationship with government and in
5 particular, politicians. We, within Eastern
6 Health, have never before experienced the
7 magnitude of an issue such as this. The
8 reaction from our politicians was
9 unprecedented and has impacted our
10 relationship with them. I know that
11 politicians come and go, but this has gravely
12 affected our system throughout this process.
13 We have lost some very important leaders
14 within Health Care in this province. I refer
15 specifically to Mr. George Tilley and Mr. John
16 Abbott. I feel very strongly that we cannot
17 afford this type of loss which is certainly
18 being felt in the health care system to this
19 day. Rules of Engagement need to be clarified
20 between the regional health authorities and
21 the governing party of the day. We never,
22 ever want to be in this position again. Our
23 health care system has to transform to meet
24 the changing expectations, but I must say, it
25 will have to take concerted effort on all of

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1 our parts because Eastern Health cannot do
2 this by itself.
3 Lastly, I look forward to continuing
4 transformation of our health care system. I
5 will be retired before it actually gets to
6 where it wants to go, but I see it going in
7 the right direction and trying to meet the
8 many changes and the many expectations that
9 the public and other major stakeholders place
10 upon the system.
11 Patients and the public have been
12 bombarded with media coverages that has
13 presented a picture of Eastern Health as this
14 nameless overwhelming large entity that did
15 not openly share and probably even manage the
16 manipulated information they shared to somehow
17 protect the organization and its insurers.
18 You see before you my face and you have seen
19 the faces of many others. We are Eastern
20 Health, an organization that is in the midst
21 of huge restructuring still and that is full
22 of people who are and provide a very good
23 service to the public of this province. We do
24 not always do everything right, but we do try
25 to do the best that we can and always with the

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1 patients' interest at hand. And I can assure
2 you that this is Eastern Health.
3 I, will all of my experience, have never
4 experienced this type of an issue and this
5 magnitude and I would say very honestly to
6 you, that we did not know how to manage this
7 and we did manage it poorly, parts of it. I
8 would also suggest to you that you would not
9 find many health care organizations who could
10 have done better, given the context of what we
11 were working in. There have been many who
12 have criticized the path that we chose,
13 including ourselves, when dealing with
14 disclosure, whether to the patients or to the
15 public. We, as others, now have the benefit
16 of hindsight here and we would do this very
17 differently in the future.
18 However, there will have to be ongoing
19 dialogue about the issue of public disclosure.
20 The principle will always be to us that we
21 will try and get as much information to tell
22 our patients as we can and then tell them
23 first. And we all know that as soon as you
24 start this process, the issue is now in the
25 public venue and there is a reality that the

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1 issue is picked up by the media before you
2 have the opportunity to talk to your patients.
3 But is the alternative to go public first? I
4 believe that there is not right answer to this
5 and there are principles to guide us and that
6 it is incumbent upon us all that we have to
7 meet with our varying expectations of this and
8 as a group, come up with some guidelines and
9 move forward in the best interest of the
10 patients and the public of this province.
11 Thank you.
12 COMMISSIONER:
13 Q. Thank you. Anything arising, Mr. Coffey?
14 MS. PATRICIA PILGRIM - RE-EXAMINATION BY BERNARD COFFEY,
15 Q.C.
16 COFFEY, Q.C.:
17 Q. I do have a couple, one or two questions that
18 I'd like--while I have you here, ma'am.
19 There was a remark that you made about,
20 when you were answering a question for Ms.
21 Newbury. You said you still have some
22 remaining problem or concerns about public
23 disclosure. Do you recall that? You did make
24 that--and she didn't ask you to go on and
25 elaborate on it, but I think in the

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1 circumstances, bearing in mind, your
2 experience in this, that it might be of some
3 assistance. Do you have some thoughts on -
4 MS. PILGRIM:
5 A. Well, I think that there is many expectations
6 of the system. I don't think that we will
7 ever be able to do exactly--like, the
8 organized health care system has come a long
9 way, as I've said before, I think that the
10 expectations that are out there--like, to me
11 the expectations are here in some cases and
12 we're here. And there has to be a meeting
13 ground because we will always have to be
14 governed by trying to get to the patients
15 first. And that's always going to be a real
16 dilemma because once you start talking to
17 patients, it's out there. But I just hope
18 that we, in this province, and I hope we can
19 do this probably through this adverse event
20 task force or as a result of a recommendation
21 or something coming out of the Commission,
22 that we can get the right people together and
23 we can really hash this out and talk about it
24 and come up with some guideline that will help
25 us all. Because I think that where we are now

