COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

October 29, 2008

Appearances:

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

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

Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al

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

Chesley Crosbie, Q.C... . . . . Members of the Breast Cancer
. . . . . Testing Class Action
Mark Pike, Q.C. . . . . NL Medical Association
Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)
Blair Pritchett. . . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities
Barry Glaspell . . . . . Counsel for Daniel Boone

LIST OF EXHIBITS

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THE COMMISSIONER:
Q. Please be seated. Mr. Coffey?
COFFEY, Q.C.:
Q. Commissioner, the next witness is Daniel Boone.
MR. DANIEL BOONE, SWORN, EXAMINATION BY BERNARD COFFEY, Q.C.
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission?
MR. BOONE:
A. Daniel Boone, D-A-N-I-E-L B-O-O-N-E
REGISTRAR:
Q. Thank you.
MR. BOONE:
A. You're welcome.
COFFEY, Q.C.:
Q. Commissioner, Mr. Boone, there's counsel here in the room for Mr. Boone.
MR. GLASPELL:
Q. I'm Barry Glaspell from Borden Ladner Gervais.
THE COMMISSIONER:
Q. Welcome.
COFFEY, Q.C.:
Q. And Mr. Boone, I understand you're a lawyer.

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MR. BOONE:
A. I am.
COFFEY, Q.C.:
Q. And Mr. Boone, can you tell the Commissioner, please, give her a brief overview of your educational and professional background, please?
MR. BOONE:
A. Yes. I graduated from the University of Ottawa Law School in 1988. I articled with the firm then known as Sterling Ryan, which through a merger with other firms became the firm of Stewart McKelvey Sterling Scales in 1990, and I've remained with that firm since that time. I became a partner in the firm in 1994. I'm currently the regional managing partner for Newfoundland, and my practice, if you like, if you'd like to have a description of my practice?
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. It's been focused mainly in the field of insurance defence, but within that, even more so in respect of issues of hospital liability,

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but as well as dealing with issues of hospital liability, I've also had a lot of experience in advising hospitals on matters such as disclosure, consent policies, policy development, end of life decisions, those kinds of things.
COFFEY, Q.C.:
Q. Mr. Boone, can you give the Commissioner some idea of how long that has--those subjects have occupied like a substantial portion of your practice?
MR. BOONE:
A. It developed, of course, as things do. The first--when I first started practising in the area in, I believe it was about 1991, our firm did the insurance based work for some of the hospitals in the province, not all. I remember that we worked for the Salvation Army Grace Hospital in St. John's, for the St. Clare's Hospital, for some of the hospitals in Labrador and others, and there was another firm in town, Ms. Chaytor's firm as a matter of fact, that did the insurance work for other hospitals within the province. So over that time, that practice developed until I became

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the only person in our office functioning in that area, and then in around 1995, the practice started to accelerate, if you like, because of--well, for one thing, the Healthcare Insurance Reciprocal of Canada became the--provided insurance to most of the hospitals in St. John's and to many of the hospitals outside and then that's progressed over time, and we are counsel to that organization.
COFFEY, Q.C.:
Q. And that's the Health--I'm sorry, what is it?
MR. BOONE:
A. Healthcare Insurance Reciprocal of Canada.
COFFEY, Q.C.:
Q. Okay, and is that what has been referred to here as HIROC?
MR. BOONE:
A. You've referred to HIROC and I have no idea why this is the case. They prefer to pronounce it HIROC.
COFFEY, Q.C.:
Q. HIROC, okay, and I appreciate -
MR. BOONE:
A. But certainly that is an acronym and the

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acronym is for the Healthcare Insurance Reciprocal of Canada.
COFFEY, Q.C.:
Q. Okay, and you have been local counsel, local in the sense of provincial counsel for them, since approximately when?
MR. BOONE:
A. I can't recall exactly when, because the first hospital in the province to become a subscriber, and I can explain to you, if you like, what a subscriber is, in the HIROC system in Newfoundland was the Waterford Hospital in 1991.
COFFEY, Q.C.:
Q. Okay.
MR. BOONE:
A. And they were followed, I think, fairly closely by the Carbonear General Hospital and then by what was then the General Hospital, the Health Sciences Centre in St. John's, and then when the Health Care Corporation of St. John's was formed, they chose to place their insurance through the Reciprocal, and that of course is the biggest hospital, you know, the biggest organization and obviously most issues

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of insurance arise out of there. So we've been counsel, I guess, since the first claims arose with respect to that.

COFFEY, Q.C.:

Q. And could you tell the Commissioner then, from your perspective, what--I'm sorry, I want to get it right, HIROC?

MR. BOONE:

A. HIROC.

COFFEY, Q.C.:

Q. HIROC, okay. HIROC's role and/or roles and functions are?

MR. BOONE:

A. Sure, and there's obviously very long answers and very short answers to that and I'll keep it as short as possible. The Reciprocal was formed--and we often refer to it as the Reciprocal as well as HIROC. When I say we, I mean counsel who do work for both, for Reciprocal and hospitals, the Reciprocal itself, they often refer to themselves as the Reciprocal. The Reciprocal was formed in, as I understand it, the late '80s, in Ontario first, in response to a previous commission of inquiry that was dealing at the time with

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problems in the health care insurance industry, among other issues, and it started as a reciprocal exchange that was confined originally to Ontario. What HIROC is is a reciprocal, and that's a fairly old insurance term, I think, but a reciprocal exchange is essentially a self-insurance pool. All of the hospitals who are part of the exchange essentially self-insure, but in reality, what they do, or in practice, what they do is they insure each other. Each of them is called a subscriber, not because of the way that they're insured but rather because of the way they insure the others. They each become--by becoming members of the reciprocal, they subscribe to provide insurance to all of the other members of the reciprocal, and in return for that, all of the other members provide insurance to them. So it's a reciprocal exchange and it's operated on a not-for-profit basis. So what happens is at the end of defined periods of time, after deducting for payment of administrative fees and legal fees and claims paid, if there are surplus funds, those are returned to the member hospitals pro

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rata.

COFFEY, Q.C.:

Q. And Mr. Boone, are you aware of whether or not like the amount that this costs annually for any one subscriber varies based upon their kind of claims history?

MR. BOONE:

A. I would presume so. I mean, obviously that's not part of my role, but I would imagine that--I really shouldn't speculate much. I know--it's a little bit more than imagine. I do know that the Reciprocal has an underwriting group and in determining what membership fees, if you like, or subscription fees must be paid by a member, they apply ordinary underwriting principles to that to determine what the overall Reciprocal's risks of loss are in the future and what the specific risks of loss would be for a particular subscriber, and these underwriting principles are applied because the Reciprocal is, although perhaps not a tradition insurance company, is yet regulated pursuant to most insurance acts. I know it's regulated under the Newfoundland Insurance Act, which refers to a reciprocal.

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And it's a fairly common way. This is a reasonably common way for health care insurance to be provided in the country. Now HIROC operates in, I think, six provinces now. Nova Scotia has its own reciprocal that effectively functions the same way.

COFFEY, Q.C.:

Q. And does HIROC do anything other than provide insurance services?

MR. BOONE:

A. It does a lot, and a lot of which I wouldn't necessarily be aware of, except obviously anecdotally and through hearsay. HIROC is member run and they--from the literature that I've read, from the meetings that I've attended with them, they pride themselves on the fact that they are member run, and what I mean by that is that the Board of Directors of HIROC are drawn from directors and executive of health care institutions across the country. So the board is essentially people who work in the health care industry. I think largely because of that, and largely because of the focus is on the members and their interests, HIROC has developed a fairly

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significant risk management program and they've done that internally. So internally, they have a risk management staff, which I think now numbers six or seven or eight, I think. They have a vice president of risk management who, you know, that might give some indication as to the importance that that seemed to have in the organization. And as well as that, they partner with other groups in respect of patient safety.

If you go on the HIROC website, for instance, you'll find their vision statement includes that they wish to partner for a safer health care system, and in order to do that, they've partnered with many other groups who work within the system, for instance, the Canadian Medical Protective Association, the Canadian Patient Safety Institute, of which they're a voting member, and various other institutions, such as Ontario Hospital Association, with the Newfoundland and Labrador Risk Managers Association. They partner with groups of that sort to sponsor educational events and to have resources available for risk management, patient safety

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issues, and as well as that, they've also independently developed some very specific risk management programs. One is the--I don't know what the acronym stands for but it's the MORE Obstetrical program, which they've developed in partnership with the CMPA and that is a program designed to make essentially obstetrical matters more safe, and it's an educational and teaching tool, and they've also recently developed a risk management self-assessment module, which is a web-based module where subscribers can go on and determine, you know, their own risks and where they might have gaps and where they might close the holes in the swiss cheese model, as it's often been called, and that RMSAM model, that's another acronym, has now, just this year, has been adopted by Accreditation Canada, which is the accreditation body for hospitals across the country, used to be known as the Canadian Council Accreditation for Health Care Facilities, and they've partnered with that organization, and made the RMSAM model available. So Accreditation Canada, in its own accreditation standards, recommends

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that members use that model. So there's a lot of activity in that respect.

They also do some other activity in terms of--that I know less about, some brokerage of other types of insurance for members and those kinds of things, but I'm not very much aware of those.

COFFEY, Q.C.:

Q. Mr. Boone, so I take it then, from shortly after the inception of the Health Care Corporation of St. John's, which would be in the mid 1990s -

MR. BOONE:

A. 1995.

COFFEY, Q.C.:

Q. '95, that you, as the defacto lawyer in Newfoundland for HIROC, and I appreciate your firm acted for them, but -

MR. BOONE:

A. Sure.

COFFEY, Q.C.:

Q. - you in fact did most of the work, I take it, certainly in those days for your firm for that client.

MR. BOONE:

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A. Yes.

COFFEY, Q.C.:

Q. Can you tell the Commissioner then, because to give her some sense of like throughout the late 1990s in through early 2000s, without of course getting into the nitty gritty of any one case, what sorts of interaction you found yourself having with representatives of the Health Care Corporation, or for that matter, any other organization, health care authority in Newfoundland at the time, in terms of dealing with matters on behalf of HIROC? Could you tell the Commissioner?

MR. BOONE:

A. Well, the interactions developed in practice over time, and as I understand it, my practice in this area is consistent with other people who do work for HIROC in other provinces. There are many interactions and these are encouraged, and many of these interactions are encouraged because, as I understand it, because of HIROC's vision for safer health care. As HIROC counsel, I understand that I am to make myself available. No one's ever told me this, but my understanding is I make

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myself available as a resource to subscriber hospitals within the province. So you know, one level of interaction that I would often get would be calls from--and these calls continue all the time, from hospitals within the province with issues that tend towards the legal and asking for input or a description as to perhaps what action they ought to take. Sometimes it involves a review of policies. Sometimes it involves directing towards resources or considerations they might take into account. Those interactions happen often, regularly and often. Very many times, no file is open in respect of those interactions, if you like. You know, a call is made, I'll give an answer and they'll proceed, you know, and that's often the case because the issue might be minor. The issue might not have significant ramifications. So we make ourselves available as a resource for hospitals in that kind of context.

As well, when subscribers or hospitals call HIROC with an issue, sometimes that might get directed around back to me, and we get involved, and as I say, oftentimes, you know,

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really nobody is billed for that. It just--it's part of the service, I guess, if you like, that we're available as a resource.

We also make ourselves available for educational events for hospitals within the province. You know, if somebody calls us and asks us to do an educational event on some aspect of legal liability, we just go and do it, and we get called about that as HIROC counsel. Sometimes we also have chats on a regular basis with the people who are involved in managing claims within the hospital. So we'll have, you know, quarterly meetings sometimes with some hospitals, less regular with others, just to get a feel for what's happening within their industry.

And then there is also then the, I guess, the next level of involvement, which would be when a claim actually gets reported to HIROC, and when I say a claim, I don't mean a formal legal action, but when an actual claim is reported or an event of loss is considered to trigger a potential loss under the policy and a report is made to the insurer. Sometimes, depending on the nature of the file, and I

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couldn't really give you a definition as to that, we might get involved early in that file. Sometimes--I'm sorry, the paradigm situation rather is that HIROC will appoint an adjuster to investigate the claim, and that adjuster will sometimes report to me, sometimes copy me, sometimes just report directly to HIROC. So we do have a level of interaction that obviously grows and expands once a claim has been reported and especially once a statement of claim has been issued, and there's a formal legal action, then we get directly involved.

COFFEY, Q.C.:

Q. And I take it then that that, those relationships that you've just described, varying various ones, developed throughout the late '90s, into the 2000s, as time went on?

MR. BOONE:

A. Yeah.

COFFEY, Q.C.:

Q. You got more and more phone calls, for example, over time?

MR. BOONE:

A. Yes, absolutely.

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COFFEY, Q.C.:

Q. And then I take it then, would it be fair to say that the relationships, such as you just described, existed by the beginning of July 2005? By the time Eastern Health came along in the spring of 2005, that sort of interaction you would have either with Eastern Health or the other health authorities at the time, that existed by that point in time?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. Okay. Mr. Boone, can you tell the Commissioner when you first heard about--the circumstances under which you first heard about what is now referred to as the ER/PR matter?

MR. BOONE:

A. Okay. I can date it with reasonable certainty, because I know that I was on holidays out of the province with my family until, I think it was the 16th of July, which was a Saturday. On the 18th of July, I had some information provided to me by Heather Predham, who is the risk manager of Eastern Health, as it was at

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the time, and I can tell you what that is when we come to it, but I also had a voice mail sometime on the 18th, and I really can't recall when that was, from Eleanor Morton, who's the VP of risk management at HIROC, and Michael Boyce, who is the VP of claims at HIROC, to tell me that Eastern Health was facing a situation in respect of which they might need legal advice, among other things, and I don't recall much other than that in the voice mail.

COFFEY, Q.C.:

Q. And do you recall what Ms. Predham had to say to you?

MR. BOONE:

A. No, I didn't speak to her.

COFFEY, Q.C.:

Q. Oh, you didn't?

MR. BOONE:

A. No, she sent me material.

COFFEY, Q.C.:

Q. Oh, material.

MR. BOONE:

A. On the 18th. I spoke to her on the 19th.

COFFEY, Q.C.:

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Q. And what do you recall about what was said then on the 19th?

MR. BOONE:

A. Yes, she called and asked me to come to a meeting. She told me no more than that.

COFFEY, Q.C.:

Q. And then what happened?

MR. BOONE:

A. I went to the meeting. Now, of course, just to--if I can just talk about this for a moment.

COFFEY, Q.C.:

Q. Sure.

MR. BOONE:

A. In attending the meeting, we're never sure when we're invited to a meeting of that sort whether what will develop will be, if you like, a HIROC file, in other words a claim file, or a matter in respect of which the hospital will need advice or anything of that sort, and it might never become a claim file, or if you like, speaking in a lawyer's parlance, may never become a file at all. In other words, it might be an issue that they'll never need to speak to us about again, and

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oftentimes when I'm called to go to meetings like that, and this was not the first time, I don't know what's going to be developing out of that meeting, and in fact, if I remember correctly, my first notation of any kind relating to ER/PR on the 19th, I recorded the client and the client part of my form is HCCSJ, which was the acronym for the Health Care Corporation of St. John's, which was force of habit because Eastern Health had only just been formed, and when I went to that meeting, that's what I wrote down. So I had no idea really what they were going to tell me, although I did know that HIROC had a feeling or a concern that there might be a claim that could arise out of the circumstances that were about to be described to me.

COFFEY, Q.C.:

Q. So what do you recall then happened? Do you recall who was at the meeting? Where the meeting was?

MR. BOONE:

A. Yeah, I do.

COFFEY, Q.C.:

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Q. Or even what time of day it was?

MR. BOONE:

A. I actually recall not the exact time of day. I don't recall the starting time, but I do recall by when it had to finish, so it would have been around lunch time on the 19th, and the reason I know that is because at 2:00 on the 19th, Heather Predham and I were meeting with Colleen Simms, who is the manager for the Mental Health Program at the Waterford site, on a file, and that I had a 2:30 meeting then with Ms. Simms that wouldn't have included Ms. Predham. So I know that the meeting on the ER/PR issue ended in enough time for me to get to the General Hospital--from the General Hospital site to the Waterford site. So it's over lunch, and I remember that the meeting did take place in the General Hospital and I believe it took place in Dr. Williams' office, but I don't have a real recall of that. It was definitely a smaller room. It might have been an office near his office.

COFFEY, Q.C.:

Q. And do you recall who was there?

MR. BOONE:

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A. Yeah. At the meeting was Dr. Williams, who was, I guess, the medical director or the VP Medical Services, who I had met before. Heather Predham was there, and Susan Bonnell, who was from communications within Eastern Health, who I think I had met before, but certainly I knew who she was. Dr. Donald Cook was there. I didn't--I don't think I understood this at the time, but he was the chief of pathology service, I believe, at that time, but I had known Dr. Cook from other files in which I'd been involved, just as a pathologist, and so I knew who he was. And Terry Gulliver was there, Terry was the lab director or presented to me as the lab director or the lab manager or some title of that sort.

COFFEY, Q.C.:

Q. Had you known Mr. Gulliver before that?

MR. BOONE:

A. No, I'd never met him.

COFFEY, Q.C.:

Q. Okay, and okay, what happened? What do you recall?

MR. BOONE:

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A. The meeting started with a description by Dr. Cook of what had evolved over the course of time, since they first learned there might be an issue, and you'll recall that there's a memo--you'll recall it better than me, I think, that there's a memo that Dr. Cook prepared that's dated May 24th of 2005.

COFFEY, Q.C.:

Q. Yes.

MR. BOONE:

A. That was one of the things that Ms. Predham had sent to me on the 18th. So I actually had that memo, and the meeting started essentially with Dr. Cook giving a synopsis of what was in that memo, and so we heard from him with respect to that, and you know, he told us--I do recall he mentioned some, I guess, if you like, the highlights of that. The sentinel case was mentioned. The further investigation that had occurred up until that point of time.

COFFEY, Q.C.:

Q. That would be up until July?

MR. BOONE:

A. Up until the 19th.

COFFEY, Q.C.:

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Q. Yes.

MR. BOONE:

A. And some other activity that they had had, and he also told me, because, of course, this is my first exposure to the ER/PR testing, to immunohistochemistry or any of the purposes for this. He also gave a description, which I think was meant for me more than anybody in the room, as to the test and its purpose, how it's done to some degree, and the things that I remember taking out of that were a couple of really important things. One was that, I remember he emphasized that the test was not diagnostic, which I would have took to mean that it was not a test to tell someone whether they do or don't have a disease. I recall that being part of the issues. He told me, or he told us, but again, I think it was mostly for me.

COFFEY, Q.C.:

Q. You felt it was directed mostly at yourself?

MR. BOONE:

A. Well, as everybody else already knew these things, because they already had their education at some point earlier than mine, and

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I was now getting mine. He told me, I remember that he mentioned that the purpose of the test is to be a guideline used in treatment by oncologists who are treating cancer patients, specifically I understood breast cancer patients. So I did have that understanding. And the word Tamoxifen was used, which was the first time I had ever heard the word, as being a drug or medication that could be available or made available, depending on some circumstances, including the outcome of the ER/PR test. I do recall at that time, that I was told, must have been by Dr. Cook, that ER/PR testing wouldn't be the sole indicator, I remember that discussion took place, for the use of Tamoxifen. That kind of discussion occurred.

And I do recall a limited discussion, but I recall a much more expanded discussion at a later meeting, about the fact that everywhere where this test is done, there are issues. There was some notion of--I don't know if it's--probably going too far to say inherent unreliability, but some problem with inter-examiner variability with the test that was

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known. That was mostly Dr. Cook's contribution. That was essentially the beginning of the meeting for me, and then Mr. Gulliver spoke, and again as I said, it's the first time I'd met Mr. Gulliver, he was the lab manager and he talked more about the specifics of the test and the problems that they had encountered since May, or had been investigating since May, and the things that Mr. Gulliver told me that I considered to be important were the following--I do have a very good recall of these. Mr. Gulliver told us, people in the meeting, as well as me, that he himself--and I think he put it that he, himself, as manager for the area or something of that nature, was 100 percent certain that the staff were doing the test correctly.

COFFEY, Q.C.:

Q. Were doing it correctly. Did you understand from that, like, as in that day were doing it correctly, or had always done it correct?

MR. BOONE:

A. Always was my impression.

COFFEY, Q.C.:

Q. Okay.

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MR. BOONE:

A. But whether or not--I can't say now whether I'm right or wrong, but that was certainly the impression I took.

COFFEY, Q.C.:

Q. That's what I'm getting at.

MR. BOONE:

A. No, I can't say that, but certainly my impression would have been over whatever period, and I didn't understand what period it was that they were looking at as being potentially problematic.

COFFEY, Q.C.:

Q. Okay, I'm sorry, go ahead.

MR. BOONE:

A. So this wasn't a recent or new development. Mr. Gulliver also told us -

COFFEY, Q.C.:

Q. So it was 100 percent.

MR. BOONE:

A. I remember those words, he was 100 percent ceratin that the staff were doing the test correctly, and I remember as well that he said--he also said that in doing the test, and I don't know if "doing the test" is an

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appropriate terminology, but in performing the test, the staff followed the instructions of the manufacturer, who I understood to be DAKO, the machine. So they followed the instructions. Another thing that was told to me, or told to us I should say, at the meeting by Mr. Gulliver was that not only were the staff and himself certain they were doing the test correctly and following instructions, but that there were also controls run, I can't recall if he said every day or every something. There was something like that.

COFFEY, Q.C.:

Q. Every run?

MR. BOONE:

A. I've heard--there's been so many descriptions of when controls are run. I can't be honest with you as to what he said at that time. I just can't recall. He spoke of controls and, of course, as a layperson without much of a scientific background, I didn't know what a control was. I had some vague, you know, Grade 11 impression as to what one would be, but I understood it to be a test or an assurance process that was done side by side

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with the test itself to ensure the test was done correctly. That's not how he described it to me, that was just what I understood in my own mind, but he did say, Mr. Gulliver, that these controls were run, and that if the controls were run and were--I can't remember what the words were--if the controls were run and were accurate, I think is what he said, then that would be an indication that the test itself was accurate, and that these were run all the time. That was my impression. Again it would be unfair of me to say whether he said every day, every run, every batch, I don't know. All the time is what I took out of it. And the next thing that Mr. Gulliver told us in the room was that in two to three days from that point forward--so that was the 19th, I think, the 19th was a Tuesday?