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1 is--I, within the health care system, I don't
2 see disclosure as a politician sees disclosure
3 and maybe I shouldn't or maybe I should. I
4 don't know that, but that's still an area for
5 me which is a grey area. I understand we have
6 to do it better, but I have to say, I really
7 don't know how to do it better.
8 COFFEY, Q.C.:
9 Q. Okay. Another thing that you did comment
10 upon, you said to Mr. Simmons that--he asked
11 you about comparing the creation of Eastern
12 Health and the process just before it and as
13 it started, comparing it to the Health Care
14 Corporation, you recall that?
15 MS. PILGRIM:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And you said you thought in terms of Eastern
19 Health, it was a poor way to bring about that
20 type of organization into being.
21 MS. PILGRIM:
22 A. Absolutely.
23 COFFEY, Q.C.:
24 Q. I wanted to ask you about that because you
25 were involved in it in a sense of were hired

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1 early on as one of Eastern Health's senior
2 executives--coming out of the Health Care
3 Corporation as a senior executive. To your
4 knowledge, were there any warning given to the
5 Department of Health or the government at
6 large about any misgivings that might have
7 existed about this process that, in late
8 '04/early '05, is occurring? Were there any
9 warnings, to your knowledge given to the
10 Minister of Health of the day or the Deputy
11 Minister of Health of the day about, are you
12 really sure you want us to -
13 MS. PILGRIM:
14 A. Well, I wouldn't have been in position to give
15 warnings -
16 COFFEY, Q.C.:
17 Q. No, no, I appreciate--I'm not saying you were,
18 I'm just asking you. Are you aware of any?
19 MS. PILGRIM:
20 A. I don't know, I would assure that at the CEO
21 levels, there were warnings about this and I
22 don't think that we kind of knew what we were
23 getting ourselves into, really.
24 COFFEY, Q.C.:
25 Q. Okay. There was, if I could, just finally,

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1 Commissioner, you were asked by Ms. Newbury
2 about this issue about peer review/quality
3 review versus a non protected, I'll call it,
4 review. You recall that. And you'd be aware
5 that Ms. Dawe, in fact, spoke to the
6 Commissioner about that when she testified
7 here. This is now six months later, to your
8 knowledge, has that process been able to be
9 developed any further to this point?
10 MS. PILGRIM:
11 A. We haven't had a completed database for six
12 months.
13 COFFEY, Q.C.:
14 Q. I appreciate and I'm not being critical; I'm
15 just asking you if -
16 MS. PILGRIM:
17 A. No, that's the main factor, was really trying
18 to get that down as good as we can get it and
19 then start doing some analysis.
20 COFFEY, Q.C.:
21 Q. Okay, and this is not analysis. This relates
22 to the idea of--the whole idea of having a
23 peer review, quality review process and you've
24 referred to the idea of more formalizing it.
25 MS. PILGRIM:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. And you told the Commissioner about that.
4 MS. PILGRIM:
5 A. Right.
6 COFFEY, Q.C.:
7 Q. And I take it there's a process in place doing
8 that, but Ms. Newbury was asking you as Ms.
9 Dawe was talking about the idea of leaving
10 aside anything that's going to be
11 confidential, a non-confidential process that
12 investigates as to why something unfortunately
13 happens -
14 MS. PILGRIM:
15 A. Well, that would be a part of what we're
16 getting into now. Because, you know, to me,
17 where that comes from is, well, what questions
18 are left unanswered.
19 COFFEY, Q.C.:
20 Q. No, no, I'm talking in general.
21 MS. PILGRIM:
22 A. Okay, I'm missing -
23 COFFEY, Q.C.:
24 Q. I'm talking about in terms of the Adverse
25 Events Policy, Sentinel Events Policy, okay.