COFFEY, Q.C.:

Q. This would be a Tuesday.

MR. BOONE:

A. In two to three days from that point forward, the lab would have all of its statistics for the years which were in question. At the time, I have to say I don't know what years

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were in question. That wasn't present to my mind, but that was the terms that were used, I think. So that in two to three days, they were going to have these statistics, and there was some discussion as to what the statistics meant, and the impression I had, and it is only an impression, was what the statistics would tell them would be whether or not they were within accepted rates of positivity, and that in turn would tell them--would be essentially a further assurance that they had been doing their tests properly or appropriately, and these numbers, these statistics, would come within two to three days, and I recall also at the meeting there was a discussion and this gets somewhat into legal advice, but other people have spoken to it, there was a discussion about a matter that we had ongoing at the time which is known around here as the Health Labrador case, which was a case that I don't think I need to go into the specific details of it, but it was a case essentially where after a mass or a group notification, a class action was started for what essentially amounted to a negligent

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notification, and that was ongoing. I know we talked about it because we were fairly active in that file at that time, it was ongoing over that period of 2005.

COFFEY, Q.C.:

Q. In fact, the Commissioner has seen in exhibits these media reports on--I think it's Judge Russell had just certified it as a class action earlier that month.

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. That would be a matter of public record.

MR. BOONE:

A. And, of course, once certification occurs, there's an awful lot of activity that has to occur amongst the lawyers, so we were -

COFFEY, Q.C.:

Q. Okay, you were actively involved.

MR. BOONE:

A. It was occupying a fair bit of our time at that time.

COFFEY, Q.C.:

Q. And do you recall why that was raised, who raised it and why?

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MR. BOONE:

A. As I understood it from Heather Predham, it was raised by Mr. Boyce and Ms. Morton in whatever conversation she had with them before she spoke to me. So, you know, it was there, it was current. They essentially asked me about it. I say "they", the people in the room asked me what I knew about Health Labrador, and, of course, you know the way lawyers are, the last thing people should really do is ask us what we know about a case in which we're involved, you know, because we can be descriptive of it, but I wasn't because the meeting was going to be short, we couldn't--you know, law is long, life is short. We could go on and on about the case, but the essentially points that I made about the case is that it was not just a case that stood alone, and that was the point that I recall emphasizing. So Health Labrador wasn't a new phenomena, it didn't represent a new development in the case law in Canada. It was really just one of numerous cases that had occurred in Canada, but also in the US and the UK, where health service providers, food

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service providers, other people who interact on a--put it this way, an intimate basis with the public, had had to make a notification and then had been sued in a class action process for that notification. In other words, leaving aside the question as to whether or not the underlying event caused any damage, the notification itself was felt either to be negligently done or the choice to do it was negligent, such that people were then claiming for damages for not physical harm, but rather the distress and the mental distress that occurred from the notification itself. So that would have been the essence of what I had said, but it went a little bit further than that because I do recall that Ms. Bonnell who was there said at the time that she had a file back in her office relating to Health Labrador communications issues, and she was going to go look at it. I never had any further discussion with her about that, but I understood that she had some other independent and perhaps a wholly different professional take on Health Labrador.

COFFEY, Q.C.:

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Q. So about--anything else about the meeting that you recall?
MR. BOONE:
A. Yeah. The main other thing that I recall, and this sort of builds upon what I've told you so far, is that Mr. Gulliver said that in two or three days his lab would have produced these statistics which would be able to tell Eastern Health--in his view, as I understood it, and I have to confess I didn't get into the intricacies as to why he believed this, but in his view, would tell Eastern Health whether it did or did not have a problem for the years in question, and that this would be brought forward within a couple of days, they were working on the numbers. Then at the end of the meeting, if you like, there was no decision as such, but the meeting broke up with, I'll call it a consensus, it might be too fine a word, but an understanding amongst those present, at least from my impression, that the best thing to do was to wait until Mr. Gulliver came up with these statistics before any further steps were taken.
COFFEY, Q.C.:

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Q. And what sort of steps did you understand at the time were being contemplated?
MR. BOONE:
A. When I--that's one thing I didn't discuss because in the meeting itself there was also a discussion not only of the problem--because there were two things going on. There was the investigation of the problem, if you like, and I can call it that for shorthand, you'll know what I mean, but there was also at the same time, of course, a lot of activity, as I understood it, by Eastern Health to determine how to respond to the problem in its relationship with its patients, which means communication. So I knew that when I went to this meeting when I went--I knew at this meeting that Eastern Health was coming up with a plan of some sort for communicating to patients, and as I took it from the decision or consensus of the group when we left the meeting, that that would be, amongst other things, put on hold until Mr. Gulliver came back with these statistics two to three days later.
COFFEY, Q.C.:

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Q. In relation to the positivity rates?
MR. BOONE:
A. That's what I -
COFFEY, Q.C.:
Q. That's what you understood?
MR. BOONE:
A. I don't--told you at the time, but that was my understanding that was what it was about, positivity rates, yeah.
COFFEY, Q.C.:
Q. Anything else about the meeting?
MR. BOONE:
A. No, I don't think so. I do recall--I can say this again because I suppose its come up, that Dr. Williams asked me, I think on the way out of the meeting, whether I was comfortable with that decision and I said yes.
COFFEY, Q.C.:
Q. The decision to wait to see the numbers, whatever Mr. Gulliver had to say?
MR. BOONE:
A. Yeah, I think so. I mean, that was the next step and they were going to make--essentially if I can put it this way, although it wasn't put that way at the meeting, further decision

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making was going to be put off until they got these statistics.
COFFEY, Q.C.:
Q. Mr. Boone, your attendance at that first meeting, do you recall having any sense at the time--because you'd been told about, you indicated, some--there had been some retesting already gone on.
MR. BOONE:
A. Yes.
COFFEY, Q.C.:
Q. Did you have any sense at that meeting as to what we've referred to here as conversion, the conversion rate was?
MR. BOONE:
A. Yeah, actually, that is one other thing I do recall at the meeting I didn't mention. I was told in the meeting that Eastern Health had at some point in time, and I can't be specific as to when, but certainly before the meeting, had tested 25 samples, that's the number that sticks in my mind, of breast cancer patients who had previous ER/PR testing, and who had previously been determined to be negative, that was how it was put, and that of those 25

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retests at that point in time, 16 had converted, and again I know the Commissioner and other people in this room have difficulties understanding what a conversion means, but at that time that word was used.

COFFEY, Q.C.:

Q. That's what I was going to ask you.

MR. BOONE:

A. Yeah, yeah.

COFFEY, Q.C.:

Q. Because you're a layperson in the medical world showing up, and the word you're hearing being used by these medical or technological people is "conversion".

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. That's their word?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. What I'm getting at is you didn't show up and provide the word yourself, obviously?

MR. BOONE:

A. No.

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COFFEY, Q.C.:

Q. So you hear the word conversion, and 16 out of 25?

MR. BOONE:

A. Yes, and I was told at that time, by the way, because it went a little bit further than that, that 12 of the 16 had been notified and it was told to me in such a way, because I'll anticipate your next question, that the others just hadn't been yet, but were going to be, and notified means their doctors had spoken to them and said that they had previously been considered--I don't know if it was ER/PR or just ER negative, and now they were being considered to be ER positive and that there, therefore, might be some change in their test that could occur.

COFFEY, Q.C.:

Q. Mr. Boone, at that first meeting, did you get any sense or were you told about--having come away with any understanding at the time that this ER/PR testing not only involved the Health Care Corporation, but involved patients outside St. John's?

MR. BOONE:

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A. Not in that first meeting, no. I had no understanding of that at that time.

COFFEY, Q.C.:

Q. So coming away--attending the first meeting and coming away from it, you thought, well, this is a St. John's problem, as it were?

MR. BOONE:

A. That was my impression, rightly or wrongly. Someone might have said something that I should have taken a different way, but that was what I came away with.

COFFEY, Q.C.:

Q. And what then happened, what next, do you recall?

MR. BOONE:

A. The next day was the 20th. I know that I had no interactions at all with the people from the hospital on the 20th. The 21st, I had an e-mail from Heather Predham, and the e-mail said that here is the latest statistics. So I presume--you know, as soon as I read it, I thought, well, this is what Terry was working on, here's the latest statistics and with these new statistics, we appear to be moving back into the best case scenario again. That

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was the words that she used, and she said the plan now is to retest all the patient is what she said, meet with the oncologists and inform the attending. Now what I understood that to mean was that they were going to meet with the oncologists--I wasn't necessarily sure as to what that was about at that time, but I did get--I read some material she sent and I got an impression as to what that meant. Inform the attending meant tell the attending or responsible or most responsible physician that there had been a change in the test. She sent to me at that time--I noted there are statistics that were prepared by Mr. Gulliver on the 21st, sort of a spreadsheet.

COFFEY, Q.C.:

Q. Uh-hm.

MR. BOONE:

A. I really don't know if I got those that day. I got those around that time, so I don't know if that was attached, but I do know what she did send me was a summary, as I understood it. I later learned, because I had no idea ever what a briefing note was, I later learned that this was some work in progress briefing note that

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had been prepared and updated often, but--so she sent me this briefing note as up to the 21st of July, I think it was, and you have that briefing note because--I actually took pains to go look for it because I know there's been a lot of briefing notes introduced into evidence, and I wanted to make sure that the one that I got was, in fact, one that you've seen and the exhibit is P-0075.

COFFEY, Q.C.:

Q. P-0075, yes.

MR. BOONE:

A. That's your exhibit that has that briefing note. Mine was slightly different because I think yours has letterhead on it and some other descriptive things, but mine didn't, mine was just the body of the text.

COFFEY, Q.C.:

Q. So she sent you that. Go ahead. That's Thursday.

MR. BOONE:

A. That's Thursday. Well, I suppose, to tell the story for me at least, because I think I could tell you what I took to be important, if I can see that exhibit--is that possible I can see

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it?

COFFEY, Q.C.:

Q. P-0075, please, yes. You'll see the exhibit come up now, Mr. Boone. As well you have control of the mouse.

MR. BOONE:

A. Okay. The first thing I'll say is again, and I think I said it before, but what you have here in all its essential terms, all words used are the ones that I have in my file, but it looks slightly different. What was important to me is if we go down to--I think it might be page two, I'm not sure. The first thing, July 18th, 2005, it says, "Laboratory managers in St. John's began reviewing the statistical data for 2000 to 2004 to see if there are any inconsistencies in the findings of positive conversions, or this could be just a matter of the sensitivity of the Ventana System being more accurate with its findings". I had been told something in my 19th meeting that they'd switched testing platforms from DAKO to Ventana. I didn't understand the significance of that. Then the next thing is July 20th, '05, which occurred before Ms. Predham e-

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mailed me that said, "Upon review of the statistical data", there's a word missing, but "it's been concluded that the positivity rates are, while on the low end of the scale, within acceptable range. Total positivity numbers for 2000 are 62 percent", and I'm sure you don't need me to read that, but they talk about positivity -

COFFEY, Q.C.:

Q. So it was those two entries, the 18th and the 20th.

MR. BOONE:

A. It goes further than that, actually. The next aspect of it is under the heading "Actions". That heading wasn't in my copy, but that's--I understood these to be actions in any event. It says "Considering the 50 to 85 percent acceptable range in standard textbooks and Mount Sinai's standard of around 70 to 80 percent, this also reconfirms that our numbers are legitimate. Regardless, the laboratory is still going ahead with the retesting of the specimens and officials will meet with the oncologists to see how they would like to proceed with informing patients of their

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conversion and possible change in treatment. Extra resources have been identified. We do expect improved accuracy on retesting due to the sensitivity of the newer equipment". When I read that--there's a lot more in that summary, but when I read that, that essentially gave me the state of play as of the 21st. So when Heather said to me in her e-mail, which I don't know if it was sent to anybody else, I think it was just to me, that we'd move back into the best case scenario again. I went looking for what was in the information that would say that, and this is what I found, and this, in fact, was very consistent with what was expected to come--perhaps not the results, but some further direction was going to come out of these lab statistics to be prepared within the next two to three days.

THE COMMISSIONER:

Q. Excuse me -

MR. BOONE:

A. Sure.

THE COMMISSIONER:

Q. You quoted there from the portion in which it

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said that they would be going ahead with retesting of specimens.

MR. BOONE:

A. Yes.

THE COMMISSIONER:

Q. Did you know at that time how--what specimens were being retested or how large that project was? Did you have any understanding of that?

MR. BOONE:

A. I have no independent recollection, and having prepared for here, I can't tell you. I just don't know. I know the words were used. I do believe I left the meeting--I think I had an idea that they weren't stopping at the 25 that they told me about, that they were continuing to do some testing. There was some indication somewhere along the way, and I don't know if it was this early or later, that the 25 chosen might not have been random for some reason. In other words, they might not have been a randomized survey, that they might not give them a good idea of what conversion rates would be.

THE COMMISSIONER:

Q. Okay.

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MR. BOONE:

A. But I really don't know if I came up with that around this time or that was later.

THE COMMISSIONER:

Q. Thank you.

MR. BOONE:

A. So at that time, I certainly didn't know the extent, if you like, of the retesting program.

COFFEY, Q.C.:

Q. And here at the bottom of the first page of this memorandum, there's a reference to 16 out of the 25, and testing on 33 more patients. Go back up.

MR. BOONE:

A. Is that the last page?

COFFEY, Q.C.:

Q. No, actually, if you'll go back up to the first page.

MR. BOONE:

A. The last of the first page?

COFFEY, Q.C.:

Q. Right there.

MR. BOONE:

A. Oh, yeah, okay.

COFFEY, Q.C.:

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Q. For some reason it's grouped under May 17th, 2005, and I gather that's probably just a poor grouping of the information in question, but testing on 33 more patients found 25 converted to positive. So there was the initial 25, and by the time this was prepared, there was another 33. See that?

MR. BOONE:

A. Yeah.

COFFEY, Q.C.:

Q. And 12, as you point out, had been informed by their oncologist.

MR. BOONE:

A. Yeah, for what it's worth, I have no doubt that what's recorded here is more accurate, but my impression was 16 of 25.

COFFEY, Q.C.:

Q. Yeah, here, "Specimens collected from 25 initially tested as negative were retested and 16 came back -

MR. BOONE:

A. Right, and in my understanding at that point--again I can't quibble with what anybody else wrote because I'm only going on my recollection. My recollection was there had

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been 25 retested, 16 of those had come back positive, and of those 12 had been told. So the 12 was of the 16.

COFFEY, Q.C.:

Q. And that's certainly there, but there's another 33 apparently here, testing on 33 more, found 25 converted to positive.

MR. BOONE:

A. Yeah, I knew that at some point in time. I don't know if I knew that that date.

COFFEY, Q.C.:

Q. No, this is on--I'm talking about when you got the memo itself.

MR. BOONE:

A. I would have read it, but beyond that--it wasn't present to my mind on the 19th that that was another group. I didn't--I remember 16 of 25 was what I had been told.

COFFEY, Q.C.:

Q. And so in terms of best case scenario, you said there had been a reference in the e-mail. In this context, and bearing in mind what you were reading here, that meant what?

MR. BOONE:

A. Well, bearing in mind--if I can just put it

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together with this notion of best case scenario with what I'd been told on the 19th and with what I read here, what I'm taking from it, and again as a laypesron, I had only been introduced this whole notion within two days, what I'm taking from it is that although there had been conversions, if you like, and I'll use that term, anybody can call me on it if you like, although there have been conversions, that these conversions had occurred in retesting on Ventana, that that was somehow or other important in their decision making. What was going to be important was to get some indication as to whether or not it would be expected, for instance, if they retested the whole patient group, what would be the outcome, and that this was some indication to them that the outcome would be such that they wouldn't expect conversions or many conversions, I guess, or--I don't know if we could say "any", but essentially that because their positivity rates were within the expected positivity rates, because they'd run controls, because they did the test correctly, because they'd

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done all those things, that the expectation would be that there likely would not be many more conversions, but I have to say, though, that's my assessment. No one said that to me in that way.

COFFEY, Q.C.:

Q. And here the second last paragraph in the memorandum refers to Dr. Williams, his title.

MR. BOONE:

A. Yeah.

COFFEY, Q.C.:

Q. "Has also asked that an investigation be conducted into the five week stoppage of immunoperoxidase staining for ER/PR receptors in 2003 by Dr. Ejeckam".

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. Prior to getting this memorandum, a copy of it on the 21st, had you heard any reference to -

MR. BOONE:

A. I hadn't heard, but I read. Dr. Ejeckam's work, if you like, was not discussion on the 19th of July meeting, but I had read Dr. Cook's memo of May of '05 which mentioned--I

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can almost quote from it. I think he said something to the effect that in the spring of 2003 our point man on immunoperoxidase staining, Dr. Gershon Ejeckam, had stopped the staining for a period of time. So I was aware that that was out there and an issue, and that was in Dr. Cook's memo.

COFFEY, Q.C.:

Q. And you--and it didn't--you have no recollection of it coming up on the 19th itself during the meeting? I'm not suggesting it did. I take it you have no recollection of it?

MR. BOONE:

A. I don't remember. I think I might if it did, but I don't remember.

COFFEY, Q.C.:

Q. If it did.

MR. BOONE:

A. It came up later in later meetings.

COFFEY, Q.C.:

Q. Yes. Here there's a reference in the last paragraph to, "Dr. Williams has also asked if we could repeat any of the negative tested specimens again on the old DAKO System to

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confirm it was indeed the system and not a lab error", and Mr. Gulliver said it is unlikely we will be able to obtain such a system at this time to retest on that method. Had that come up on the 19th, do you know?

MR. BOONE:

A. No. Well, not within my recollection.

COFFEY, Q.C.:

Q. And again I don't want -

MR. BOONE:

A. I don't even remember it making an impression on me when I read this summary back at that time, and it didn't resonate with me.

COFFEY, Q.C.:

Q. What then happened? Up to the 21st, you had Ms. Predham's e-mail and you read the material she sent.

MR. BOONE:

A. If I recall correctly, when you say what next happened, the next thing that happened didn't involve me, but it was an event, I suppose of significance. I understood by some point--if I remember correctly, and I'm trying to remember the times, the 22nd was a Friday, that week.

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COFFEY, Q.C.:
Q. Yes, it would be.
MR. BOONE:
A. I had an understanding by the 22nd that there had been some meeting between or among officials from Eastern Health and officials from the Department of Health.
COFFEY, Q.C.:
Q. Uh-hm.
MR. BOONE:
A. And that at that meeting there was further discussion as to the question--discussion, because I don't know if they ever discussed it before, discussion about the question as to whether or not there should be a direct and broadbased communication to patients, and I'll use that as a shorthand for either a public notice or a general mail out, some kind of broad communication, that that had been the subject of discussion, but my understanding was that it was left inconclusive, and I got that understanding on the 22nd, I believe from Ms. Bonnell, but I'm not sure. On the 22nd, later in that day, I got a call from Denise Dunn, who is Dr. Williams' assistant, asking

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me to go to a meeting on the 24th on a Sunday morning, which stuck out with me because I don't go to many meetings on Sunday mornings.
COFFEY, Q.C.:
Q. And then what happened?
MR. BOONE:
A. I went to the meeting.
COFFEY, Q.C.:
Q. That's on the 24th, Sunday.
MR. BOONE:
A. Yeah.
COFFEY, Q.C.:
Q. Do you recall where that was and who was there?
MR. BOONE:
A. Yeah, the meeting was in--there's a large boardroom--at the Health Sciences Centre, the administration is based mainly in the basement.
COFFEY, Q.C.:
Q. Go ahead--I'm sorry, Mr. Boone, go ahead.
MR. BOONE:
A. The basement is where most of the administrative offices are, and there's a large boardroom in the basement and the

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meeting took place there.
COFFEY, Q.C.:
Q. And what do you recall about who was there? We do have--if it would assist, we do have at least some notes that were taken.
MR. BOONE:
A. Okay, that's fine.
COFFEY, Q.C.:
Q. If we could bring up, please--and this may be of some assistance because this is a larger group.
MR. BOONE:
A. Actually, I can tell you that because I can picture that meeting.
COFFEY, Q.C.:
Q. Okay, well -
MR. BOONE:
A. I remember a lot about that meeting.
COFFEY, Q.C.:
Q. Okay, without bringing it up, we'll see what -
MR. BOONE:
A. It's not a test, I know, but, I mean, just so I can tell you that this is my recollection. I remember that, well, obviously I was there, Heather Predham was present, Susan Bonnell was

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present and she had someone who I didn't know very well, if at all, from her Communications Department, whose name, I think, was Deborah Thomas, or maybe she had a married name as well. Dr. Williams was there. I recall George Tilley being there, the CEO, for some part of that meeting, but my recollection is not that he was there for the whole time, for what that's worth. I remember that Dr. Laing was there, and that was the first time I had met her, and I came to know that she was a medical oncologist. Dr. Kwan was there, and I didn't--I remember at one point in time I referenced him in a note or something as "Dr. Kwa". I actually had known who Dr. Kwan was by reputation, but I didn't realize this was the same man, that he was a surgeon. So he was there. I think that that's--no, Terry Gulliver was there, and Dr. Cook was there. So those were the people who were there.
COFFEY, Q.C.:
Q. Paul Gardiner?
MR. BOONE:
A. I don't remember Dr. Gardiner.
COFFEY, Q.C.:

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Q. You know who Paul Gardiner is?
MR. BOONE:
A. I've met him. I don't remember him being at that meeting. He may very well have been, though, there was a lot of people there. And I'm sure people in the room didn't know who everybody else was.
COFFEY, Q.C.:
Q. And your understanding in going to that meeting was what? What was the meeting to be about?
MR. BOONE:
A. Well going into the meeting, I had only had the conversation, if you like, I think it was a conversation on a voice mail with Ms. Dunn and I was only asked to go to a meeting about ER/PR, so that's what I went to, I went to a meeting about ER/PR.
COFFEY, Q.C.:
Q. Okay, and what do you recall about it?
MR. BOONE:
A. A fair bit actually, I recall a lot of the discussion--if I recall correctly, I don't recall anybody functioning really as a Chair at the meeting or anything like that, but I

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remember that Dr. Cook was called upon by Dr. Williams to speak to the testing, the immunoperoxidase testing as a process, and he did speak to to it and I don't know how much of the other people in the group would have had, you know, I'm sure each--people came with their own knowledge, but he spoke to the testing process. I recall, well one thing for certain I recall that he talked about at that time was that there was no standardization in North America for the performance of this test, that it wasn't a standardized test. I believe at that time and I don't know if this came from Dr. Cook himself or if somebody chimed in from the side, that there was this notion of unreliability in the test, and so that came up again during the course of that Sunday morning meeting. I think from that point then, I believe that there was a discussion about Ventana and this is the first time I ever really started paying attention to the change in platforms was the Sunday morning meeting. There was a discussion about Ventana and I believe that there was a suggestion made, I think it might have been by Mr.

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Gulliver that the move to the semi-automated or the move away from the semi-automated to the fully automated system was going to give better results, and that that discussion occurred. And I recall at a certain point in time at the meeting--and the sequence of events I don't recall, I just remember the various things that were said. Dr. Laing I remember having a discussion about a concern that she had that Ventana was overcalling positives, overcalling positivity rates, so what I took it to mean, again as a layperson trying to drink this in from the corner of the room, what I took it to mean was that she was saying that just because now we had DAKO results and we were getting Ventana results which appeared to show conversions, that we can't take it that they are true conversions, if you like, and that a concern would be that in fact the person who was on DAKO called negative, on Ventana called positive, might in fact have been really negative. And she expressed a concern at that time and this goes to the issue of notification because, of course, in the media that sort--things are

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balled up together, there's no specific agenda, there's no--nothing of that--so everybody is just talking about the issue. I remember one thing that Dr. Laing said at the time was that she was concerned that if they went to patients who had converted, if you like, from their DAKO test to the Ventana test and told them that they were then positive for ER/PR results, that they could then be either put on a treatment or taken off a treatment as a consequence of that and then if it turned out that Ventana was overcalling the positivity, that then you would have to go back to that patient and tell them, look, we've given you some kind of hope that you're going to be able to take a different treatment and you can't. And essentially she said, I remember her using the term "we'll be going around in circles and we'll be dashing hopes" and that she was really concerned about that. So then there was a further discussion about controls, I remember controls came up again, there was discussions about controls and I think this comes from the lab people, I don't know if it came from Dr. Cook or Terry

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Gulliver, but someone from the lab side of the fence, if you like, spoke to the fact that if you look at the reports, the pathology reports of ER/PR testing, you're not going to see controls referred to in all reports, but that that doesn't mean that they weren't read, that some pathologist had a practice of not reporting them and that we could take it, though, that controls were present in all cases, you know, which again gets back to this whole notion as to whether the test was accurate or not accurate. Then I recall Dr. Kwan, I didn't know at the time who he was, but it was Dr. Kwan who said a couple of things, one thing he said was that as far as he knew, ER/PR testing was really just a guideline and clinicians had to use their own judgment and I remember distinctly him referring to a case of an older woman who had had breast cancer and her systems could support chemotherapy and he essentially, although she was negative for ER/PR, he had nothing else to give her, so he gave her Tamoxifen and it seemed to help. I remember that description of the case on his part and I

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might be going into far more detail than you really -

COFFEY, Q.C.:

Q. No, no, what you can recall.

MR. BOONE:

A. This is it, unfortunately it's a lot, but -

THE COMMISSIONER:

Q. Not from my standpoint.

COFFEY, Q.C.:

Q. Not from the Commissioner's perspective.

MR. BOONE:

A. Really? Okay, all right. In any event, so I recall that discussion. I did recall that Dr. Kwan went--I think he went from that description to a reference to Dr. Ejeckam and what he said was, well, you know, we don't really know--sorry, what he said was "We need to know whether the new results we're getting are a consequence of an error in our old system or the consequences of the new system." And that's how he spoke to it and then Dr. Laing said something again about the overcalling the positivity because this was circling around the room. And a lot of these conversations weren't of the sort that were

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held to the whole room, I mean, some of these conversations were going down around the side of the room and this was a big meeting. And I recall that Dr. Kwan said, "Well we do also have the issue about Dr. Ejeckam's memos back in 2003 and whatever work he did, we need to find out about that." And Dr. Laing at the time, I don't know--I have to say in my recollection, I don't know if these things were directly connected, so I have to be careful about this, but Dr. Laing said "Back then we have tests that came back as negative and we suspected they shouldn't be negative and we sent them back for retesting and they still came back as negative", something along those lines, but again, I can't say that was directly connected to Dr. Kwan's comments or not. And then there became this further discussion about the fact that Ventana is so much better that the old system had forty some odd steps within it and that most of those were human steps and that the Ventana system took them away, and that as a consequence, the new system was going to give better results just by its nature because it was going to

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reduce the room for error and that discussion continued. And I don't think I remember anything else in a substantive part of the meeting, but I do remember the summing up, if you like, because there was a summing up at that meeting. And I don't remember at that time if--the only thing that George Tilley, in my recollection spoke to at the meeting, was that he felt that they wanted--because of Dr. Laing's concerns about Ventana, he wanted someone from Ventana to come down and assess what they were doing with the system. And then we got into essentially, well now we know all this, we've had all these further conversations, many which really were probably inconclusive, what are we going to do? And so Dr. Williams called for a plan and when he called for the plan, the first person that spoke was, in my recollection, was Dr. Kwan. And Dr. Kwan said there should be no public statements at this time, that we are getting closer and closer to concluding that what we are seeing is the benefits of our new technology; in other words, Eastern Health was going to get exactly what it had paid for, it

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was paying for a system that was supposed to be better, it got it. Then there was a--Dr. Williams at some point in time mentioned, and I think again he was addressing Dr. Laing's concerns about the Ventana overcalling. He said that they should duplicate conversions in an outside lab before they went back to the patients who had converted on Ventana. I don't think I really realized myself the significance of that at that time, but I think looking back on it, it meant that they weren't necessarily going to tell the people who had converted on Ventana if there were any left who hadn't been told

COFFEY, Q.C.:

Q. Hadn't been told yet?

MR. BOONE:

A. Who had not been told.

THE COMMISSIONER:

Q. I'm sorry, I missed who suggested that.

MR. BOONE:

A. Dr. Williams, he said it because I remember he said duplicate positive conversions, is what he said, which, you know, in the context of the meeting would have made sense because

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people were saying Ventana might be overcalling and then Dr. Laing had expressed this fairly significant concern about her patients and whenever I encountered Dr. Laing, she always spoke about her patients, you know, it always came from the perspective that she was speaking for concern for her patients and she spoke fairly strongly about the fact that she didn't want to put her patients in a situation where their treatment was going to be switched inappropriately or for an inappropriate reason. So I think what Dr. Williams was trying to do was to account for that concern on her part. But they were going to continue to retest was another part of the plan--sorry, not retest, they were going to continue to investigate, that was part of their plan. I don't know what retesting was going to take place, I don't have a recollection of any discussion of that on the 24th and that they were going to get someone in from Ventana, and that was the essential plan. Oh, and one other thing was that they were going to talk about, they were going to talk to other hospitals across the country to

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see what their experience was. So those were all the things that occurred in that meeting of the 24th--in my recollection.

COFFEY, Q.C.:

Q. Did Dr. Laing, do you recall explain the basis for her concern about Ventana overcalling?

MR. BOONE:

A. No, well she very well may have, I never--in never stuck with me if she did.

COFFEY, Q.C.:

Q. Because Mr. Gulliver was there as well on behalf of the lab and I take it you had gotten the impression from him, well the machinery is working properly, the technologists -

MR. BOONE:

A. Oh no, I think you're taking too much out of that because in fact, Mr. Gulliver was talking about DAKO, he wasn't talking about Ventana. Those comments that he made to me on the 19th had nothing to do with Ventana.

COFFEY, Q.C.:

Q. Okay, well at the 21st--the 24th, I'm sorry, this is a Sunday morning, when Dr. Laing is expressing this concern about the Ventana possibly overcalling, overcalling in the sense

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of showing too many positives or producing too many positives, was there any response from the technologists' side of the meeting, which would be Mr. Gulliver, about that, to address that?

MR. BOONE:

A. There may have been -

COFFEY, Q.C.:

Q. You don't recall and -

MR. BOONE:

A. Of course, and again, I don't want to give any kind of impression that the meeting was chaotic, but as big meetings around great big boardroom tables often transpire such that you have a lot of side conversations, conversations amongst small groups and those things happen.

COFFEY, Q.C.:

Q. Sure.

MR. BOONE:

A. You know, and so I really can't say whether or not there was any address by Mr. Gulliver of that or Dr. Cook.

COFFEY, Q.C.:

Q. You don't recall any and you're saying that's

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not to mean it didn't happen, Mr. Coffey -
MR. BOONE:
A. Absolutely not because that meeting, if I remember correctly, it was certainly more than a hour long, I don't know if it was two hours and quite obviously what I've just recounted for you can only be a part of what happened at the meeting, it's only what I remember.
COFFEY, Q.C.:
Q. What then happened, Mr. Boone? This is Sunday morning meeting ends, what's next?
MR. BOONE:
A. The next interaction, if you like that I had with Eastern Health on this issue was when I attended a meeting on the 27th and a similar meeting, if you like.
COFFEY, Q.C.:
Q. How is it you came to go to the meeting on the 27th?
MR. BOONE:
A. I don't remember. I really don't remember, I can't remember who called me about that meeting, I know I went to it.
COFFEY, Q.C.:
Q. Do you recall where the meeting was?

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MR. BOONE:
A. The same room.
COFFEY, Q.C.:
Q. And do you recall who participated in that meeting?
MR. BOONE:
A. I know you have minutes of that and maybe I'll ask you to help me with that one, mostly the same people. I think if I remember correctly the difference, some differences in that meeting. That's a meeting where I remember Dr. Gardiner being--although I hadn't remembered him being at the 24th and maybe I just mixed that up. I remember that Dr. Laing and Dr. McCarthy, Joy McCarthy who hadn't been at the previous meeting participated by telephone, they were either away somewhere or something like that and there was, you know, the usual speaker phone set up in the middle of the table and they participated. I'm pretty certain that George Tilley was not there at that 27th meeting. I think the other case of characters were all in attendance.
COFFEY, Q.C.:
Q. And the 27th would have been a Wednesday.

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Exhibit P-0513 please? These are the handwritten version of the notes, page 2 please?
MR. BOONE:
A. You're going to tell me there's a typed version.
COFFEY, Q.C.:
Q. Oh yes.
MR. BOONE:
A. Thank you.
COFFEY, Q.C.:
Q. You're listed there as the third person, Dr. Cook, Terry Gulliver, Deborah Thomas again, Ms. Bonnell, Ms. Predham, Drs. Laing, McCarthy by phone, Dr. Kwan, Mr. Tilley--his name is crossed out in the notes, Dr. Paul Gardiner and Dr. Bob Williams. Does that accord with -
MR. BOONE:
A. In all ways, including the fact that I don't remember George Tilley being there, so in fact, his name is crossed out is consistent with that and Dr. Gardiner was there, I know, so -
COFFEY, Q.C.:
Q. So what do you recall about this meeting?

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MR. BOONE:
A. The first part of the meeting was a discussion--I remember essentially three components to this meeting, if you like, that's how I conceptualize it in my recollection. The first was a discussion of data again, you know, this was the statistics on positivity rates. The second was a discussion on what other hospitals were doing across the country and the third was a discussion as to essentially well what should Eastern Health do, that's kind of the way I remember it. As to the discussion of the data, I remember that statistics were presented and I understood--I don't know why these were different from what had been presented on the 21st in that spreadsheet that you've seen and I've seen recounted in the summary, I don't know if further work was done on them or if they were approached differently, I just don't know, but--or if they included other years, other samples, I have no idea, but for some reason or another the statistics had changed to some degree and that these were being presented as new

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statistics. And the statistics that stand out in my mind were an average over five years, I think, and I don't know what five years they were, maybe '99 to 2004, I'm speculating there, though, an average of 73 percent. There was a discussion of a low of 62 percent but everything else was in the range. And then there was a discussion of the rates after Ventana came on stream, which I understand was some time in '04 and I think that might go to a point that you talked about earlier, whether or not there was a discussion about Dr. Laing's concerns about overcalling the Ventana, I'll come to that. So these things were occurring, so they were having these further discussions. So if you like, and again, this is my impression of how the people in the meeting were feeling, if they took assurances out of the statistics presented on the 20th of July, my impression was they took a greater assurance of what was presented to them on the 27th of July, for what it's worth. And then there was a discussion about what other labs were doing. I remember lots of hospitals being mentioned, Montreal General,

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Montreal Jewish, Sloan-Kettering, various hospitals were spoken of through the course of the meeting.

COFFEY, Q.C.:

Q. Who was providing that information?

MR. BOONE:

A. I remember Dr. Cook had called hospitals himself. I had some impression that Terry Gulliver had as well and certainly I remember him talking about it, about what other labs were doing. I don't know if that was because of recent calls or just some knowledge that he had. And something tells me and somebody else spoke to it, but I don't recall them having done an investigation and someone else, might have been Dr. Laing or someone knew what other labs were doing, but again, it's too hazy, so that kind of discussion was going on but the impression that came out of it, at least for me sitting as an observer and trying to take something out of this, a science that I truly didn't understand, the impression that came out of it for me was that St. John's was really doing nothing different than anybody else, that everybody is doing the same thing.

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I believe at that meeting, I'm not entirely sure, but I believe someone mentioned that somebody else had a problem in their lab somewhere but didn't do a look back, I remember that terminology being used. And "look back" I would take to be a retesting of the people who had had the test. And I recall in the meeting there was a discussion about this notion as to what it meant as to why Dr. Laing felt that the Ventana was overcalling. And I think it--I know it had to do with the statistics from '04 on, for positivity on Ventana. My recollection and the number might be wrong, was that it was something like 86 percent or something and I recall Dr. Laing saying that was too high. I wouldn't have had the parts, if you like, at that point in time to assess why she was saying that, but she thought that that was too high, which I again thought was consistent with her notion that they were overcalling the Ventana. I don't recall any response on the part of Mr. Gulliver at all to that, I just remember that was a further elaboration on why she thought that.

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COFFEY, Q.C.:

Q. And anything else about the meeting?

MR. BOONE:

A. The first two components of it, you know, as I've conceptualized, I've described to you. The third was well what are we going to do, and my understanding as to what we are going to do was Dr. Williams was summing this up at this point in time and again, this notion that we are getting closer and closer to concluding that what we are seeing, meaning the conversions in the earlier conversions, was the consequences of new technology, as opposed to something wrong in the manner in which we were proceeding before. And that there would be--there would not be any, again, some kind of a broad disclosure at that point in time and that--but they would meet, "they" being the group of people who were at that table, I suppose, would continue to meet. And when I say "they", I think mostly the scientific people, if you like, the people who truly should have had something to contribute to it, you know, the doctors and the techs and those people, they were going to continue to meet

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and continue to investigate and this was going to be going on for some time, that's my understanding.

COFFEY, Q.C.:

Q. Did you have any sense of the -

MR. BOONE:

A. No, actually there's one other thing I should say.

COFFEY, Q.C.:

Q. Yes, fine.

MR. BOONE:

A. The only other thing that came out of it in my recollection was that retesting was ongoing on Ventana at that time and -

COFFEY, Q.C.:

Q. Using the Ventana.

MR. BOONE:

A. Using the Ventana and, because it was being done in St. John's and of course, they only had Ventana at that time, DAKO was gone. And Terry Gulliver said that in two to three weeks, they would have all the retests done, you know, which again was some indication as to when they could act or when they'd act or something like that. That was as much as I

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remember.

COFFEY, Q.C.:

Q. This is -

THE COMMISSIONER:

Q. Excuse me, at this phase was your understanding of what all the retests meant any greater than it had been before, or did you even think about what they were talking about when they said they would have them all done?

MR. BOONE:

A. I had no real good perception as to whether or not they were retesting, you know, I can use these terms now because I know, '97 to 2004, '97 to 2003, all negatives, all positives, I just didn't know. Retesting was going to continue, that was what I remember.

THE COMMISSIONER:

Q. All right, thank you.

COFFEY, Q.C.:

Q. This is Wednesday, July 28th and according to the note here, it's a conference call beginning around 5 p.m. in the day which is towards the end of the day.

MR. BOONE:

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A. Well it wasn't a conference call.

COFFEY, Q.C.:

Q. No, I appreciate it wasn't a conference call, it's styled here on the particular note, I should take it the conference call aspect probably refers to Drs. Laing and McCarthy.

MR. BOONE:

A. Oh sure, it says there by phone.

COFFEY, Q.C.:

Q. But Mr. Boone, by the end of that meeting, on Wednesday the 27th, had you heard anything about Bev Carter?

MR. BOONE:

A. Yes, because in that meeting I remember--she wasn't there, but I remember Dr. Williams recounted a conversation that he had with Dr. Carter where she mentioned--I'm trying to remember, she mentioned a statistical range of 68 to 80 percent. I think that was in reference as to what they should be achieving, as opposed to what anybody was achieving. That's the only thing I heard about Dr. Carter.

COFFEY, Q.C.:

Q. That was it, so the idea that she might have

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been about to embark or having embarked upon a large scale examination of what had gone on before or looking at the old slides and results and so on, and the Commissioner has heard evidence of this, Mr. Boone, so I just want to ask -

MR. BOONE:

A. I have a vague recollection of someone saying that Dr. Carter had sent slides somewhere, but if you're saying large scale, it doesn't accord with my recollection because I remember some talk of five slides out somewhere.

COFFEY, Q.C.:

Q. Yes, and we've heard about evidence that she sent some slides to Mount Sinai.

MR. BOONE:

A. Yeah, I don't remember anything else, that's it.

COFFEY, Q.C.:

Q. But in terms of, kind of there's a large scale review set out in a letter in mid July, just to let you know this, okay, it's referred to, it's in an exhibit here, the Commissioner has heard of it, and she spells out what she--her plan of action, as it were and I'm just asking

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you, you have no recollection of that ever having been brought to your attention during this timeframe?

MR. BOONE:

A. I can't say it wasn't and again, these are long meetings and what I've described to you is really probably snippets that I happen to recall as being significant.

COFFEY, Q.C.:

Q. Do you think you would recall if you had been told, like in these early meetings, look, there's a large scale review going on by a local breast pathologist, do you think -

MR. BOONE:

A. I can't say whether I would or wouldn't have, I really don't, you know.

COFFEY, Q.C.:

Q. Because again, there's no suggestion -

MR. BOONE:

A. You have to remember that this is the 27th and the first I heard of it was the 18th of July, I never knew anything about the science, so in nine days, I don't think I would have enough appreciation to really know what was important. When I considered something to be

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important, it was because somebody else attached an importance to it, you know, if you like, because I would have had no other basis upon which to do so.

COFFEY, Q.C.:

Q. And did the topic come up, up to this point, at the end of this meeting or prior to this, did the topic come up, well why are we using the Ventana to use the retesting if there's a concern about the Ventana?

MR. BOONE:

A. I don't recall it coming up.

COFFEY, Q.C.:

Q. What then happened, Mr. Boone?

MR. BOONE:

A. That was the 27th of July. I had one--if you're asking what then happened -

COFFEY, Q.C.:

Q. Yes.

MR. BOONE:

A. I presume you're asking what then happened that involved me.

COFFEY, Q.C.:

Q. That involved yourself, yes--or that you were informed of that had some relevance to you.

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MR. BOONE:

A. Right, well let's put it this way, my next interaction with Eastern Health on the ER/PR issue, which I think is probably what you're asking for, was on the 19th of August of '05 and I have, I can tell you that I have no independent recollection of this having occurred, but my file tells me it did. I had a telephone call, I believe it was to Heather Predham. I'm a little troubled by it since I heard some of the evidence because I understand that Ms. Predham might have been on holidays during some of that time, but at some point in time on the 19th of August, I spoke with Heather Predham by way of an update and in that update, she told me a couple of things. She said that all of the tests, all of the samples I think, I can't remember the terminology that was used, all of the samples were going to be resent out to Mount Sinai for retesting--an outside lab, I don't think she said Mount Sinai. So an outside lab was going to look at all the test samples, I didn't get any definition from her as to what period of time or anything, but I presume they negative

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samples, I made that assumption. She told me that they were also trying to get an appreciation on or starting to get an appreciation of how many of the people who had been determined on testing to be negative were already started on Tamoxifen, which would have been consistent with my recollection from earlier discussions that the ER/PR testing is only a guideline, if you like, or doesn't determine treatment, so that some people would have gotten Tamoxifen even though their ER/PR test might have been negative. I would have known that at that time, so she was telling me they were trying to get a handle, effectively, on how many people who were negative were already on Tamoxifen. And the third thing she told me at that time was that the Department of Health or the Minister of Health, I can't remember what she said, was continuing to apply pressure, and I would have taken this to mean from the 21st of July, that was the only other interaction I knew, continuing to apply pressure on the corporation to make a public disclosure, but the corporation resisted it on two grounds. One that there was nothing to

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report and I'll describe that for you in a second, and the other was that the oncologists felt that their patients would be too stressed by such a disclosure. And when she told me that there was nothing to report, I think what that meant and maybe I'm thinking too much, but I think what that meant was there was nothing to report to individual patients until the results came back. So I think that was less to do with a broad-based disclosure than an individual discussion with patients, but that with respect to the overall public disclosure, that the corporation--and I wrote it that way in a place where I wrote it, that they would--they had resisted the Minister's overtures in respect of disclosure because mainly this ground that their patients would be too stressed by it. The oncologists felt their patients would be too stressed by it. That was a phone call, that was it, I can't imagine how long it was, I don't remember if it took place in my office, somewhere else, I have no idea.

COFFEY, Q.C.:

Q. And so then from the 27th of July to the 19th

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of August, in terms of your own interaction with, in relation to this ER/PR matter, there was nothing else that you recall, in terms of this whole disclosure issue that you can recall?

MR. BOONE:

A. I think you've asked a lot of questions in one. Maybe you should -

COFFEY, Q.C.:

Q. I appreciate that, but the disclosure issue in terms of the disclosure to the patients or disclosure to the public, because -

MR. BOONE:

A. I'll tell you, I'll put it to you this way because maybe it's the easiest way to answer your question, from the 27th of July until the 19th of August, I had no interaction with Eastern Health on any aspect of the ER/PR issue.

COFFEY, Q.C.:

Q. Okay, well on that and at the end of the meeting on the 27th of July of 2005, your understanding was what in relation to informing the patients about this or informing the public about this, going away from that

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meeting?

MR. BOONE:

A. Going away on the 27th, my impression would have been that they were still thinking about it because this was part of the work that was going to done, I mean, the impression I had through these meetings, if you like, was that this was going to be--they were going to stick with this until it got done, whatever got done meant and that these people were going to work, these people at Eastern Health were going to work through this, that amongst the things that they were working through were essentially the investigative aspects of the case and the question of disclosure and communication. So I would have taken it that they would have continued to discuss that after the 27th. But on the 27th, the main thing I took away from that was that they weren't going to be disclosing at that time, mainly because they felt that they were seeing really the results of new technology.

COFFEY, Q.C.:

Q. And if we look, please, at Exhibit P-0936? This is an e-mail of July 28th which is the

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next day, 9:50 a.m.

MR. BOONE:

A. Oh yes, okay, I remember this.

COFFEY, Q.C.:

Q. And this is Ms. Predham's e-mail to, original e-mail to Mr. Gulliver and Dr. Cook and Dr. Williams and this is talking about "trying to get the results for the time we ran both the DAKO and Ventana".

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. So she sends it on to yourself and others saying, "This is for your information".

MR. BOONE:

A. I do remember this. I just breached a rule, I always tell witnesses not to be so definitive because actually I did have some interaction on the 28th of July, by the look of it. But I do recall this e-mail and getting a copy of it, yes.