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1 MS. PILGRIM:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. If one patient gets hurt by medical care, then
5 right now you would understand fully that, if
6 it's a peer review quality review, it wouldn't
7 get on the patient's chart, occurrence report
8 wouldn't get on the patient's chart, but the
9 fact that the patient was told about the fact
10 that something unfortunate had happened would
11 get on their chart.
12 MS. PILGRIM:
13 A. Right.
14 COFFEY, Q.C.:
15 Q. And under the policies, they're supposed to be
16 told, if it's known, as to why it happened.
17 MS. PILGRIM:
18 A. Right.
19 COFFEY, Q.C.:
20 Q. If there's peer review and quality review gone
21 on in respect of that event, it wouldn't end
22 up on the chart?
23 MS. PILGRIM:
24 A. No.
25 COFFEY, Q.C.:

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1 Q. Is there nay policy in place right now to
2 require a non-peer review, non-quality review
3 investigation to occur to enable the patient
4 and the patient's chart to be told why it
5 happened? Is there any process in place right
6 now?
7 MS. PILGRIM:
8 A. You mean other than our plans to put something
9 on the chart about disclosure?
10 COFFEY, Q.C.:
11 Q. Yes. Not only the fact that there's
12 disclosure, but why?
13 MS. PILGRIM:
14 A. I mean, there's really--no, there's no policy
15 to guide us in this at all. We really don't
16 have things about these multiple patient.
17 COFFEY, Q.C.:
18 Q. I'm not talking about multiple; I'm talking
19 about single.
20 MS. PILGRIM:
21 A. No, I know. With the single patient, well you
22 would, through disclosure, you would tell the
23 patient as much as you could.
24 COFFEY, Q.C.:
25 Q. Well, that's what I'm getting at.

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1 MS. PILGRIM:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. If the only things known about why it occurred
5 are peer review or quality review processes -
6 MS. PILGRIM:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. - how would you find out anything then to tell
10 the patient about why it happened, if you
11 don't have some other investigation?
12 MS. PILGRIM:
13 A. Well, usually there probably would be an
14 internal, or an internal summary of some sort
15 that would be done. You know, an internal--
16 trying to fit the pieces together which is
17 what we're trying to do now.
18 COFFEY, Q.C.:
19 Q. If I could please, because there was something
20 Mr. Browne asked and I want to clarify it.
21 It's P-0400. He asked you a question about
22 the core communication group as it were. Do
23 you remember that and whether or not the
24 physicians would be part of that?
25 MS. PILGRIM:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. This is an e-mail of January 30, 2006. It
4 deals with key messages for potential media
5 inquiries following The Independent story of
6 January 29. It's from Susan Bonnell. It's to
7 Robert Williams, Heather Predham, Joyce Tilley
8 and Kara Laing. So, Dr. Laing, I take it,
9 whether she was part of a core media group or
10 not, was being, at that point, kept in the
11 loop in terms of key messages.
12 MS. PILGRIM:
13 A. Kara would give you more, kind of, scientific
14 advice just to make sure it's factually right,
15 but she wouldn't have been actively involved
16 in who was saying what in terms of the people
17 who were actually communicating with the
18 patient.
19 COFFEY, Q.C.:
20 Q. Okay. And if I could, finally, Commissioner,
21 you did make a remark that, look, after the
22 consolidation of Eastern Health, in the
23 initial stages, a number of people involved
24 were really, in fact, getting to know each
25 other. And I appreciate that that would be

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1 so, but in the main, the people who handled
2 this particular, the response to ER and PR in
3 the beginning, in 2005, in effect, the main
4 characters all had known each other fairly
5 well in the Health Care Corporation, hadn't
6 they?
7 MS. PILGRIM:
8 A. We'd know each other, but we were certainly
9 separated now with the responsibilities that
10 we had within Eastern Health. It made it much
11 more difficult to communicate with each other,
12 with this regional responsibilities and Bob
13 Williams down in Burin and whatever. You
14 know, it becomes more difficult. You're not
15 as closely knit a group.
16 COFFEY, Q.C.:
17 Q. Thank you very much, Commissioner. I thank
18 you very much, Ms. Pilgrim.
19 MS. PILGRIM:
20 A. Thank you.
21 COMMISSIONER:
22 Q. And my thanks, Ms. Pilgrim for your, I know,
23 longer visit that either of us had
24 anticipated. And now that you've seen the
25 view of the room from this side, I guess you

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1 would rather go around there. Okay. We'll
2 meet at 9:30 in the morning and Ms. Pilgrim
3 can decide whether she wants to stay with us
4 or not. Thank you.
5 Upon conclusion at 5:15.

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

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