COFFEY, Q.C.:

Q. And you understood you were being sent this why? What was your--just to be kept apprised?

MR. BOONE:

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A. Information.
COFFEY, Q.C.:
Q. Information. If we could, Exhibit P-3465? And this, in fact, apparently she forwarded it again to yourself, directly.
MR. BOONE:
A. Yeah, it looks like it.
COFFEY, Q.C.:
Q. And Exhibit P-0934? And this is, just to put it in context for you, Mr. Boone, this is an e-mail of July 28th, 2005 at 2:43 p.m. from Ms. Predham to, well yourself and others, referring to having discovered a website and an article and then there's another e-mail later on in the same day to yourself and others, same group, 3:36 p.m. indicating she had tried a phone number and got a recording saying it was out of service.
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. This would be UK NEQAS, I suspect.
MR. BOONE:
A. I think that's right, I believe that Ms. Predham was looking for resources to assist in

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understanding the test--the possibility of testing errors, that kind of thing. I would have had my own obvious interest in that kind of thing--resources of that sort.
COFFEY, Q.C.:
Q. And so there was some information forthcoming from Ms. Predham on the 28th to yourself. Were you aware of whether or not HIROC had provided any, was, you know, after the 27th provided any information to Ms. Predham in relation to this whole disclosure, patient disclosure, public disclosure issue?
MR. BOONE:
A. I'm not aware of it and in fact, I'd be--I'd have to say that I'd be certain that it didn't occur because if it occurred, I would have known about it. I mean, I'm basing that only on the practice that we had amongst ourselves that it would have been unusual for HIROC to have a direct communication once I got involved with the subscriber that didn't involve me.
COFFEY, Q.C.:
Q. And we're up to August 19th and in effect, I've got to sum up, you've told the

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Commissioner you were told on the 19th of August that, by Ms. Predham, that Eastern Health had made a decision up to that point not to accede to the request by the Department or views of the Department in terms of patient disclosure?
MR. BOONE:
A. I don't know if it was patient disclosure. My impression was, I'll call it a broad disclosure which would be people who hadn't converted and the public generally. That was my understanding, I didn't think it had anything to do with patient disclosure.
COFFEY, Q.C.:
Q. And in terms of people, in the meantime, up to and including the 19th, what was your understanding at that point, in terms of patients who did convert? I'm trying to get some sense for the Commissioner because going off on the 27th -
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. There was no real mention of Mount Sinai.
MR. BOONE:

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A. Right.
COFFEY, Q.C.:
Q. In a mass retest.
MR. BOONE:
A. No, but there was some kind of mention of it, again, you know, I think I pieced this together in looking back at the history of the file at the time. At the time, in the summer of '05 and certainly for some time after, I was of the view that patients who converted were told essentially right away. But when I look back and think about the fact that, you'll recall on the 24th of July that Dr. Williams had indicated that because of the concerns about Ventana about wanting to duplicate conversions before people were reported to, that presumably there was some working being done to duplicate those conversions, leaving aside whether there was going to be a mass retesting and I would then presume that they would have reported to the patients, but that's all speculation and presumption on my part. I had no direct knowledge.
COFFEY, Q.C.:

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Q. So, Mr. Boone then, you know, what's your next recollection then of your involvement?
MR. BOONE:
A. My next recollection is the 26th of September of '05.
COFFEY, Q.C.:
Q. Okay, and I'll take that up with you in a second.
MR. BOONE:
A. And before we go there, could I ask you when you take your morning break? Because I don't know.
COFFEY, Q.C.:
Q. Usually around 11:10-11:15, but we can break earlier if you -
THE COMMISSIONER:
Q. If you'd like to have a break now?
MR. BOONE:
A. I'd like to, if we could. It doesn't have to be now, but I mean, you can go -
COFFEY, Q.C.:
Q. Okay, there's just one -
THE COMMISSIONER:
Q. We'll break at 11.
COFFEY, Q.C.:

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Q. Yes, if that's okay?
MR. BOONE:
A. That's fine, yeah.
COFFEY, Q.C.:
Q. Because this'll--that'll be convenient. Mr. Boone, I wanted to ask you then, from your perspective, by September of 2005, what, if any, input had you provided to Eastern Health in relation to whether or not patients should be told about the fact that they were being retested, whether the public should be told about it? Had you provided any input into that?
MR. BOONE:
A. Yeah, I think so. The one thing I do recall in that process, and I definitely recall, was back on the 19th of July when Dr. Williams asked me whether I would be comfortable with the decision they made to wait for a couple of days, and I said yes. That was an input, if you like, into the decision.
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. Beyond that, I don't recall ever being asked

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by Eastern Health whether they should--for any advice on the question as to whether they should notify patients or make a broad disclosure or anything of that sort. I wasn't asked, certainly not asked formally, and as these things occur, I may have had informal conversations with people and if anybody says they did, I couldn't say that I didn't, but I don't recall it. I certainly do not recall any kind of conversation about that. I went to meetings, I observed them make their decisions. I wasn't asked for input at the meetings, and I walked away from the meetings with some impression as to what they were doing.
COFFEY, Q.C.:
Q. And you don't recall being asked and you don't recall offering as well?
MR. BOONE:
A. No.
COFFEY, Q.C.:
Q. Okay. All right.
THE COMMISSIONER:
Q. Do you want to take the morning break?
COFFEY, Q.C.:

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Q. Yes, if we would then, Commissioner.
MR. BOONE:
A. Sure, thank you.
THE COMMISSIONER:
Q. Sure, we'll take 15 minutes.
(BREAK)
THE COMMISSIONER:
Q. Please be seated. Mr. Coffey?
COFFEY, Q.C.:
Q. Thank you, Commissioner. Mr. Boone, you were about to tell the Commissioner then about your next involvement in this. I believe it was in September?
MR. BOONE:
A. It was, September 26th of 2005 was the next time I was involved in the file of ER/PR.
COFFEY, Q.C.:
Q. And what do you recall about that?
MR. BOONE:
A. I had a phone call from Heather Predham at my office. It was essentially by way of update. This is what's been going on. This is what is going on. The most important thing I took from her discussion was that there were 300 samples that were due back from Mount Sinai

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the next day. So then I would have known that the outside lab they were sending to was Mount Sinai. 300 samples were due back the next day, that was the first batch. She told me that they had a quality review done or were doing it. I can't remember which it was, but that was part of what they were doing, but Heather and I know that--Heather knows that I have a practice that I don't look at quality reviews. I don't want to know what they are. I don't want to know what they say, so she wouldn't have told me anything about what was going on in respect of that, although at one point in time, I did ask her for the terms of reference, just to get an idea for retaining our own experts.

But she told me that--I think that was most of the information that she conveyed to me at that time, and the most important thing was the 300 samples were due back, retested samples due back from Mount Sinai the next day. So I did nothing further and just took that information.

COFFEY, Q.C.:

Q. And then?

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MR. BOONE:

A. And then. The next thing that happened was on the 27th of September, I don't know how it came to be, but I went to a meeting at Dr. Williams' office at 4:00 on the 27th of September. I don't know how that meeting came to be set up. I don't know who called me for it, but I went to the meeting, and at that meeting, they gave me information on the retests, if you like. Most of it was by Dr. Williams. Heather Predham was there, but my recollection is Heather wasn't there the whole time and I don't know if that meant she came late or left early. I don't remember. It wasn't a very long meeting in any event, and it was one of many meetings that Dr. Williams was having that day, as I understood it.

The information imparted to me at that time was that rather than 300 samples having come back from Mount Sinai, 73 had been returned or I don't know if I'm using the right terminology. They had gotten back 73 retests from Mount Sinai. Of the 73 retests that they had had returned to them, I remember these numbers, 41 people had been confirmed as

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being negative. 20 of the people had conversions which were considered to be significant at that point in time, and I might be able to describe that by describing the next number. The next number was 12. Dr. Williams told me there was 12 people whose test results had changed or there had been conversions, I guess, but of those 12, he had some information from Kara Laing, Dr. Laing, that they would have been already on Tamoxifen, so those 12 people. So effectively there were 20 people of the 73 test results that had come back who appear, on the basis of Mount Sinai testing, to have been qualified for Tamoxifen, but were not on it.

COFFEY, Q.C.:

Q. And so was there anything else at the meeting?

MR. BOONE:

A. Yeah. Dr. Williams discussed--because throughout at least the meetings that I went to, and I understood that--because I understood that once I left that meeting on the 27th of July (sic.), that activity didn't cease in respect of ER/PR. When I left that meeting on the 27th of July (sic.), there was

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a lot of really concerned people. There were health care professionals who were trying to work through this really significant issue that appeared to be then one that could affect their patients in a great way, or it might be nothing, and they were trying to work their way through this when I left them.

One of the issues, of course, that they had in front of them was the question as to whether to tell patients, whether to tell the public, whether to tell--to give a broad-based disclosure, all these things. So that came up in the discussion with Dr. Williams and what he told me was that on the 27th, he told that his plan or at least a plan, I don't know if it had been approved by anybody, I don't know who would have to approve it, was to have a public announcement of the fact of the retesting and whatever they would put in there about what the results were at that time, and that further, that the plan for telling the people who had retested would be by amended pathology reports or addenda to pathology reports that would be then sent to the treating or attending physician for the

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patients who had converted. So that was essentially the two parts of the plan, if you like, as at that time, that was the 27th of September.

COFFEY, Q.C.:

Q. So you understood a public announcement about the fact that retesting was going on?

MR. BOONE:

A. Mr. Coffey, I got to say, a public announcement. I don't know what it was going to entail.

COFFEY, Q.C.:

Q. Okay.

MR. BOONE:

A. But certainly, you know, one would expect it would say that there had been retesting, that there might be a problem, and you know, all the things that you would expect someone to put in that kind of a public announcement would have been what would have been in mind, but that was Dr. Williams' plan himself. If he was entitled to make a plan, I don't know, but that was what he wanted to do, those two things.

COFFEY, Q.C.:

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Q. And addendum reports would be prepared for which patients?

MR. BOONE:

A. The patients, well, I guess of the group that he had discussed with me, it would have been--and I don't know if it would have been the 20 or the 32, you know, whether it would be all patients who had converted or patients who had converted where there was no obvious--where there was an obvious need for reconsideration of treatment. I don't know which one of those were going to get these addenda reports or amended reports.

COFFEY, Q.C.:

Q. And did you provide any input at that time?

MR. BOONE:

A. Yeah, I told him that that seemed to be a good thing to do, and that's about as far as it went, but I mean, there was nothing on which to comment at that time because there was nothing presented, in terms of a formal plan, but certainly I supported him in that. Dr. Williams, I recall what Dr. Williams was saying at that time was that a lot of the, if you like, dead ends and wrong roads down which

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they might have gotten over the summer had not proved in any way fruitful and what they were faced with was something that, I think he characterized it as a serious problem, and that people must be told, and that made perfect sense to me.

COFFEY, Q.C.:

Q. And by serious problem, in the context, you understood that meant what?

MR. BOONE:

A. An issue that needed to be explained, if you like. You know, in fact, there were going to be conversions is what he was saying to me. This is--he wasn't expecting that this 20 of 73 was going to be other than representative of what was to come, and that therefore, represented a serious problem. It didn't mean that it was all their fault or it was all their mistakes. That's not what he was talking about. What he was saying to me was that we now have a situation where we have 20 of 73 or 32 of 73, if you want to look at it that way, and I think what Bob, or Dr. Williams, was suggesting was that his anticipation was that that kind of ratio

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might, in fact, hold, and that would then have changed the view, for instance, that it was only Ventana or the update or upgrade to Ventana that explains it or those kinds of things, because I had understood, at least by that point, that Mount Sinai was testing on the DAKO platform. So all of those things were indicative of the fact that it was something that needed to get out, and he was of the view that it should.

COFFEY, Q.C.:

Q. I take it then, and you just referred to your understanding that, even at some point, that Mount Sinai was using the DAKO platform.

MR. BOONE:

A. Yeah.

COFFEY, Q.C.:

Q. Do you recall when you first learned that?

MR. BOONE:

A. No. No, I mean, it couldn't have been early because early there was no Mount Sinai testing, and I don't know when it--it might have been mentioned as an ancillary point somewhere along the way, because people talk what other hospitals did, but I don't recall

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anybody specifically telling me that, until the results came back.

COFFEY, Q.C.:

Q. And I take it then, bearing in mind Mount Sinai was doing the retesting and reporting the results and Dr. Williams was telling you that Eastern Health was acting upon those results, in terms of dealing with the patients?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. That this serious problem, you recall him describing it as, would not be attributable to the change in platforms per se?

MR. BOONE:

A. I don't recall if he said that or I just presumed that that was--you know, that would have followed naturally for me from the discussions I'd overheard in the summer, so I can't really say that Dr. Williams said that.

COFFEY, Q.C.:

Q. What then happened? Anything else--first of all, anything else -

MR. BOONE:

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A. I wasn't there very long, because you know, Dr. Williams, as you can imagine, had more people to deal with than me, at that point in time.

COFFEY, Q.C.:

Q. Anything else in that meeting of September 27th?

MR. BOONE:

A. Do I?

COFFEY, Q.C.:

Q. Anything else in the meeting of September 27th that you can recall?

MR. BOONE:

A. Nothing that was significant.

COFFEY, Q.C.:

Q. Okay.

MR. BOONE:

A. I mean, that was the most significant things was the results came back with an unexpectedly high rate, if you like, of conversion. That meant that the other things that they considered as being potentially causing the earlier conversions were not accurate, and that somebody--people have got to be told about this, and that was Dr. Williams' view at

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that time, and my understanding was when he said public announcement, it would either be a media release or a briefing or something like that, but I don't know a lot about that stuff. But that's what he was anticipating would occur from the 27th.

COFFEY, Q.C.:

Q. Now had you, up to that point, ever been shown--in your dealings with Eastern Health, had you become aware that they had, back in the summer apparently, prepared draft press releases?

MR. BOONE:

A. As I think I mentioned to you when I talked about the meeting of the 19th, I knew they were working on things of that nature, you know, and it doesn't take much of a leap to think that if they're thinking about how to communicate, they'd be looking at press releases, letters, you know, all kinds of things. There was some work being done in that area, and I was aware of that. Whether that work included draft press releases, I wasn't aware of that, but I think, you know, it would have been a fair assumption to have

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made.

COFFEY, Q.C.:

Q. That was back in the summer?

MR. BOONE:

A. In July, yeah.

COFFEY, Q.C.:

Q. In July, and how about letters to the patients, individual patients?

MR. BOONE:

A. I don't recall that being discussed. I can't say it wasn't, but I don't recall. And when you say the patients, what patients?

COFFEY, Q.C.:

Q. Well, the patients who were to be retested.

MR. BOONE:

A. No, I don't recall that. I can't say it wasn't happening though because no one shared it with me, you know, and there was work being done in that area.

COFFEY, Q.C.:

Q. And on the 27th of September, did Dr. Williams, do you recall, indicate to you that he had some knowledge about, or had reason by then to believe that he knew something about the reasons for the problem?

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MR. BOONE:
A. No, we never had any -
COFFEY, Q.C.:
Q. Okay, and just in the context here, we do know that Dr. Banerjee had come and gone by that point. Ms. Wegrynowski had come and gone by that point.
MR. BOONE:
A. We had no discussion of that sort.
COFFEY, Q.C.:
Q. But he didn't intimate to you, "look, Dan, I know -
MR. BOONE:
A. No, what I took to mean when he said serious problem, was not a serious problem because we've made all these mistakes in the past. It was a serious problem because we have had now a ratio of conversions which would, to anybody, be unacceptable, and he expected that to hold through in what was going to come. That's what the serious problem was.
COFFEY, Q.C.:
Q. What happened then? What's next?
MR. BOONE:
A. The next thing that happens for me, I don't

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remember the days of that week, so I don't know when the 27th was. So I had this meeting with him at 4:00 on the 27th. The next thing that happened for me was I became aware, on the 29th, I think, was the Friday -
COFFEY, Q.C.:
Q. 30th actually.
MR. BOONE:
A. 30th, was it?
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. Okay. On the 30th, that there was going to be some kind of press coverage of the issue, and that was the next thing I heard. I believe I heard that from Heather Predham and Susan Bonnell or one or other of them told me that on the 30th, that this was coming.
COFFEY, Q.C.:
Q. And do you recall anything else about that?
MR. BOONE:
A. No. No, I mean, it was information to me and I was grateful to have it, I suppose, but they had a lot more to do than worry about me, you know, so that was as much as they communicated

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to me, this was coming.
COFFEY, Q.C.:
Q. Were you asked for any input in relation to that? Like any contact that Eastern Health was having with the media concerning that at that time?
MR. BOONE:
A. No, I don't recall. No, certainly not, I wasn't.
COFFEY, Q.C.:
Q. And what then do you recall, Mr. Boone?
MR. BOONE:
A. Well, The Independent story came out, of course, and there was a lot further press coverage as well over that period. So in the next two-week period or more, I think the Sunday would be the 2nd of October, I guess.
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. So in that two-week period until, you know, Sunday two weeks hence, there was a lot of continued coverage, both in The Independent and other media. I remember there was NTV stories, CBC stories. There were CBC national

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stories, national radio stories at least. There was television coverage. The Telegram covered it. I remember there was coverage then because--and when I say I remember this, at some point in time during that period, I think someone sent me some of the press clippings, and that someone would have been someone from Eastern Health communications, I take it. So I could see that there was a lot of press coverage during that period, and I remember even some of the R & B papers outside of St. John's had stories. There was a lot of stories. It was a lot of coverage, and I saw a lot of them myself, of course, as well.
COFFEY, Q.C.:
Q. And what then happened, in terms of your involvement?
MR. BOONE:
A. The next thing that happened with me, I can't remember if it was the 5th or the 6th of October offhand, but you'll be able to tell me because you have an exhibit that relates to this, I think, is there must have been some discussion at Eastern Health that they expected--I'm going to speculate for a second,

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if you permit me to. I presume that what they were doing was contemplating or speculating that physicians were going to get questions from patients, and as a consequence someone must have decided to send a letter to physicians, and I was asked to review that. I don't recall if that date was the 5th or the 6th.

COFFEY, Q.C.:

Q. And did you do so?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. And did you respond to it?

MR. BOONE:

A. I did. I'm pretty certain you have my e-mail in evidence.

COFFEY, Q.C.:

Q. Yes.

MR. BOONE:

A. So do you want to pull it up?

COFFEY, Q.C.:

Q. Yes, and I'll -

MR. BOONE:

A. I'll tell you what I was saying.

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COFFEY, Q.C.:

Q. If we could, please, Exhibit P-2589? And first of all, this is--it's a series of e-mails, but the first of them, in the line here, is one of October 5th, if we could, 2005 from Dianne Smith to a number of individuals within Eastern Health. The subject is ER/PR notification, and "forward on Pat's behalf, please review attached once more, and provide your comments and/or changes."

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. And then the same day, "once more, please review this copy. Disregard the previous message," and then there's an e-mail from Ms. Predham to various individuals on the next day, October 6th, saying "looks fine, except that I think the word 'Tamoxifen' is missing twice. I added it to the attached. It mightn't be Tamoxifen but a word is missing. Also we refer to the lab three different ways, St. John's Pathology lab, immunohistochemistry service and Eastern Health lab. Does that matter? I'm picky this morning. Dan wanted

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to see it before it went out, so I sent it to him as well." Do you recall communicating to Ms. Predham that you wanted to see this letter to physicians?

MR. BOONE:

A. I don't recall it, but obviously I did.

COFFEY, Q.C.:

Q. And why would you have wanted to see that?

MR. BOONE:

A. I think, Mr. Coffey, I'm not going to be facetious here, but anytime a client wants to put words together in a sentence and send them to somebody else, lawyers like to stick their nose in it. I mean, quite frankly, that's the best that I can put it. You know, if people-- I would want to look at it to make sure that, from our perspective, I would have considered it to be accurate based on what I knew, and that's about the best I can say.

COFFEY, Q.C.:

Q. And here's the draft itself. It's dated October 4th, 2005. It's stamped "draft". I take it this is the letter that accompanied that e-mail to you?

MR. BOONE:

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A. Yeah.

COFFEY, Q.C.:

Q. And if we could look, please, then at P-0088, and this is a series of e-mails of October 6th generally.

MR. BOONE:

A. Yeah, and mine is part way down the page.

COFFEY, Q.C.:

Q. Yours is there towards the bottom of the page here. At 9:52 a.m. you've written an e-mail to Ms. Predham, and it reads, "As per my voice mail of concerns with referring to a quality review in correspondence, and with characterizing the retesting of samples as part of the quality review, as I understand it, the retesting was done from a patient care perspective. I also would like to reconsider the necessity of referring to that one patient whose test results started it".

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. And if we could go back then because it might help in asking you about your remarks there. P-2589, please, this is the letter itself.

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Could you tell the Commissioner then what concerns you had?

MR. BOONE:

A. Okay. I'll take them backwards from the way I recounted in my e-mail, if you like. In the third paragraph, it says, "Recently a patient initially tested in 2002 with the DAKO System was reported as ER/PR negative and converted". I expressed a concern as referring to that person who later became known, or maybe earlier, as the index case. My concern there really, frankly, wasn't legal. That person was a person who was a member of a family, of a doctor, fairly well known, and I was just concerned that if we didn't need to put it in there, why would we, because people--the letter was going to doctors, people in the medical community. So it wasn't a legal concern at all, it was more a concern for Dr. Dean and his family, I suppose, if you like. Whether I'm entitled to have that concern, I don't know, but I was. The next thing was the question of referring to quality review at all, I think was the next part of it I said.

COFFEY, Q.C.:

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Q. Yes.

MR. BOONE:

A. I think that the Commissioner has struggled with this throughout the course of the hearing and lots of people had to deal with it, but the notion of what to do with quality reviews how protected they are and all those kinds of things, is obviously a matter that we're all going to have to deal with going forward, but from my point of view up until that point in time, I was always of the view that if a quality review was done, it wouldn't be spoken of as such to people except for the people who were going to get the reports, the results of it. I don't think much turns on it, but it just was a practice and a recommendation of mine in the past. The third thing that I mentioned was I didn't agree, if you like, and "agree" is too strong a word, I didn't understand that what they were doing when they sent their test results to Mount Sinai was quality review. It had a quality review element, if you like, because they were hoping that the end result of it was going to tell them whether or not they had a problem in

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their previous tests, but it was mainly done in respect of the care of the patients. That's why they did it, and again back to the meetings that I attended, I remember that was all they cared about, let's find out if our patients need changes in tests. So to me, that wasn't--that didn't bear the hallmarks of what one would call a quality review, and I just said what I said.

COFFEY, Q.C.:

Q. And what then happened? Actually, I'll go back perhaps to assist you, P-0088. Here this is a e-mail at the top here--actually, here on October 6th in the middle of the page at 9:52 is your e-mail to Ms. Predham.

MR. BOONE:

A. Yeah.

COFFEY, Q.C.:

Q. The one we just looked at, and then there's another e-mail here, the same day, 10:14 a.m. from Ms. Predham to Ms. Pilgrim and Dianne Smith. She writes, "Here is Dan's feedback. I figure we might as well say quality review since Dr. Williams has been saying it all along. How about this, "Recently it was

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discovered that samples tested in 2002 with the DAKO System and reported as ER/PR negative, were retested with the Ventana System, and now reported as ER/PR positive. A summary search indicates Tamoxifen may benefit a patient up to ten years after diagnosis. It was felt important to retesting all samples determined to be negative for ER/PR", and then she says, "I checked with Dan. He's okay with this". Do you recall that?

MR. BOONE:

A. I don't recall it, but it's obvious what she says.

COFFEY, Q.C.:

Q. And what, Mr. Boone, then happened?

MR. BOONE:

A. What then happened from my perspective, and I keep emphasizing that -

COFFEY, Q.C.:

Q. I appreciate that.

MR. BOONE:

A. I don't know everything--I shouldn't smile. The next thing from my perspective is I was called to a meeting with Dr. Williams on October 6th of 2005, and that meeting took

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place in his office, but it wasn't to be just with Dr. Williams. Heather Predham was there for part of it, but I don't think all of it, but the purpose of the meeting was so that Dr. Williams and I could speak to Peter Browne on the phone, which we did.

COFFEY, Q.C.:

Q. And that relates to the ER/PR matter?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. Okay, are you able to discuss that -

MR. BOONE:

A. I don't know. Mr. Browne was part--it was a conversation between two lawyers with a client present. I'm in your hands, the Commissioner's hands, and Mr. Browne, as to whether I can or can't.

THE COMMISSIONER:

Q. Mr. Browne, do you want to (inaudible).

BROWNE, Q.C.:

Q. (Inaudible) involved an individual patient.

COFFEY, Q.C.:

Q. Oh, okay.

BROWNE, Q.C.:

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Q. That's the issue that Ms. Predham talked about.

THE COMMISSIONER:

Q. Yes, I do recall your being on your feet about that before.

COFFEY, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. So I take it, we're not pursuing that?

COFFEY, Q.C.:

Q. No, we're not.

THE COMMISSIONER:

Q. All right.

COFFEY, Q.C.:

Q. So was there anything else other than that patient -

MR. BOONE:

A. No, that was the only -

COFFEY, Q.C.:

Q. That was it. When then happened?

MR. BOONE:

A. I think the next thing that happened with my next interaction was my e-mail of October 18th.

COFFEY, Q.C.:

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Q. And if we could look, please, at Exhibit -

THE COMMISSIONER:

Q. I'm sorry, Mr. Glaspell, I really should have turned to you with that one as well, but I presume you're content.

MR. GLASPELL:

Q. Yes, I am.

COFFEY, Q.C.:

Q. Thank you, Commissioner. Exhibit P-0308.

THE COMMISSIONER:

Q. That's the disadvantage of being the new person in the room. We've been here a long time.

COFFEY, Q.C.:

Q. Mr. Boone, this is an e-mail from Heather Predham to Dr. Laing and other individuals on October 18th, 2005. The subject is a patient letter.

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. That particular letter was a draft that was attached. She said, "I have attached a draft letter with the suggested changes. Before we send it out, we'll need to consider the

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following", and there are three bullets. She says, "I guess we also have to remember we will get negative reaction from the letters", and she goes on to talk about that, and, "Finally, I think we should be aware that we will not be able to notify everyone. Several on the list have moved, and we have no other contact information. I'm going to send this on to Dan Boone as well. I'm not sure how HIROC will feel about notifying people at this point in time and whether the media attention will make any difference. Let me know what changes you want made".

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. So can you tell us, please, before the e-mail you sent, what if any communication you had with Ms. Predham about it?

MR. BOONE:

A. Yeah. I recall that I was having a conversation with Ms. Predham. It actually related to ER/PR. It related to some specific--I don't think the details are important, but it related to some specific

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notion of some samples that had come back, or there had been duplicate samples sent to Mount Sinai, something like that, and I was having this conversation with her from my office. Then she said she was going to send me a letter that the corporation intended to send to all the patients who were going to be retested, and she did send that letter.

COFFEY, Q.C.:

Q. And you read it, the letter?

MR. BOONE:

A. Yes, yes.

COFFEY, Q.C.:

Q. And if we could look at a copy of it, Exhibit P-2590. This is another version of that same e-mail we just looked at, Ms. Predham, of October 18th, but when one goes to the last page of this exhibit, there's a draft, October 17th, 2005.

MR. BOONE:

A. Yeah.

COFFEY, Q.C.:

Q. "Dear Patient letter". This is the letter?

MR. BOONE:

A. Yes.

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COFFEY, Q.C.:

Q. And what--what then happened? So she sends you the e-mail.

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. With the letter attached?

MR. BOONE:

A. Right, and I e-mailed her back.

COFFEY, Q.C.:

Q. Okay. Do you know if you had any communication with her before you sent the e-mail about what might be in your e-mail?

MR. BOONE:

A. She told me that what she was going to send me was a letter that was going to go to all patients who were going to be retested.

COFFEY, Q.C.:

Q. Yes.

MR. BOONE:

A. And I told her that I wasn't sure about whether that was necessary, or something like that. I said send the letter over anyway because you might need something from me, so she did.

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COFFEY, Q.C.:

Q. And if we could look, please, at Exhibit P-2967. This is your--2967, thank you. This is an e-mail from yourself to Ms. Predham, as well to D. Hawkins, and M. Boyce, of HIROC?

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. And it's October 18th, 2005, at 2:04 p.m. The subject is "patient letter", and this is the text of your e-mail, and I'll ask you about that in a moment, but there is another e-mail in this exhibit just before this, in the middle here from Ms. Predham, October 18th, 2005, at 1:13 p.m. to yourself.

MR. BOONE:

A. That same day?

COFFEY, Q.C.:

Q. Yes, this would be--here's October 18th, 2005, at 1:12 p.m. in which she's sending the draft letter to Drs. Laing and Williams and so on. A minute later, or within--she sends you an e-mail saying, "I played innocent of your response so you can surprise me", and that went to you, which I gather with this e-mail

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that she sent to a number of individuals and a the draft letter attached, and then we see your response the same day at 2:04 p.m.

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. So about an hour later or so?

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. And that's why I asked you about this reference to whether you had any interaction with Ms. Predham between--just before you sent your e-mail?

MR. BOONE:

A. Well, I told you what happened. If I recall correctly, when Heather and I were having the conversation, she was sending me the e-mail, you know. Heather is like a lot of people, I think, and probably a lot of us do it too much, we'll talk to somebody on the phone and we'll be sending e-mails at the same time often to the same person. So I would imagine she was referring to that earlier conversation. Of course, I don't know because

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it's not what I wrote, she wrote it.
COFFEY, Q.C.:
Q. And here then you've written, "My initial reaction is I do not agree with sending this letter at this time", and you go on to talk about why. Could you--I'm going to ask you about particular statements you've made here. You note, "There are a significant number of people whose results will not be changed".
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. And by that point in time, I take it, you would have understood that the ratio would probably be 35/65, 60/40, 40/60, that kind of -
MR. BOONE:
A. 20/73.
COFFEY, Q.C.:
Q. Yes, whatever, or, in fact, in terms of changed results -
MR. BOONE:
A. I mean, that's--that's the kind of -
COFFEY, Q.C.:
Q. Changed results would be 32/73.

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COFFEY, Q.C.:
Q. Yeah, I guess. The impression I had, and this is mainly from my conversation with Dr. Williams because he had some reason to believe that the ratio was going to hold, so, therefore, most people whose tests results were sent off would not be changed. In other words, the majority of.
COFFEY, Q.C.:
Q. And you go on to say, "Notifying these people may be seen as raising their hopes for treatment possibilities".
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. "In some cases, these expectations or hopes will not be satisfied".
MR. BOONE:
A. "In most cases".
COFFEY, Q.C.:
Q. I apologize, you do say "in most". "There's a possibility that we could be sued in a class action by those people who receive this proposed correspondence whose test results do not change".

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MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. "Otherwise, these people would not have a cause of action, so sending the letter actually exposes us to a liability which does not now exist". Why would you have told her that?
MR. BOONE:
A. Well, I think it speaks for itself, but I'll tell you what I was thinking.
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. If we can start off with the question--well, we've already discussed the second sentence, that there are a significant number of people whose results will not change. "Notifying the people may be seen as raising their hopes for treatment possibilities which will not be satisfied". Although there's not a direct connection from it, I think looking back on it that that comes somewhat from what the oncologists were saying, or Dr. Laing especially, was saying in a meeting in July

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that I attended when she spoke about the fact that if you retested on Ventana, raised people's hopes for treatment expectations, and then had to tell them that, in fact, on retesting again that they weren't positive, that they would--that their expectations would be dashed. That's the kind of thing I was thinking about. Now really I'm outside my professional expertise there, this is just what I'm expecting someone will say if this happens. "There's a possibility that we could be sued in a class action by those people who receive this proposed correspondence whose test results do not change". Any time over the last ten years especially where a lawyer is advising either a health care provider or a service provider of some kind, there's somebody who has to make a mass notification, there's always the possibility of a class action. A class action is based not on the underlying events, if you like, but rather on the notification itself. In some places I know it's even called a notification penalty, you know, because effectively the thinking is you're going to get sued one way or the other,

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and I guess I would take it that the job of a lawyer advising Eastern Health in this case would be to try to reduce the possibilities of that occurring, and that's what that was addressed to. The last sentence again, I think, to lawyers perhaps speaks to itself, but others it might not, because what I was saying is that the people who had retests and then the results changed--so we take the people who had converted, if you like, they would have a cause of action; it might not be a valid one, but they would have a right to sue over that because they will be suing over the underlying event, if you like, the negligence as they would likely allege that led to their treatment changes occurring, but the people whose test results did not change would not otherwise have a reason to sue. In other words, in fact, their test results would be confirmed negative. So what I was talking about here was trying to reduce the possibility that the people, in fact, who were not physically affected, if you like, whose treatment results did not change, would be able to sue Eastern Health for the

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consequences of that. So that's the first paragraph, that's what I was talking about. Of course, what you have to remember too is that what also was in my mind at this time was that there had been intense media coverage of this circumstance over the two to--I think two week period mostly since The Independent story first broke. My understanding, right or wrong, would have been that virtually everybody who was involved in this would already know about it. So to some degree, the letter was, if you like, redundant, it was telling people something they already knew, and so I was concerned about that.

COFFEY, Q.C.:

Q. Why would you be concerned about telling people something they already knew?

MR. BOONE:

A. Well, for the reasons I outlined in my first paragraph.

COFFEY, Q.C.:

Q. Oh, the first--because of that?

MR. BOONE:

A. Right, yeah, I mean, because--you know, telling someone something they already knew

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there's nothing inherently wrong with that, but if doing so leads to a greater exposure to a legal action, then that's a concern to a lawyer.

COFFEY, Q.C.:

Q. And what if anything distinguished in your mind telling people--or Eastern Health telling people back on October--well, The Independent story on October 2nd, or in the media coverage that followed, October 3rd, and so on, what if anything distinguished Dr. Williams, for example, speaking about the retesting that was going on of negative ER results?

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. Going out over the media airwaves -

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. And all these patients hearing it.

MR. BOONE:

A. Perhaps nothing.

COFFEY, Q.C.:

Q. And saying -

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MR. BOONE:

A. Perhaps nothing. The fact of the matter is once this kind of thing occurs, the possibility of being sued in a class action for the health care provider is there. There's really not a lot you can do about it, and the health care provider's main concern, of course, is with the health and welfare of its patients. So it has to act as best as it can act to fulfil those interests or to meet those interests and concerns. So really nothing, but if this letter had been presented to me, for instance, perhaps--maybe I shouldn't speculate, but if it was presented before the public was aware, my feelings about it might have been entirely different.

COFFEY, Q.C.:

Q. And what did you understand the purpose of the letter was?

MR. BOONE:

A. To tell people that they're being retested.

COFFEY, Q.C.:

Q. I take it, to bring it home to individual patients who might otherwise not be aware that they -

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MR. BOONE:
A. That wouldn't have been my thinking. I would have thought you would have been telling people who were already aware.
COFFEY, Q.C.:
Q. So what would the purpose of the letter be then? I just -
MR. BOONE:
A. I don't know, but that's part of my reaction, quite frankly.
COFFEY, Q.C.:
Q. And what was your basis for thinking that all patients would already be aware?
MR. BOONE:
A. I couldn't say all patients. I would just expect that the vast majority of them would have been.
COFFEY, Q.C.:
Q. And why--what difference would it make whether it was a vast majority or all? I mean, why-- the people, I mean, who would be the difference between the vast majority and all, what about them?
MR. BOONE:
A. I never thought about it.

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COFFEY, Q.C.:
Q. And you go on then to say, "I've not given significant thought to -
MR. BOONE:
A. If I could back you up a little bit.
COFFEY, Q.C.:
Q. Sure.
MR. BOONE:
A. I never thought about it, but I thought about it, and I'll explain that to you in a minute.
COFFEY, Q.C.:
Q. Okay, if you could then.
MR. BOONE:
A. Okay, what I was thinking is, and this relates to what I anticipated would have happened with respect to this letter, my letter was a recommendation, my e-mail was a recommendation as to what I thought was the best thing to do. If someone had come back to me, for instance, and said, you know, Boone, you're wrong, all these people don't know, or maybe not even virtually all of them know and we want to have a more effective communication with our patients, then that would have changed my reaction to the letter because obviously one

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of my assumptions in writing this e-mail as I did was that the people who were receiving the letter would already know.
THE COMMISSIONER:
Q. Do you understand that if you had been a patient with breast cancer, you would necessarily know whether you've even had an ER/PR test?
MR. BOONE:
A. That was an understanding that I had developed, whether it was right or wrong, over the short period of time in which I was involved in the meetings that I had, that breast cancer patients were very aware of treatment possibilities and these kinds of things and that most of them had physicians with whom they followed up on a regular basis, and that they very much would be. Whether I was mistaken in that assumption, I really don't know, but I certainly had it.
THE COMMISSIONER:
Q. Okay.
COFFEY, Q.C.:
Q. And you went on then to write, "I have not given significant thought to the issue from

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the perspective as to whether it is appropriate to test these specimens without advising the patients. However, again my initial thought is that the original consent would be broad enough to cover retesting. With the media coverage and the information already disseminated by you, I would think that most of the people who have tested negative would have enough information to consider whether they would like to be retested, if they have not, and to inquire whether they have been retested".
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. So could you elaborate on that for the Commissioner, please?
MR. BOONE:
A. That whole paragraph is dedicated to the question of consent, and--because this is the first time I was presented with a letter to be sent to a patient group, to this patient group who were about to be retested. So in thinking about it as a lawyer, one of the things I thought, well, I don't think the letter needs

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to go for effective communication because these people are already aware of this. The second thought I would have had was there any other legal reason to send the letter, and one potential legal reason could be for use in obtaining, if you like, an implied and informed consent. So that would have led in my mind to think about consent. In other words, I don't think these people need the letter for effective communication, which would have been the first paragraph. The second paragraph is saying now I'm going to give some thought as to whether or not this letter needs to be sent in order to ensure that we have the consent of the patients for retesting, and the reason I thought about this is because that could be a reason to send the letter, that could militate in favour, if you like, of sending the letter notwithstanding that otherwise the communication was effective because I don't think a public notice would achieve that level of informed consent, but my thought was that the original consent, and when I say that, I mean, the original consent to have an ER/PR testing done, or the battery

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of tests which include ER/PR, would be broad enough to cover retesting, and I still think that that is the case, and people are retested all the time, you know, without being told that they have been retested. So I still think that the original consent would be brought enough. The rest of the paragraph is dedicated, if you like, to notional constructs of informed consent. You're trying to think about what would be the people--the patient population you're speaking of, what would they be thinking, what would be in their mind, what would be available to them, what would they likely do if they actually got this letter, was it needed to give it to them in order to get that consent. So that's what that's directed towards, although perhaps not eloquently worded, but that's what it's directed towards.

COFFEY, Q.C.:

Q. I take it, in essence, you're telling Ms. Predham that because of the media coverage, anyone who knew themselves to have originally been ER/PR negative, and who did not want to be retested, could voice their concerns in

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that regard to Eastern Health?

MR. BOONE:

A. Right, because, of course, then they would have the necessary information available to them to make that determination, and if they did not, we could presume that they wouldn't.

COFFEY, Q.C.:

Q. Had you been asked to provide a comment about consent?

MR. BOONE:

A. Not specifically, but, of course, I mean, I just told you what my thinking was. I mean, I'm presented with a letter. The first question that comes to my mind is does this letter need to be sent. There's a risk associated, which I've outlined, with sending this letter. From my perspective from the point of view of the effectiveness of the communication, it did not need to be sent. I might have been wrong, but that's what I believed to be true. The second thing I would then turn my mind to as a lawyer would be, well, is there any other legal reason to send this letter other than the question of effective communication, and the first thing

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that came to my mind was the issue of consent.

COFFEY, Q.C.:

Q. You then concluded by saying, "Therefore, I do not see how the letter advances the health care of the affected patients and it increases our exposure to claims for damages".

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. "I would recommend against sending it". So would you agree then that this is--I appreciate it's advice, you're not the CEO of Eastern Health, but that this e-mail was advice to Eastern Health from you to the effect of because of the potential to increase the exposure to claims for damages, the letter should not be sent?

MR. BOONE:

A. Right, but you have to consider that what's involved here at any time is a balance. The last sentence, which says--the "therefore" is misplaced because I don't think anything that I say in the last paragraph flows from the first two, but when I say I don't see how the letter advances the health care, I'm not a

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health care professional, I have no right to make that conclusion, but no one had argued to me that this was necessary to advance the health care of the patients involved. If it was, then regardless of any exposure to damages, the letter had to be sent, period. If communication was not effective without the letter, then the letter had to be sent, period. These are the things that I was considering in terms of making my recommendation. No, I'm not the CEO of Eastern Health, and I was not a decision maker, but this was my recommendation. I felt it at the time, and to be honest with you, if I was asked the same question right now, I'd give the same answer.

COFFEY, Q.C.:

Q. If you could look back at Exhibit P-2590, page one, please, this is Ms. Predham's e-mail which had sent along the patient letter to you.

MR. BOONE:

A. Uh-hm.

COFFEY, Q.C.:

Q. And here she had posited, and you would have

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gotten this e-mail as well -

MR. BOONE:

A. Yes, she did.

COFFEY, Q.C.:

Q. She posited that--just above the paragraph in which she refers to you, she said, "Finally, I think we should be aware that we will not be able to notify everyone. Several on the list have moved and we have no other contact information".

MR. BOONE:

A. Right.

COFFEY, Q.C.:

Q. So at the time, I take it, you would have been aware that even Eastern Health itself, even if it wanted to, would have a problem tracking down individual patients?

MR. BOONE:

A. Yeah, but I have to say from my point--I did read that, it was in the e-mail, but I don't think it played any part in my deliberation as to what my recommendations would be.

COFFEY, Q.C.:

Q. And did you see at the time, or give any consideration at the time to any downside in

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not sending a letter, or any problems with not sending a letter such as was proposed here?

MR. BOONE:

A. Well, I think it would be like--the downside considerations would have been for others because you have to remember that in the context of my own dealing with Eastern Health, and the practice that I have, and HIROC's dealing with Eastern Health, and the way these things work, these processes are reasonable cooperative in the sense that, you know, we view ourselves as working towards the same goal. I would have considered, if you like, that in sending that e-mail, I was contributing to the discussion that was ongoing as to how to notify. I didn't think I was ending the discussion, I was contributing to it. I would not have been aware of any downsides, none occurred to me, but as I said, there were potential downsides and the two that would have come to my mind most would have been the effectiveness of other communication. In other words, was the other communication effective enough without this letter. and second, whether there was a health

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care reason which would have been for other people to tell me, to send the letter in any event.

COFFEY, Q.C.:

Q. Well, would you agree that potentially those two are connected in that if a patient doesn't know that they're being retested, that it's not brought home to them, that that could have implications for their health care?

MR. BOONE:

A. I don't think I would have put those two things together in that way. I'm not saying they're wrong. I just don't think that I did.

COFFEY, Q.C.:

Q. There's a reference here too to, "I'm going to send this on to Dan Boone as well. I'm not sure how HIROC will feel about notifying people at this point in time, and whether the media attention will make any difference". What was your understanding of the media attention making any difference?

MR. BOONE:

A. I have to say, Mr. Coffey, I didn't write that and you can interpret that sentence in so many different ways. I'd be speculating. It meant

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nothing to me.
COFFEY, Q.C.:
Q. That's what I'm asking.
MR. BOONE:
A. It meant nothing to me from the point of view of formulating my recommendation.
COFFEY, Q.C.:
Q. What then happened, Mr. Boone?
MR. BOONE:
A. The next thing that occurred that involved me--I say involved me because I was copied on it. I was provided with on the 19th, along with a lot of other people, a draft press release that had been prepared by Susan Bonnell and her staff, and it was for publication later that week, I understood. It was sent to me, I wasn't asked to comment on it. I did note that in the draft press release, it said that they were going to contact all patients--all patients will be contacted, I think, or something of that sort was stated in the press release.
COFFEY, Q.C.:
Q. And did you make any inquiries about the nature of the contact?

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MR. BOONE:
A. No.
COFFEY, Q.C.:
Q. Were you told eventually?
MR. BOONE:
A. At some point, yes. I understand that that press release went into the paper, I think, on the 22nd of October, which would have been a Thursday. Not before, but after, I learned that the contact intended was phone calls, not letters.
COFFEY, Q.C.:
Q. Did the subject matter of letters ever come up again, do you recall?
MR. BOONE:
A. In what sense or context?
COFFEY, Q.C.:
Q. In the sense of was it raised with you, was it revisited at any point in time that you recall? I'm not suggesting it was. I'm just asking. You were asked for your input, you gave it, and then the next thing you hear is, well, there's phone calls being made.
MR. BOONE:
A. Right.

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COFFEY, Q.C.:
Q. To the very same patients.
MR. BOONE:
A. And again--look, again I'm not going to be too picky because I'm not sure--I'm pretty certain what you mean is did the subject matter of letters to patients who were going to be retested come up again.
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. And the answer to that is, no, no one raised it with me again. I wouldn't necessarily have expected that they would. It just -
COFFEY, Q.C.:
Q. What then happened?
MR. BOONE:
A. Lots.
COFFEY, Q.C.:
Q. Okay.
MR. BOONE:
A. I'm sorry, but at this point in time I don't know what--I don't know what else happened, from what perspective, I don't know.
COFFEY, Q.C.:

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Q. Okay, we understand that--well, perhaps I'll assist you. Exhibit P-0693.
MR. BOONE:
A. I should mention, by the way, that in and around the--I think it was the 14th of October, Eastern Health got the first notification you're about to show me, I think.
COFFEY, Q.C.:
Q. Actually, this came later, but I'll go back to that actually because it'll put it in -
MR. BOONE:
A. Okay. So October 14th, there was what we would have considered a reasonably clear indication that Eastern Health was going to get sued over ER/PR testing.
COFFEY, Q.C.:
Q. Yes, and that's Exhibit P-0353. This would be some e-mails, and it's referred to in passing in the e-mails of October 14th, from Joyce Penney to a number of individuals, refers to something in CEO's office on October 14th, and then on Monday, October 17th, there's a note from Ms. Predham to number of individuals saying, "I have forwarded the letter on to Dan Boone. He will reply on our behalf. I'm sure

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I'll be in touch". So this is the notification from Roebothan, McKay, and Marshall, that's what you're talking about there?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. The letter, okay. If we could, please, Exhibit P-0693. This is an e-mail from Ms. Predham to a number of individuals. It's December 13th, 2005. She says, "Hello everyone, we've received a Statement of Claim regarding ER/PR", and it goes on to talk about that. The Commissioner has seen this already. This is, I take it, the first formal--the action itself?

MR. BOONE:

A. Yes, it was.

COFFEY, Q.C.:

Q. Okay, and you were -

MR. BOONE:

A. And the only one for a time.

COFFEY, Q.C.:

Q. And you would have been--you, on behalf of your firm, were retained to deal with the

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matter?

MR. BOONE:

A. Yes, we would have been retained by--we were already retained in a sense. We were involved in this file, but the retainer would have then have expanded to include the defense of Eastern Health in respect of this claim.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit P-2065. Mr. Boone, this is a series of e-mails beginning in March of 2006. I'll show you an e-mail on page four of this. It's March 16th, 2006, at 9:14 a.m. from Ms. Predham to yourself. It's involving an ATIPP request. It says, "For your information, I'll put whoever is going to coordinate this in touch with you so you guys can figure out how to determine what is excluded or not", and just to put it in context for you, Mr. Boone, there's a series of e-mails that begins with this March 15th one here, at 3:42 p.m. from Ms. Predham saying, "I've just received the ATIPP request from Mark Quinn at CBC for", and she spells out what it is and talks about the nature--from her perspective, her involvement

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in it, and the time frames and so on. Why was this e-mail sent to you?

MR. BOONE:

A. Well, I guess I'd have to say, Mr. Coffey, at this point is that everything we've talked about up to this point, as I understand it, has been the subject of either a clear waiver of privilege or not. As you know, as a lawyer, as a solicitor, I'm bound to not disclose confidential information given to me by a client or discuss privileged matters, and I think at this point we're getting beyond what at least I understand has been the subject of any clear waiver of privilege, so I'm going to have to take direction from somebody as to whether I can speak about any issues such as this.

COFFEY, Q.C.:

Q. Okay.

MR. BOONE:

A. I mean, I can tell you that--no, I guess I can't tell you anything until I have some direction as to what I can do.

COFFEY, Q.C.:

Q. And well, if I could, on that point, and

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perhaps just to refer to an actual public exhibit here now, Exhibit P-1960, 1960, because this follows in that kind of series of e-mails throughout March 2006. This is an e-mail of March 27th, 2006 at 11:22 a.m. from Ms. Predham to, again, there's a whole list of--a fairly long list of people, and she says "Deanne Emberley will be coordinating this request right now. We are currently on day nine. So if you could forward your information to Deanne, ASAP, we would greatly appreciate it. I know the corporate communications information is on route. In speaking with Dan Boone, we do have an additional exception. Anything Dan was present for could be identified as being solicitor privileged. Please let Dianne know ASAP when you anticipate getting the information for her. When it is reviewed and the exempted information identified, she will let you all know the information that must be released. If you have any questions, don't hesitate to call."

So knowing that, I mean, at least that is there in terms of there's the initial one, the

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reference to the fact that--or not the reference, the e-mail to yourself and what is said here. I'm not--this is just said here that you apparently indicated that Dan was present for--anything you were present for could be identified as being solicitor privileged. Are you able to comment upon that at all? And if not, fine.

MR. BOONE:

A. I guess, Mr. Coffey, the same statement I made earlier would have to apply.

COFFEY, Q.C.:

Q. Okay.

MR. BOONE:

A. I understand what you're suggesting, and I fully appreciate what you're suggesting is that there may have been some kind of waiver of privilege in respect of this.

COFFEY, Q.C.:

Q. In respect of just that narrow -

MR. BOONE:

A. I'm not in a position, sitting here as a witness, to make that determination and I'm duty bound, as a lawyer, to keep the confidences of my client and so what I'm

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saying to you is that up until this point in time, I think everything we've spoke about has been areas where clearly there's been a waiver of privilege. If there has been, I don't know, and I'm not in a position to make that decision, and everything I know about the ATIPPA request of March 2006, I know because I was consulted as a lawyer.

COFFEY, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. Mr. Coffey, my suspicion is that there may be others of these. So why don't we just go through and then we can deal with any outstanding issues that involve a question of whether or not solicitor-client privilege applies at the end. Is that all right? Unless something arises where you feel that it impairs -

MR. BOONE:

A. That's fine with me. I guess from my point of view, as I said, Commissioner, I really just need direction on it. I mean, as you know, I can't just open up and talk about things that are confidential.

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THE COMMISSIONER:

Q. Well, I'm just--in terms of the flow, if we can just put this aside.

COFFEY, Q.C.:

Q. Sure.

THE COMMISSIONER:

Q. If we discover there were a number of things, then we'll make sure that Mr. Boone has that opportunity, but -

MR. BOONE:

A. And Commissioner, Commission counsel have been kind enough to give us a list of topics about which they--that they wished to discuss with me, and there's already been some exchange of positions, I understand, that goes beyond my pay scale at this moment that deals with that.

THE COMMISSIONER:

Q. Okay.

COFFEY, Q.C.:

Q. And there's--if we could, just to identify certain exhibits, P-3464, and this is an e-mail of April 26th, 2006 from Ms. Predham to Deanne Emberley and yourself, letter to Mark Quinn. The attachment says "reply, partial access.doc. Here's the draft of the letter.

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We will have to mail it in the morning because this took the last of the good out of me." And just to--this is a draft of a letter of April 25th, 2006 to Mr. Quinn responding to his request for access under the Access to Information and Protection of Privacy Act. So there's that letter again related to the whole ATIPP response, it's there.

THE COMMISSIONER:

Q. So we have three exhibits?

COFFEY, Q.C.:

Q. Yes.

THE COMMISSIONER:

Q. Relating to the ATIPP response. Is that correct?

COFFEY, Q.C.:

Q. Yes, that's my understanding, Commissioner.

THE COMMISSIONER:

Q. Okay.

COFFEY, Q.C.:

Q. And perhaps for now, Commissioner, if we could, if we could just put that aside for the moment?

THE COMMISSIONER:

Q. Yes.

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COFFEY, Q.C.:
Q. I'll come back to that because there's another matter that -
THE COMMISSIONER:
Q. I'm just trying to keep the flow going and if it turns out that we can identify a number of these, then we'll take a break and give opportunities for instructions to be taken on the issue, rather than to break every time.
COFFEY, Q.C.:
Q. Thank you, Commissioner.
THE COMMISSIONER:
Q. If we get bogged down then, we can do it immediately.
COFFEY, Q.C.:
Q. Exhibit P-0782? Now Mr. Boone, this is a--it's on the letterhead Pastoral Care and Ethics. We understand it's from--of course, it's described as June 20th, 2006 from Rick Singleton to Dr. Bob Williams re: ethics consult, ER/PR, June 19th 2006.
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. And you were present, as well as a number of

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other individuals.
MR. BOONE:
A. Yeah, and I can tell you, just so you won't get bogged down, that from my perspective, my role there was not such as would render that privileged.
COFFEY, Q.C.:
Q. And I had understood that from your counsel. So in relation to this, can you tell us, please, what you recall about this? Like for example, how you ended up there at all and -
MR. BOONE:
A. I was--I ended up there at all because I was invited by Mr. Singleton through Ms. Predham. Ms. Predham, I think, actually got in touch with me, but Mr. Singleton asked for me to come.
COFFEY, Q.C.:
Q. And go ahead then, what happened? What do you recall about -
MR. BOONE:
A. I went.
COFFEY, Q.C.:
Q. And what happened? What do you recall?
MR. BOONE:

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A. Okay. I can tell you what--I should tell you that from my point of view, I have considered this, and I don't see any difficulty in giving you my recollection as to what happened within the ethics consult itself.
COFFEY, Q.C.:
Q. Yes.
MR. BOONE:
A. And I have no problem with that. I have an independent recollection of the consult. I'm reading it off the screen here, but everybody who's listed as present was present in my recollection. I remember everybody there. At the time, it was funny, I didn't know Dr. Denic. I had never met him. He was introduced to me as the acting clinical chief of pathology, but I didn't--I actually didn't even catch his name. I know him now much better obviously. Dr. Cook, I knew. Dr. McCarthy I've met once or twice. Dr. Bandrauk, I never knew, although I understood that she was an intensivist and an ethicist. In other words, she was a--she's not an intensive ethicist. She was a person who was a clinician in the area of intensive medicine,

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and she was also an ethicist in that she was affiliated with the university, not with Eastern Health, and that--and Heather Predham was there. So I remember all those people being there.

The discussion was going to be about the question, as I understood it at the outset, further testing of the samples of people who had become deceased up until that point. In other words, would their samples be retested in the same manner as the other samples had already been, I thought, completely retested, but in January of '06.

I don't know how that system or that question percolated up to become a question which was the subject of an ethics review. I don't know who initiated that kind of a discussion. My knowledge of ethics reviews is it usually comes from somewhere, a clinician or somewhere else, would ask for an ethics consult, in other words, where they sit down with their colleagues and people who have other knowledge of the matter to talk about what they should do, and that's what an ethics consult is, as I understand it.

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We went into the meeting. Mr. Singleton, who I have been in ethics reviews before. He has sort of a process that he followed, and the first step in the process was he asked Dr. Cook to give a description of the case, if you like, you know, what was the case under consideration, and Dr. Cook then did so, and he talked about, you know, all the things that you guys have heard a lot of and I've heard of many times, but he talked about ER/PR testing, the purposes for which it is done, the general process by which it is done, immunohistochemistry. The fact that there is--you know, there are no standardized ways to test for ER/PR, that ER/PR is--I remember them talking about, especially under the DAKO system, was a 40-step process with a whole lot of potential for problems and that problems were known to exist in this test worldwide. That kind of description was given by Dr. Cook at the outset and that would have been for the--I had already heard almost all of that before, but I presumed it was for Dr. Bandrauk and Mr. Singleton.

We then went into the issue of virtually

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right away as to--the issue became different than what I originally thought, because the original thought process that I had going in was it was about the question as to whether or not they were going to continue to retest. I don't know if I was right or wrong about that, but that was my impression. But it became also the question as to whether or not they would disclose to people who had already been retested, because I don't think I appreciated that people had been retested already.

COFFEY, Q.C.:

Q. This is some deceased -

MR. BOONE:

A. Some deceased samples had been tested.

COFFEY, Q.C.:

Q. Okay.

MR. BOONE:

A. There were some numbers of that that were spoken of during the ethics review. I honestly don't recall what those numbers were, but a substantial number had already been retested. Then Dr. McCarthy spoke about her view of disclosure and Dr. McCarthy spoke, again fairly passionately, about her view on

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this, and it was one that, to me, made a lot of sense intuitively, emotionally, and intellectually, if you like, but what she told us was that she and the other oncologists deal with their patients and their patients' families near end of life. It's a big part of what they do, and once the patient, the cancer patient has passed, the oncologists don't consider that their job is done, and that they feel they still owe a lot of obligations to the families of the deceased people, and that, you know, the families go through mourning processes and, you know, these are fairly well known, I suppose, as to what they might be.

I remember she spoke to us about the fact that she and her colleagues, the oncologists, they don't just let the patient, the deceased patient go out the door. They continue to follow up with the family. They go to the wakes. They go to the funerals. They are there for questions afterwards. They're there to talk to people for comfort. They're there for anything anybody wants and their time allows them to give. They're there for them. And that from her perspective, at a certain

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point in time, from her years of observation of this process, families of deceased cancer patients, and I honestly don't know whether you could say it of other families too, but certainly families of deceased cancer patients achieve a point in their life where they have found closure. They have managed to deal with their relatives' usually untimely death, and they've moved on. And that Dr. McCarthy felt quite strongly that to go back now, in this circumstance, and to open up that closure that had been achieved by recounting to people the results of retesting or asking them about other retesting would be a bit too much for the families to bear and that she felt, and her recommendation strongly was, as a person who was, you know, deals with these people, I suppose, the patients at first instance, was that we ought not to--Eastern Health ought not to continue to retest and not to disclose to families where retests had occurred, unless they wanted us to.

She also spoke, I remember this at the time, she said this wasn't just her view, but this was also the view, I remember she said of

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Dr. Ganguly and Dr. Laing that these--and I knew these people to be other oncologists within the program, and what she was saying was that, you know, we're the people really who know these patients. We're the people who know their families. We know what happens, and we are concerned that if we continue to do this, we're going to cause these people suffering that's untoward.

After that conversation on the part of Dr. McCarthy, I recall a conversation that occurred, initiated by Mr. Singleton, responded to mainly by Doctors McCarthy and Cook, on the question as to whether or not it could be obvious to anybody looking back that a change in a test result could have, you know, been a direct connection with a death that had occurred, and the answer was no, that that couldn't happen. You couldn't make that leap.

The next part of the discussion that I recall was from Dr. Bandrauk and Dr. Bandrauk was the ethicist, and Mr. Singleton, she and Mr. Singleton had an exchange essentially about, you know, these issues that they'd

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heard and when I say it was them, it was because at this point in time, they started to apply their professional ethicist hats or put them on and use them, and they talked about things that, although perhaps the concepts aren't foreign, the titles or the names of the concepts were new to me. They talked about the negative right to know or the right not to know, and these are not things that I have ever encountered as a lawyer, but they made sense to me. It didn't--what they were saying was that in certain situations, people have a right not to be told things. My only familiarity with that kind of approach, if you like, would be in the--I think what the law calls a therapeutic privilege. That's not what they were talking about, but it sounded similar to me, you know, that kind of thing. So but what they were effectively saying was that, as I understood it, they were putting their ethicist stamp on the concerns that had been expressed by Dr. McCarthy, and saying that from their ethical standpoint, they believed that her position could be supported, and that was how it was outlined.

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Effectively, at that point in time, I think the decision was made that that consult was going to recommend--because as I understand it, a consult only has some kind of abilities to recommend. It doesn't have any ability to make a decision. It's not an adjudicative process.

At that point in time, as I understood it, the consensus and the consult was that this was going to be the decision, if you like, or the recommendation of the consult. But then we had a further discussion about other things that were ancillary to that, if you like. One thing that came up--do you want me to keep going or do you -

COFFEY, Q.C.:

Q. Yes, go ahead.

MR. BOONE:

A. One thing that came up after that, and this actually directly involved me and was the only thing to which I really spoke that afternoon, was okay, so--actually, sorry, I should back up. There's a gap. Someone said, I don't know who, "if we're going to make this decision, we have to give the patients'

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relatives a choice of some kind. We have to some how or other facilitate a choice on their part," and I don't know from where the suggestion came within the room, but someone suggested that there could be a notification, a broad notification or a press release of some sort that would tell people "we're not going to retest the samples of your deceased relatives, and we're not going to tell you about any that have been retested. But if you want us to do us, we will do so at your request" and that made sense to me too. I mean, you want to give people a choice, rather than just presume the choice on their part.

And then the question came, well, let's say someone sees such an ad and comes and asks us for this retesting to be done, how do we know to whom we respond? You know, then who's the person to whom we respond? And we then got into discussion of what lawyers might call consanguinity, you know, who's the closest relative, you know, those kinds of things. In the hospital setting, they often talk about next of kin and who is next of kin, and I spoke at that time and I had said "look, the

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Hospitals Act"--because I'd been dealing with this for years and years and years, "the Hospitals Act left a gap when a patient died as to who could access their records. There's no provision in the Hospitals Act" at the time, and I think actually the new Act had come in place at that time, and it still hadn't been filled, but the Hospitals Act at the time gave no direction to a hospital as to what it could do for release of patient records once someone died.

Lawyers being lawyers would, I think, interpret that if a person can access their records, then their personal representative can also do so, and what that would mean to lawyers would be that then a person who wants access to the deceased family's records would have to go out and get an estate administered or a will probated and become a legal appointee, and for years up to that point in time, and I'm willing to bet it would be 15 years up to that point in time, I have been advising hospitals in that setting, rightly or wrongly, that in the event that a patient comes to them--or sorry, a relative of a

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deceased person comes to them with some complaint, vague or clear, about the treatment that their relative received, that in those settings, the hospital ought not to stand on the interpretation of the Hospitals Act which I've just given you, and make those records--they should make those records available to people, because these are people who are complaining about the care. The hospital is the custodian of the records. It always seemed wrong to me that the hospital would say you have to go out and get a will probated or an estate administered before we're going to give you the records. That just seems totally wrong. There's a lot of money involved in that. Doesn't make any sense.

So in that setting, when someone was considering either a complaint to a professional body, a complaint to the hospital or even suing the hospital, the view that I had expressed to hospital authorities across the province was that they should make those records available, and so that's--that was my two cents worth, if you like, and that, to me, was near the end of the meeting, and that's my

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recollection of that consult.

COFFEY, Q.C.:

Q. If we could just look at the bottom of the page here on this exhibit 0782, if we could? Sorry, gone a bit too far.

MR. BOONE:

A. This is the report of the consult?

COFFEY, Q.C.:

Q. Yes.

MR. BOONE:

A. I don't think I ever received this.

COFFEY, Q.C.:

Q. No, and there's no suggestion.

MR. BOONE:

A. Okay. I don't believe I ever did.

COFFEY, Q.C.:

Q. If I could just take you to--there's an assertion in here, in what Mr. Singleton wrote. He refers to "the obligation to disclose the information to families is based, from ethnics perspective, on the negative right of families to the information about the deceased."

MR. BOONE:

A. Yes.

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COFFEY, Q.C.:

Q. And he goes on to speak about that. "The obligation to inform is different in this situation than if situations where a mistake has been made, where the information would make a difference or a potential difference in the care plan or interventions of a patient." I wanted to ask you about, and you've indicated that there was discussion about it couldn't be said categorically one way or the other whether or not in any particular patient's case it might have prolonged their life, but I wanted to ask you about the assertion that if--that should be presumably in situations where a mistake has been made. Do you recall any discussion about mistakes or the notion of mistakes and whether there had been any mistakes made by anyone in relation to the testing process?

MR. BOONE:

A. No. No, I don't recall it. I mean, there was discussion as to whether there was one, I suppose, but I don't recall anybody saying this is a mistake.

COFFEY, Q.C.:

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Q. Oh yeah, but was there a discussion about whether or not any mistakes had been made?
MR. BOONE:
A. No, the discussion was in the context of whether it could be said that any mistakes that had been made could be directly connected to someone's death. That was Mr. Singleton's question. He asked that. I don't know if this really--I'm having trouble following the sentence, so I don't know if it really reflects what I said or not. I've told you what my recollection is. Whether that reflects or not I think is probably for you to decide.
THE COMMISSIONER:
Q. Just to make sure I'm clear, you're saying that the part of the discussion that could be said to relate to mistake was whether a connection could be made between anything that occurred within Eastern Health vis-a-vis ER/PR and the death of some individual? Is that it?
MR. BOONE:
A. I think -
THE COMMISSIONER:

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Q. In the sense of is it a direct route or, I mean, -
MR. BOONE:
A. Yeah, that's my understanding.
THE COMMISSIONER:
Q. I'm not quite sure what it is -
MR. BOONE:
A. Sorry, Commissioner.
THE COMMISSIONER:
Q. I guess what I'm saying is that I'm not quite sure perhaps what Dr. Singleton was looking for, let alone sort of -
MR. BOONE:
A. What he got.
THE COMMISSIONER:
Q. - what he got from it.
MR. BOONE:
A. Perhaps if I could, one of the things I'd ask that could be done, you have to back up a little bit. I think the question was not whether or not anything done within Eastern Health, in relation to ER/PR, could be connected to a death. My understanding was whether or not anything--if there was any mistakes in the lab, could they be connected

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to the death. In other words, it was more remote than that, if you appreciate what I'm trying to say.
THE COMMISSIONER:
Q. Okay.
MR. BOONE:
A. In other words, there wasn't a discussion along the way of what--you know, as I think all of you now would know would occur, which would be whether or not the clinician takes the test and what they do with it. There was none of that discussion. The chain was not, if you like, followed right through from beginning to end.
THE COMMISSIONER:
Q. Okay.
MR. BOONE:
A. The question that was asked and posited by Mr. Singleton was whether or not, let's say there was a mistake in a lab test and which I think--no, actually, let's say there's a change in a test result.
THE COMMISSIONER:
Q. Yes.
MR. BOONE:

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A. Can somebody say that that change, if the change had been known, if they got it right the first time, could that have prevented the death, and that was the -
THE COMMISSIONER:
Q. That sounds to me like a direct relationship, nothing complicated, kind of question.
MR. BOONE:
A. Yeah, that's exactly what it was. That was the kind of discussion that then followed, was that, and the discussion that followed was not very long and was not very complicated. I remember that.
THE COMMISSIONER:
Q. As opposed to an impact kind of question?
MR. BOONE:
A. Yeah, there was no--I mean, no discussion about--I mean, I think all of you would know what essentially the steps along the way would be to allow someone to make that decision. Those steps were not discussed individually, not were all the steps outlined or anything of the sort. It was a change in a lab result, can we tell if the lab result had been different first, would the person not have

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died? That was the question that was posited.

THE COMMISSIONER:

Q. All right.

COFFEY, Q.C.:

Q. Here, in this report, third paragraph, Mr. Singleton had written, "important facts to the history," and understand, which presumably is "understanding of this case include the following. There were no mistakes or technical errors at the root of this problem. It is impossible to know in any specific case if the outcome for any individual patient would have been different. Intervention for post-menopausal women have positive impact by lengthening life in 47 percent of patients treated." The second assertion, "is it possible to know in any specific case if the outcome for any individual patient would have been different?" You've already referred to that.

MR. BOONE:

A. That's definitely the conversation that I heard.

COFFEY, Q.C.:

Q. Do you recall anyone or any assertion during

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that meeting to the effect that there were no mistakes or technical errors at the root of this problem?

MR. BOONE:

A. I don't recall anything being said like that. I don't know what the root of the problem would be or what he would have been--Mr. Singleton would have been thinking was the problem. I really don't. I can't interpret the sentence, but I don't--if what he's saying is that somebody asserted that Eastern Health did nothing wrong here, I don't think I ever heard that.

COFFEY, Q.C.:

Q. And that's in the context, because if you look back, he says "the problems with the results was rooted in the test procedures used in the time period from 1997 through 2005" and he goes on to talk about it there, so presumably that's the problem he's talking about, and you certainly don't recall any reference to--or anybody asserting, "look, there were no mistakes -

MR. BOONE:

A. If that's what that assertion is intended to

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convey, nobody said anything of the sort.

COFFEY, Q.C.:

Q. If we could look, please, at Exhibit P-781? And I take it, Mr. Boone, in relation to the ethics consult, you did not receive a copy of that report. Did it ever come up afterward, except in the context of Commission of Inquiry, but do you ever recall it being raised?

MR. BOONE:

A. I don't recall. When you say "it" do you mean the consult or the report?

COFFEY, Q.C.:

Q. The consult, the ethics consult itself, that ethics consult, the issue dealt with there.

MR. BOONE:

A. I know at some point in time, whatever the recommendation of the ethics consult, which I presume was followed -

COFFEY, Q.C.:

Q. Well -

MR. BOONE:

A. I don't know if it was or not, but it was reversed, if you like. At some point in time, I know that Eastern Health was told to retest

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all the samples, including those of deceased.

COFFEY, Q.C.:

Q. Oh, yes, and that would be May of '07.

MR. BOONE:

A. I'm not sure when that was. I do know it happened. But beyond that, I mean, I don't have any--I didn't follow the ethics consult through whatever route it was supposed to go. Let's put it that way.

COFFEY, Q.C.:

Q. No one consulted--what I'm asking, I suppose, is no one consulted you further about it, in the way that you'd been consulted -

MR. BOONE:

A. And nor would I really have been expected to, you know.

COFFEY, Q.C.:

Q. Exhibit, this is P-0781, and it's an e-mail from Mr. Singleton to Dr. Williams of June 20th, 2006, 10:20 a.m. and he writes "Hi, Bob. Yesterday we had the ethics consult on ER/PR. Very good discussion and outcome. I will forward this summary later. In the meantime, an issue came up that I want to bring"--I'm sorry, "want to give you a heads up on. Dr.

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Denic had a document or report from a external review of the lab process, etcetera, here. He read from it and mentioned he would use the report as part of information he was sharing with others. It seems the reported opinion had been done for Dan Boone and he did not want the information shared, as at this time it is privileged. Dr. Denic understood from you that he was not to copy it, but Dan seemed to be a bit concerned that it was being quoted, the expert being referred to. Dan's concern seems to be about the privileged status of the report, which he may need in a proceeding later on. Anyway, just thought you might want to know there was a bit of fuss about this." Signed Rick.

Now, Mr. Boone, I'm not going to ask you anything about the report itself or anything. I just wanted to ask you to confirm, does that account accord with your recollection of what happened at the meeting, in relation to that topic?

MR. BOONE:

A. Frankly I'm at a bit of a loss as to how I can answer the question, I mean, what we're

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talking about here is privileged material and let's put it this way: I had a privileged report, someone that I just met for the very first time whose name I couldn't even spell had it, that caused me a concern.

COFFEY, Q.C.:

Q. No, no, no, I'm not asking you all in terms-- all I wanted to know is if what's here, what's written here in terms of the account that there was something read out and that the account that you spoke up and that apparently ended -

MR. BOONE:

A. Well I just told you what my account of it was, I really don't recall anything else.

COFFEY, Q.C.:

Q. Okay, in your account to the Commissioner before I refer to this, this was not referred to, you do recall it, I take it, occurring?

MR. BOONE:

A. Sure, but I wasn't going to refer to it, I mean, look, I don't see why I should refer to a report that was privileged and I don't see how it even came to the attention of this inquiry.

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COFFEY, Q.C.:

Q. And well, we're in the position where it has come to our attention, okay, and witnesses have spoken about it, so I'm simply asking you can you confirm that that is an accurate account of what happened in relation to that matter at the time. I don't want to know what's in the report at all.

THE COMMISSIONER:

Q. You have been very careful about that, Mr. Boone, not to go into what was said or what might be in the report or even who -

COFFEY, Q.C.:

Q. Not even what Dr. Denic said.

MR. BOONE:

A. I had sent my report to Dr. Williams under cover of correspondence which you have seen -

COFFEY, Q.C.:

Q. Oh yes and -

MR. BOONE:

A. Let me answer.

COFFEY, Q.C.:

Q. Sure.

MR. BOONE:

A. That said that this report is solicitor and

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client privileged and is not to be shared with anybody, it's part of our solicitor's work product. When I came to the meeting, Dr. Denic had it. I was not aware of having--I certainly didn't give any instructions that he could have it. There was nothing really wrong with that, he's the clinical chief of pathology, I may have shared it with him in the right circumstance, but not at that time and he had it. I don't recall him reading from it. I recall him having it and I recognized what it was and I recall taking it up with him at the time and expressing surprise, I suppose and a little consternation that a report that I would have considered to have been privileged was in the hands of somebody who I didn't know. So, I mean, that's the best that I can recall about it.

COFFEY, Q.C.:

Q. And if we could, please, Exhibit P-1167? And Mr. Boone, this is just an e-mail from Leona Barrington, August 8th, 2006 to a number of individuals, you'll see you're last in the list of the main recipients.

MR. BOONE:

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A. Right.
COFFEY, Q.C.:
Q. It's a transcript of the CBC, The Current program. She writes, "Good afternoon, attached is the transcript from The Current, CBC's National radio program regarding the Myrtle Lewis case" and I understand it's a matter of public record that your firm acts for Eastern Health in relation to that matter?
MR. BOONE:
A. Yes, we do, yes.
COFFEY, Q.C.:
Q. And this is the matter, Ms. Lewis' case would be the action that initiated the class action proceedings, would that be -
MR. BOONE:
A. I can't recall, the representative of the Plaintiff is Verna Doucette.
COFFEY, Q.C.:
Q. Okay, may not be. Verna Doucette actually is--I stand corrected.
MR. BOONE:
A. Ms. Lewis is or purports to be a class member, I think.
COFFEY, Q.C.:

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Q. Yes, that's it, I apologize, it is Verna Doucette but Ms. Lewis was related somehow or alleged to be related somehow to the class action.
MR. BOONE:
A. Yes.
COFFEY, Q.C.:
Q. In this context. And so, and again for the Commissioner to kind of flesh out your account, by that point in time, the class action was on the go, as it were.
MR. BOONE:
A. I think I learned of the class action coming in the--I'm going to say late May of 2006 through various sources that it was coming, but it was actually--I was sent a courtesy copy by Mr. Crosbie of a Statement of Claim issued under the Class Actions Act on July 14th at 2006.
COFFEY, Q.C.:
Q. Uh-hm, and I asked you about it only because the next exhibit I'm going to refer you to -
MR. BOONE:
A. Right.
COFFEY, Q.C.:

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Q. - to put it in some context, P-0125, page 34 please? Well actually if we could, just to give Mr. Boone the sense of this, page 31 please?
MR. BOONE:
A. Can you tell me what this is?
COFFEY, Q.C.:
Q. Yes, and I'm going to show you, this is -
MR. BOONE:
A. Oh, this is one of the collection of documents, is that right?
COFFEY, Q.C.:
Q. Yes, this is a collection, a large collection of briefing notes internal to the government. This particular one as you'll see is a briefing note, Department of Health and Community Services, this is one that ended up in Executive Council, you can see the distribution list up here. Titled "Update on Pathology Reports Legal Action for Women Diagnosed with Breast Cancer." Do you see that?
MR. BOONE:
A. Yes.
COFFEY, Q.C.:

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Q. And the issue is "current status of pathology testing and legal claims related to women diagnosed with breast cancer.
MR. BOONE:
A. Okay.
COFFEY, Q.C.:
Q. And the Commissioner has seen the text of this on a number of occasions. Page 3 of the document, page 33 of the exhibit, you'll notice here is "current status, legal activity. Currently we have two legal claims that have been filed, Michelle Hanlon's and Verna Doucette" and then there's a reference to recent media reports identified Myrtle Lewis.
MR. BOONE:
A. Yes.
COFFEY, Q.C.:
Q. Then under summary, refers to legal action initiated by Ms. Myrtle Lewis. I don't know if that's technically correct, but anyway, that's there. And it goes on to say here under "Action Required" okay, "This notice is provided for your information purposes only. Should the Premier require further detail,

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officials from Eastern Health, as well as their legal counsel will be available for an in-person briefing."

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. Are you able to tell the Commissioner -

THE COMMISSIONER:

Q. Excuse me, Mr. Coffey, Mr. Glaspell is going to speak. Yes.

MR. GLASPELL:

Q. There was an exchange of correspondence between counsel, letters dated October 17th and October 18th. We identified eight different areas where Mr. Boone could be asked questions and then we've been dealing with the privilege issue in delicate fashion. This-- and I haven't heard the question yet, but this is not an area. It's one of the eight areas that were identified.

COFFEY, Q.C.:

Q. Yeah, I appreciate, Mr. Glaspell and if I could just ask the question, it may or it may not be--the question is simply, Mr. Boone, were you aware that you were being off--I

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presume you're the legal counsel, you were being offered up, as it were?

THE COMMISSIONER:

Q. Do you have a problem with that question. The question is whether or not he was--you understand what this document is, sir, it's prepared with the exception of one person, the others are officials of the Government of Newfoundland and Labrador. Ms. Predham is an employee of Eastern Health.

MR. GLASPELL:

Q. Right. What is the question?

THE COMMISSIONER:

Q. The question is whether or not Mr. Boone was aware that somebody who drafted these documents or reviewed them were indicating to the Government of Newfoundland and Labrador, in effect the Premier, that he was available for a briefing. So it's a question of whether or not he knew he was being offered to make a briefing--whether anybody had consulted him to say you can go brief the Premier?

MR. SIMMONS:

Q. If I might offer a suggestion, if Mr. Boone, himself, has any doubt at all about whether

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this is an appropriate area, this might be one of those things which can be heard with the others and (inaudible).

MR. GLASPELL:

Q. (Inaudible).

THE COMMISSIONER:

Q. All right then, well if Mr. Boone himself was the writer there.

MR. BOONE:

A. I don't have any problem, I'll answer it.

THE COMMISSIONER:

Q. He doesn't seem to have that problem, Mr. Simmons, so if you're willing to defer to Mr. Boone's view on this -

MR. SIMMONS:

Q. I'm being (inaudible).

THE COMMISSIONER:

Q. Thank you.

MR. BOONE:

A. I never saw this briefing note until the Inquiry and I don't remember if I actually read it since, I think I knew this was there. I recall at one point in time and I don't know who prepared this briefing note or whether it's a government briefing note. I have to

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say that until I got involved in this Inquiry, I don't think I ever knew in my life what a briefing note was or -

THE COMMISSIONER:

Q. Let alone how complicated they are, Mr. Boone.

MR. BOONE:

A. I have no idea. But I do recall at some point in time a lawyer from the Department of Health approached me. I don't know if it was--it might have been around that time and she asked me for some information and I remember giving her some basic information, including some of the documents that we had filed in respect of the certification briefing, that would have been later. I had an earlier contact from someone with Health, a lawyer though, looking for information on, you know, where we were and the status of the action, that kind of thing and I was very concerned about that because, of course, the Government of Newfoundland and Labrador would not be my client under any notional view of the world, and so I would be concerned with disclosing to the government whatever litigation strategies might be or whatever else might be because I

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was grown up enough to realize that whatever I said to anybody from government would quickly get circulated through the halls at Confederation Building and then later become announced in the House. So I wouldn't be sharing legal strategy in that way, but I do recall saying to somebody and I honestly can't recall if it was facetious or otherwise, that the Premier is a lawyer and he'll understand that if he would like to know anything, I'll tell him. But that was about it, you know, within the strictures of our own solicitor/client privilege, but I don't know if that's what that refers to. I have a feeling that I'm being too speculative here, that what I said was probably a little bit too facetious to make it into a briefing note. Maybe somebody intended that I would do it, but certainly I would have told people before that time that I would not--would not meet with officials from the Department of Health to discuss matters of legal strategy.

COFFEY, Q.C.:

Q. Thank you very much, Mr. Boone. Exhibit P-2658 and this is an e-mail from Leona

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Barrington of October 20th, 2006, it's to a number of individuals, you're there in the middle of the cc'd people. The subject is "Taking Action in The Independent." "The attachments are taking action in The Independent on October 20th, 2006." She writes, "Attached is an article on ER/PR that appears in this week's Independent, I am going to begin to put together a communication strategy around the release of the rate of error results, as well as the announcement of us beginning to retest. After speaking with Heather, we would like to aim for an end of November announcement. Terry/Nash will we be ready by then, please advise." So I take it that the actual--you being on the distribution list for the media story, we've seen other ones and you've told the Commissioner that at times you were just copied on, the distribution list apparently they were including you on some of the ER/PR, so your name would be there anyway in terms of that.

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

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Q. Okay. The underlying topic in the e-mail itself, the text of the e-mail relates to this matter of, what turned into, I understand, the December 11th, 2006 media briefing.

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. That's kind of where it ended up. And I'll come to that in a moment, but I'd like you first of all to look at P-1193 and this is an e-mail of November 8th, 2006 from Denise Dunn to Bob Grace, that's ER/PR--it's not Bob Grace, it's Bob Williams actually, Bob and Grace Williams. ER/PR presentation and she begins by saying, "Since you've been involved in ER/PR, Dr. Howell would like to invite you to the presentation to surgeons, pathologists and lab technologists on October 20th at 5:00 p.m." And she concludes by saying "For your information Dr. Denic will then be doing a presentation to executive management on November 21st. Dan Boone will be attending that one."

MR. BOONE:

A. Yes.

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COFFEY, Q.C.:

Q. Okay. And I refer you to that by way of an introduction to the next exhibit. Exhibit P-2108. These are minutes of an Executive Management meeting held November 21st, 2006 at 8:30 a.m., and there's a list of those present. The guests for ER/PR presentation are listed there, your name is the last on the list. And then there's a--after the reference to who is welcomed it says, "A copy of the detailed slide presentation that was given to the medical staff was circulated." And then presentation ER/PR, "Dr. Denic's presentation focused on the reliability of the test and the variables that influence the results. Discussion focused on documentation and standardized procedures semi-automated systems verses the new Ventana system" and then he goes on to describe Dr. Laing's presentation, what that focused on and then on the next page, there's a note, "The following points were raised during the presentation"--check mark--"The organization cannot speak publicly on the findings and recommendations of the review because there is currently a class

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action lawsuit ongoing. This information is protected under The Evidence Act. Discussion ensued regarding the need to share the experience with the other pathologists within the province. Dr. Howell and Dan Boone to discuss further prior to making any"--I presume it is decision, it reads "discussion" but it probably should be decision--"to discuss the reviewer's report with the provincial pathologists", do you see that?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. Do you recall--what, if anything, do you recall about that, Mr. Boone?

MR. BOONE:

A. About what? You told me a lot.

COFFEY, Q.C.:

Q. Okay, well in particular -

MR. BOONE:

A. I recall going to the Executive Management meeting. I recall that I went there really for my information purposes. It was a great opportunity to hear the experts talk about a case that I was defending, that's why I went.

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I never saw the minutes. As a matter of fact, I'm seeing these minutes I really do believe for the first time. I don't think I even went back and read them since this started, so this is new to me. What do I recall about it? If the organization said they couldn't speak publicly on the findings and recommendations of the review because there's currently a class action lawsuit ongoing, I wouldn't have agreed with that. This information is protected under the Evidence Act, I agree with some of that. Discussion ensured regarding the need to share the experience with other pathologists, I remember that. I don't remember any discussion that Dr. Howell and I were going to get together to discuss further at all, no discussion of that. And I don't remember ever having that discussion with him.

COFFEY, Q.C.:

Q. Then or afterward.

MR. BOONE:

A. I had lots of discussions with Dr. Howell, I don't recall that discussion.

COFFEY, Q.C.:

Q. You've indicated that the assertion that the

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organization cannot speak publicly on the findings and recommendations of a review because there is currently a class action lawsuit ongoing, I think you indicated just now you would not -

MR. BOONE:

A. Maybe I overstated myself, Mr. Coffey, because the worse part of it is right now we're getting into areas that -

COFFEY, Q.C.:

Q. Okay.

MR. BOONE:

A. - I have no idea if they are privileged still or I think they were privileged to begin with and again, you know, my responsibility as counsel is to maintain the confidentiality of my client and the information conveyed to me by my client and to keep privilege the advice I give. Until someone shows me that I can speak to these issues, I really don't think I can.

COFFEY, Q.C.:

Q. And I won't pursue it any further, Mr. Boone, I appreciate that.

MR. BOONE:

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A. That's fine.

COFFEY, Q.C.:

Q. The point, in fact the real point I was asking about was if you had any recollection of what's in fact in the bold print there, which is the -

MR. BOONE:

A. I don't.

COFFEY, Q.C.:

Q. And you've indicated you don't recall.

MR. BOONE:

A. I don't recall having read it, I don't recall it being spoken of at the Executive Management meeting, although it may have been and I certainly don't recall speaking to Oscar Howell about that particular issue as described there.

COFFEY, Q.C.:

Q. Okay. Exhibit P-0184 please? Mr. Boone, this is an exhibit, an e-mail of December 9, 2006 from Susan Bonnell to a number of individuals including yourself and Ms. Bussey from your firm. The attachments are--and they're all listed there. She writes, "hello again. Following conversations with Nash, Heather,

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Dan and Oscar, I've revised the original drafts in anticipation for a meeting at 1:00 p.m. today. We can make further revisions at that point. I will bring copies with me. Please note that I have added speaking points to the slides, especially for Oscar, less so for Kara and Nash. I guess the most significant change we'll note from the original materials is the lack of reference to a "rate of error". We can anticipate this will be a major pressing point with the media"--and she goes on to talk about it and then she speaks about "Re: the dead, we must also be prepared"--and she speaks about that. Mr. Boone, what, if anything, are you in a position to tell the Commissioner about what you recall about what could or couldn't be said to the media in that December 11th briefing?

MR. BOONE:

A. Unfortunately I'm going to have to say nothing on my own, because, as I said before, I gave advice and maybe going too far to say I gave advice, advice was given but any advice given was privilege. Any information conveyed to me

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was confidential; unless someone waives it or establishes a waiver, I can't speak to any of this.

COFFEY, Q.C.:

Q. No.

MR. BOONE:

A. So unfortunately I can't--now in the meantime, if you want to pursue with counsel whether or not I can speak to that, I certainly have no problem.

COFFEY, Q.C.:

Q. And we'll do that when we break to discuss that other matter.

MR. BOONE:

A. You're telling me I'm not going home at lunch, are you?

COFFEY, Q.C.:

Q. You can go home for lunch, I'm just going to ask that you come back please, okay.

THE COMMISSIONER:

Q. Mr. Coffey, it is close to the lunch hour, so I suggest you make the place to break soon.

COFFEY, Q.C.:

Q. Yes, why don't we then--in fact, this is a good spot, so we'll break for lunch and we'll

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attend to those matter over the lunch hour, Commissioner, thank you.

THE COMMISSIONER:

Q. All right then, 2:10.

(ADJOURNED FOR LUNCH)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. If we could, please, perhaps before I go to the exhibit, Mr. Boone, before lunch you did indicate to the Commissioner that, I believe it was the September 27th, 2005, Ms. Predham--was it Ms. Predham or Dr. Williams, one or the other, had made you aware about the external reviews. You did comment that at some point you became aware that there were external reviews done.

MR. BOONE:

A. Yes, I think in both occasions, 26th--sorry, I should back up, the 19th of August when I spoke to Ms. Predham, I was aware that they were going to be done, I didn't know by whom or anything else.

COFFEY, Q.C.:

Q. Uh-hm.

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MR. BOONE:

A. On the 26th of September, I had become aware that they had been done and on the 27th of September I think Dr. Williams mentioned them again, that's about it.

COFFEY, Q.C.:

Q. And you've indicated that your normal arrangement or understanding with Ms. Predham is that you don't want them, you don't receive them.

MR. BOONE:

A. No, we don't receive them, no. As acting for the hospital in defence of a claim, we make it a point not to review external quality reviews or peer reviews.

COFFEY, Q.C.:

Q. And in relation to the reviews conducted by Ms. Wegrynowski and Dr. Banerjee, did you ever receive them?

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. And are you able to say when in the context?

MR. BOONE:

A. Yes, after Judge Dymond's decision.

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COFFEY, Q.C.:
Q. And how about being told about the contents of them, in a summary way of what the reviewers had found?
MR. BOONE:
A. Very little. I saw some recommendations that I understood might have come out of the review, but I never understood that they were directly from the reviewers as much as they were people's extrapolation of recommendations.
COFFEY, Q.C.:
Q. And were these these spreadsheets?
MR. BOONE:
A. No, there was some information, you mentioned an Executive Management meeting I went to on November 21st.
COFFEY, Q.C.:
Q. Yes, 2006, yes.
MR. BOONE:
A. I believe at that point in time there was some discussion of that.
COFFEY, Q.C.:
Q. Okay, and that's the one where there was the ER/PR presentation?

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MR. BOONE:
A. The slide presentation by Dr. Denic and Dr. Laing and I can't remember who else.
COFFEY, Q.C.:
Q. Okay, so at that point there was some discussion about--and some kind of a listing of recommendations that you saw at that point.
MR. BOONE:
A. That's right.
COFFEY, Q.C.:
Q. Okay, if we could please look at Exhibit P-0926? And this is, in terms of your involvement in the matter, this is an e-mail of July 19th, 2005 at 8:22 a.m. from Ms. Predham to a number of individuals and I just want to take you through some of this and ask you some questions.
MR. BOONE:
A. Okay.
COFFEY, Q.C.:
Q. "I had a long conversation with representatives from HIROC yesterday evening"--that would be Ms. Predham--"as a bit of background they are currently defending a class action lawsuit against Health Labrador

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re: processing of equipment. Apparently the aspect of this lawsuit in which they are most vulnerable was the method that people were informed. Ches Crosbie has alleged in the lawsuit that people suffered significant and mental anguish from the way they were told and that the risk of disease from their exposure did not warrant the stress and anxiety they suffered by being told. The organization felt the need to disclose publicly, ran it by their legal counsel and then wrote letters to every person affected and sent out a news release (sound familiar???). Their vulnerability comes from a lack of weighing out the risk from the exposure verses the anxiety of being told about it. In this case, the risk from the exposure was very small. This leads to our situation, it's not that they don't want us to disclose, they just don't want us to disclose until we are sure of our facts. I've had a quick voice mail from Dan after my chat with HIROC. They contacted him after they hung up from me reiterating this and that they will be in touch again in the morning. So I guess we will have to re-evaluate where we are

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before we plan to send those letters, et cetera. Should we chat about this face to face? Signed Heather." Mr. Boone, the voice mail from yourself--or that you left that time to Heather Predham and what she describes as re-iterating this, which presumably is -
MR. BOONE:
A. I wouldn't have known what I was reiterating, so -
COFFEY, Q.C.:
Q. And I appreciate you wouldn't know it, do you recall what it was you said in the voice message that you left?
MR. BOONE:
A. No, I'd really have to say I'd be speculating significantly if I did that. I mean, I've read this e-mail before, I've tried to use this e-mail to refresh my memory. I don't believe that I have any recollection of what I actually said in the voice mail except for I might have said--I'd be speculating, I think.
COFFEY, Q.C.:
Q. Okay, and in relation to this, the reference to here "where we are before we plan to send those letters, et cetera." Now, on the 19th

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of July, the 20th or 21st of July of 2005, did you become aware that Easter Health in--proposed to and in fact intended or planned to send letters to individual patients?

MR. BOONE:

A. I'm pretty certain I answered that question this morning because I told you that at the time that I went to the meeting on the 19th, I was aware that they were planning some form of communication with patients and perhaps an even broader communication. Did I become aware that there were letters? I really can't recall when I became aware that there were. I didn't see any letters, I didn't see any communications that were in draft of anything of the sort.

COFFEY, Q.C.:

Q. And can you tell the commissioner by what point in time you were aware that there was a plan to send letters? Just kind of thinking it through in terms of well, by a certain point in time I must have known that they planned to send letters.

MR. BOONE:

A. You have to remember that after the 19th of

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July, I went to two meetings. I don't recall the letters, you know, the subject of letters to patients or anything else really being discussed at those meetings. I recall generic discussions, if you like, of broad based disclosure which, you know, could have meant letters, could have meant anything, but I don't recall the actual specific question as to whether or not there were letters drafted being discussed. I don't remember it anyway.

COFFEY, Q.C.:

Q. Now, if we can look, please, at Exhibit P-2940, page 12 and these are notes of Ms. Predham which were provided relatively recently to the Commission and this is dated July 20th, there's a reference to Dr. Williams you'll see.

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. And there's also a reference to--she says "Sunday afternoon" and I gather, if I recall correctly, she told the Commissioner that may have had something to do with a plan meeting for Sunday. "Dan, media release".

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MR. BOONE:

A. I see that.

COFFEY, Q.C.:

Q. Yes. "QI would be notifying patients if there is a problem with what we did"--there's a blank--well actually it's "If there's a problem with what we did, by making an exposure, will we create a"--blank--"can't expect HIROC to pay for it."

MR. BOONE:

A. Are you sure that word is "exposure". I don't read it that way.

COFFEY, Q.C.:

Q. Well, can you think of -

MR. BOONE:

A. I can't think of anything else it would be, but it doesn't really look like that to me. I presume that you've had evidence on that point.

COFFEY, Q.C.:

Q. Yes, and "someone else is going", and it's hard to know what that -

MR. BOONE:

A. It looks like "going out" to me.

COFFEY, Q.C.:

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Q. Going out. So do you recall discussing with Ms. Predham any of these topics at that point in time, July 19th and 20th.

MR. BOONE:

A. The Sunday afternoon, I presume--I'll just take it from the top.

COFFEY, Q.C.:

Q. Yes.

MR. BOONE:

A. The Sunday afternoon, I presume, refers to the meeting that eventually took place on Sunday morning. It says, "Dan, media release". I would presume that that was some expectation I was going to review one. I obviously wasn't going to draft one. I didn't. I don't recall being asked to do it. I'm pretty certain I was not. "QI notifying patients", I really don't know what that means. "If there is a problem with what we did", I don't know what that means. I don't know what any of the rest of it means, quite frankly. I've never seen it before except when it came in evidence in the inquiry last week.

COFFEY, Q.C.:

Q. Well, did you ever--do you recall ever

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discussing the topic which is referred to there, "by making an exposure", I'm going to suggest that it's exposure, "will we create a", can't expect HIROC to pay for it, in this case probably in the context, "A cause of action, can't expect HIROC", who is your client, to pay for it. Do you recall that coming up on July 19th or 20th with Ms. Predham?

MR. BOONE:

A. Okay, I guess I'll put it this way, I think you've made some conclusions as to what that means, and I presume they're supported by the evidence, I don't know if they are or not, because I certainly don't read into it what you apparently are reading into it, so when you say the topic, maybe you can be more precise and ask me -

COFFEY, Q.C.:

Q. Do you recall the topic of HIROC, if Eastern Health did something such as send out letters -

MR. BOONE:

A. Right.

COFFEY, Q.C.:

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Q. When you look back at that July 19th e-mail, it certainly spells of the idea of sending letters.

MR. BOONE:

A. Yes.

COFFEY, Q.C.:

Q. Labrador, and so on.

MR. BOONE:

A. Yes, yeah. It doesn't say HIROC knew about it, but certainly Eastern Health talks about it.

COFFEY, Q.C.:

Q. Did the topic come up on July 19th or 20th that you recall between yourself and Ms. Predham, or anyone else for that matter involving Eastern Health, connected with the idea that HIROC would refuse to pay for something that Eastern Health did which HIROC had cautioned against?

MR. BOONE:

A. No, I'm absolutely certain it didn't come up.

COFFEY, Q.C.:

Q. Did the topic come up about--did you give or were you asked about, and to your knowledge, was HIROC asked about whether or not Eastern Health should communicate with individual patients directly by phone call or by letter?

MR. BOONE:

A. When?

COFFEY, Q.C.:

Q. July 19th or 20th?

MR. BOONE:

A. No.

COFFEY, Q.C.:

Q. The reference in the e-mail--if we could look at P-0926. Here, that last larger paragraph says, "This leads to our situation. It's not that they don't want us to disclose, they just don't want us to disclose until we are sure of our facts".

MR. BOONE:

A. Uh-hm.

COFFEY, Q.C.:

Q. Do you recall that coming up?

MR. BOONE:

A. Yeah, I think that was--what I said to you before that I don't have a great recollection of either Mike Boyce and Ellen Morton's voice mail to me, or mine to Heather. I do recall that being part of what they talked about,

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being sure of the facts.

THE COMMISSIONER:

Q. "They" being?

MR. BOONE:

A. Sorry, Mike and Ellen, Mike Boyce and Ellen Morton.

COFFEY, Q.C.:

Q. Sure of what facts? Did you have any understanding of what facts?

MR. BOONE:

A. I certainly wouldn't have when I got the phone call because I knew very little at this time. As I got to the meeting on the 19th, and that meeting concluded, I would have presumed that the facts about which they needed to be sure were whether or not they had a problem which could affect a broad group of patients. I mean, that would seem to me to be a fact that would be necessary to know before you disclose to those people.

COFFEY, Q.C.:

Q. How about if you disclosed publicly?

MR. BOONE:

A. Sorry?

COFFEY, Q.C.:

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Q. How about publicly?
MR. BOONE:
A. I would -
COFFEY, Q.C.:
Q. Disclose to the people is one thing, to disclose publicly -
MR. BOONE:
A. I would think even more so, yeah.
COFFEY, Q.C.:
Q. Now here in this e-mail, Ms. Predham seems to analogize between the Health Labrador situation and she frames that this leads us to our situation, Eastern Health's at the time. What would be the concern about Eastern Health disclosing without being sure of the facts?
MR. BOONE:
A. As I outlined to you before, the concern that I would have had, which I presume and I'm fairly certain was also the concern that HIROC had, was the possibility of a negligent notification because there is in the case law something know as a negligent notification. In other words, you tell some people, a group of people that a problem may have occurred, may affect them, cause them distress and

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anxiety as a consequence of it before you've done your due diligence to determine whether or not there is or is not a problem. That would be the concern that I would have had.
COFFEY, Q.C.:
Q. And HIROC having so informed Eastern Health, if Eastern Health went ahead, anyway, without being sure of their facts, what situation would then ensue?
MR. BOONE:
A. In what respect?
COFFEY, Q.C.:
Q. Well, if they went ahead and were--did perform a negligent disclosure.
MR. BOONE:
A. Right.
COFFEY, Q.C.:
Q. Or was something that was alleged to be a negligent exposure--disclosure, would they then be subject to being sued?
MR. BOONE:
A. I would presume.
COFFEY, Q.C.:
Q. And in that context here, would there be some concern possibly about HIROC paying for it?

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MR. BOONE:
A. Concern on who's part?
COFFEY, Q.C.:
Q. Well -
MR. BOONE:
A. Mine or HIROC's?
COFFEY, Q.C.:
Q. HIROC's, Eastern Health, either one?
MR. BOONE:
A. I'll put it to you this way, coverage was never an issue here. As far as I can see in this whole series of events, I can never see a point in time when it could have been considered that if Eastern Health acted when it felt it ought to, that it wouldn't be covered under its policy. I certainly know of no condition of the policy which would have led to anybody to have that belief, and I can tell you that from experience, just because they don't take, for instance, my direction, it certainly wouldn't resonate or result in a denial of coverage. I know of no principle of insurance law or condition of the HIROC policy which would lead to that.
COFFEY, Q.C.:

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Q. How about if they went ahead on the 19th, unsure of their facts and made a disclosure, anyway?
MR. BOONE:
A. Well, that would be an event of coverage, not an event of denial of coverage.
COFFEY, Q.C.:
Q. Despite HIROC having cautioned them against doing so?
MR. BOONE:
A. I think maybe you're using--caution is too strong a term.
COFFEY, Q.C.:
Q. Advised them against doing so?
MR. BOONE:
A. I mean, you're using the term "caution" in the same manner in which you might suggest that some enforcement official would caution somebody. That's not the way, in my experience, that HIROC works or HIROC's counsel works with its subscribers. You have to remember that HIROC is -
COFFEY, Q.C.:
Q. And -
MR. BOONE:

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A. Just a second, let me answer, that HIROC is a reciprocal organization which is owned by Health Care Providers. Its Board of Directors are people who are from health care backgrounds and sit on health care boards. HIROC works in a manner which tries to be cooperative at all times with its subscribers, and its supportive of its subscribers fulfilment of what they consider to be their ethical and medical imperatives to their patient. So I can't imagine a circumstance, and I certainly have never seen one in sixteen years of acting for HIROC, where HIROC has suggested that if an organization follows what it considers to be an ethical or medical imperative, or does something for a reason that they think is a good reason, that they won't be covered under their policy for the consequences of that.

COFFEY, Q.C.:

Q. If, as apparently is recorded here in the e-mail was the advice from HIROC, or at least Ms. Predham understood it that way, "HIROC just doesn't want us to disclose until we are sure of our facts", if despite that

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understanding by her on behalf of her understanding, and through her, Dr. Williams and so on, despite that understanding, Eastern Health had went ahead unsure of their facts and disclosed, was there a potential for HIROC to say we are going to deny coverage because we told you not to do it, and you went ahead anyway?

MR. BOONE:

A. Well, I'll try to answer that question in a couple of ways, if I could. First is that in my experience with HIROC and in the work that I've done for and with HIROC since 1991, I have always and consistently worked as defence counsel. In the insurance setting, coverage is considered to be a matter to which defence counsel can't speak. So I've never been called upon to give a coverage opinion arising out of the HIROC policy, except perhaps sometimes subscribers want to know is there enough limits here to cover this, which is a different question altogether. Although that is the case, I have worked pretty closely with HIROC over those 16 years. I've been to their annual general meetings. I've read their

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material. I know the people there. I can't imagine a situation where HIROC would say to a subscriber, "if you don't listen to us, we're not covering you." I have never seen it. I've never heard of it. I can't imagine it would occur.

COFFEY, Q.C.:

Q. And then I take it then there's nothing in your dealings with Ms. Predham on the 19th or 20th of July 2005 that you can recall, anything you might have said or done, that could have led her to the conclusion that you can't expect HIROC to pay for it?

MR. BOONE:

A. Do I recall, you said, on the 19th or 20th, and as I told you earlier, I went to a meeting on the 19th. I don't recall dealing with Heather Predham on the 20th.

COFFEY, Q.C.:

Q. I'm not suggesting you did. This is just written on the -

MR. BOONE:

A. You asked me whether or not in my dealings on the 19th or 20th. I didn't have any dealings on the 20th.

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COFFEY, Q.C.:

Q. Well, on the 19th then, if they were your sole dealings, is there anything you did or said, from looking back on it, which from your perspective might have allowed her or caused her to draw the conclusion or reach the conclusion that you can't expect HIROC to pay for it if we go out and tell the patients being unsure of our facts.

MR. BOONE:

A. I have to say first, I'm taking you at your-- what you're saying that that's somehow what she meant by that note, because I don't read that note that way.

COFFEY, Q.C.:

Q. "Can't expect HIROC to pay for it," if you got another explanation, Mr. Boone, you're welcome to provide it.

MR. BOONE:

A. I'm not here to speculate, but I could. Maybe they wanted HIROC to pay for the testing. I don't know what it was. But you've got your evidence from Ms. Predham and I wasn't here for that. But taking that that was somehow other evidence, there's nothing that I can

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think of that I would have said to her that would have led her to think that that was the case.

COFFEY, Q.C.:

Q. Okay. Thank you very much, Mr. Boone. Those are my questions.

MR. BOONE:

A. Thank you.

THE COMMISSIONER:

Q. Mr. Pritchard?

MR. PRITCHARD:

Q. Thank you, Commissioner. I don't have any questions for this witness. Thank you for your evidence, Mr. Boone.

THE COMMISSIONER:

Q. Mr. Simmons?

MR. SIMMONS:

Q. I have no questions, thank you, Commissioner, Mr. Boone.

THE COMMISSIONER:

Q. Mr. Browne?

BROWNE, Q.C.:

Q. No questions, Commissioner. Thank you for your evidence, Mr. Boone.

THE COMMISSIONER:

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Q. Mr. Eaton?

EATON, Q.C.:

Q. No questions, Commissioner.

THE COMMISSIONER:

Q. As tempting as it is, Mr. Eaton? Ms. Newbury?

MS. NEWBURY:

Q. No questions.

THE COMMISSIONER:

Q. Mr. Glaspell?

MR. GLASPELL:

Q. No questions.

THE COMMISSIONER:

Q. I think you have the record, Mr. Boone, and I don't think there could be anything arising out of no questions, Mr. Coffey.

COFFEY, Q.C.:

Q. (Unintelligible). No, thank you.

THE COMMISSIONER:

Q. Okay then. Thank you very much, Mr. Boone, for your assistance.

MR. BOONE:

A. Thank you.

THE COMMISSIONER:

Q. Is the next witness ready? We think?

COFFEY, Q.C.:

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Q. Ms. Chaytor is up next.

THE COMMISSIONER:

Q. All right then. Mr. Glaspell, I suspect you won't want to be staying with us, so I just wish you a bon voyage and thank you.

MR. GLASPELL:

Q. Thank you very much.

THE COMMISSIONER:

Q. Now sir, if you'd just come up to this seat. Thank you. Ms. Chaytor?

CHAYTOR, Q.C.:

Q. The next witness is Joseph White.

THE COMMISSIONER:

Q. All right then, thank you.

MR. JOSEPH WHITE, SWORN, EXAMINATION BY SANDRA CHAYTOR, Q.C.

REGISTRAR:

Q. Would you please state and spell your complete name for the Commission?

MR. WHITE:

A. Joseph White, J-O-S-E-P-H W-H-I-T-E.

REGISTRAR:

Q. Thank you.

THE COMMISSIONER:

Q. Thank you, Mr. White.

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CHAYTOR, Q.C.:

Q. Good afternoon, Mr. White.

MR. WHITE:

A. Good afternoon.

CHAYTOR, Q.C.:

Q. Commissioner, there's two new exhibits this afternoon, P-3580 and P-3581.

THE COMMISSIONER:

Q. Entered.

EXHIBITS ENTERED AND MARKED P-3580 AND P-3581

CHAYTOR, Q.C.:

Q. Mr. White, perhaps you can begin by telling the Commissioner, what is your occupation?

MR. WHITE:

A. Generally referred--I'm self-employed, generally referred to as field service technician, field service rep, or field service engineer. Take your pick, they all mean the same thing.

CHAYTOR, Q.C.:

Q. Okay, and what is it that you service?

MR. WHITE:

A. For the last 20 years, I've been servicing lab equipment in the hospitals.

CHAYTOR, Q.C.:

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Q. And so that's been 20 years you've been doing that?
MR. WHITE:
A. Yeah.
CHAYTOR, Q.C.:
Q. And lab equipment here in the hospitals in St. John's?
MR. WHITE:
A. I've serviced lab equipment in every hospital in the province.
CHAYTOR, Q.C.:
Q. Okay, and what type of equipment would you service in the labs?
MR. WHITE:
A. Basically anything with a plug. I've serviced chemistry analyzers, hematology analyzers, blood gas analyzers, tissue processors, microtomes, microscopes, anything else you can--everything basically in the labs.
CHAYTOR, Q.C.:
Q. Okay, and so in terms of then servicing microscopes here in the City of St. John's, have you ever had any concern in doing that as to the level of maintenance carried out on the equipment?

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MR. WHITE:
A. A specific?
CHAYTOR, Q.C.:
Q. Yes, has there ever been any time when you've had a specific concern as to whether or not the microscopes--the level of general maintenance that was being carried out?
MR. WHITE:
A. About a year, maybe a year and a half ago, Barry Dyer at pathology at the Health Sciences, Barry is the pathology manager, as you know. He called me in one day and he asked me if I'd go over to St. Clare's and check the condition of a microscope for, I think it was Dr. Carter or Dr. Cook or both of them at the time. So I went over that afternoon and I checked the microscope. I can check it pretty quick, just to tell if there's a problem with it, and this would have been a single-head microscope at the time. Dr. Carter and Dr. Cook, most times when pathologists are looking at a microscope, they normally have a multi-head microscope where one pathologist can use it teach another pathologist, and they can look at the same

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specimen at the same time. In any case, this was a single-head scope. I believe it was an ICON 11 fosco (phonetic), about 25 years old. The age of it is not important because microscopes last a long time. I checked the optics on the microscope and they were about 40 percent contaminated, and they wanted it fixed. There's not much that I can't fix when it comes to a microscope, but this was like absolutely disgusting, for lack of a better word.
CHAYTOR, Q.C.:
Q. And where was this microscope located?
MR. WHITE:
A. It was in--just outside the OR.
CHAYTOR, Q.C.:
Q. So it was in a room just outside the OR?
MR. WHITE:
A. Yes, that's correct.
CHAYTOR, Q.C.:
Q. And did you check the microscope to see whether or not it had any stickers or labels on it to indicate when it had last been maintained or serviced?
MR. WHITE:

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A. I did, but there was nothing on it, and according to the condition of the microscope, I don't know if it ever had any service.
CHAYTOR, Q.C.:
Q. And Mr. White, then what did you do in that circumstance? Were you able to assist them and repair the microscope?
MR. WHITE:
A. Because it was in the OR, the location of it, I guess the pathologist use it for stat work, it was in such bad condition that I told, I believe Dr. Carter and Dr. Cook at the time, that there was nothing I could do with it, and I told them I would go over and speak to Barry about it, about getting a replacement to replace the one that was there. So I left right away. I thought it was that important, and I went right back to the pathology lab at the Health Sciences and Barry just happened to be in his office, and I told him the condition of the scope and I thought it was serious enough that he had to replace the scope right away.
CHAYTOR, Q.C.:
Q. And what happened?

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MR. WHITE:
A. He told me he had no money, and he had no replacement scope for it.
CHAYTOR, Q.C.:
Q. And were you able to be of any further assistance?
MR. WHITE:
A. I said to Barry, "well, if you want," I said, "I'll go speak to Terry. Maybe there's something that Terry can do." It was very important. He said "you can if you wish." I went to Terry's office. He just happened to be in. You very seldom see Terry in his office.
CHAYTOR, Q.C.:
Q. So you know them well enough to be calling them Barry and Terry? They're well known to you over the years, I take it?
MR. WHITE:
A. Well, 20 years, I've never called him Mr. Gulliver or Mr. Dyer.
CHAYTOR, Q.C.:
Q. And I take it you were frequent in the lab, so you were well known to them?
MR. WHITE:

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A. Every day for the best part of 20 years.
CHAYTOR, Q.C.:
Q. Okay. Sorry, go ahead, and so you spoke to Mr. Gulliver, and what did -
MR. WHITE:
A. I told him the condition of the microscope. It was pretty bad, and he needed to replace it, and I told him I spoke to Barry and Barry said there was no funds available to purchase one, and Terry said "well, how bad is it?" And I explained to him well enough that he knew that that had to be replaced like right away. So he said "do you have one?" and at the time, I don't think I had one, but I said I could probably put together one. I said "what they need over there," I said, "is a dual head teaching microscope so Dr. Carter and Dr. Cook can look at it at the same time" and he said "can you do something?" I said "well, I can probably put one together tonight and install it tomorrow," and he said "go ahead and do it." That's what I did.
CHAYTOR, Q.C.:
Q. Okay. So, rather than them have to go through the expense of buying a new microscope, you

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were able to put together something from parts that you had.
MR. WHITE:
A. Correct.
CHAYTOR, Q.C.:
Q. And you did that for them that night.
MR. WHITE:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Okay. And I take it that was at a much less cost than it would have been for them to go out and buy a new microscope?
MR. WHITE:
A. If they had to buy a new microscope to put--an equivalent microscope to what I had put there, it would have been at least 10--15 thousand dollars. They would have had to go to tender. It would have taken several months and they just couldn't wait and what I sold them, it was well under $2,000.00.
CHAYTOR, Q.C.:
Q. Okay. And Mr. White, were there other occasions throughout the years in dealing with the lab, particularly in St. John's, where you've had concerns about the maintenance of

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their machines and the financial ability to properly maintain the equipment?
MR. WHITE:
A. There's many time--I speak to basically to all the managers, almost on a daily basis, some are in/some are out, sometimes you'll only see them once a week, that type of thing. But of all the mangers I spoke to and I'll just give you a particular year for instance, maybe not necessarily this particular year, but I'll pick 2004 for instance. I'd speak to either Mr. Gulliver, Mr. Dyer, Barry or Terry, however you want to refer to them, and we'd be discussing issues about like, are you purchasing new equipment because I do sales and service, installations, whatever I need to do to make a living basically. And they'd say well, we're looking at getting maybe some microscopes. And I'd ask them, did you go out to tender? No, we haven't. Oh, don't you have any money left in your budget? No, we don't have last year's budget yet. So, this would have been, say, December 2004 and they had several months left in the fiscal year, which ends of course, on March 31 and you

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would think they had money left to buy equipment or do maintenance or whatever the case was. And they would tell you that they didn't have 2003's budget. I mean, that's-- and this didn't happen on one occasion. This happened over a period of several years and several different mangers told me the same thing.

CHAYTOR, Q.C.:

Q. Okay. And Mr. White, would you have interactions with other laboratory staff besides Mr. Gulliver and Mr. Dyer? Would you interact with the other staff? For example, the staff working the microtomes, would you have occasion to speak to them?

MR. WHITE:

A. Every time I would walk into a lab, I spoke to every single person that I met. And a lot of times, the lab techs, if they were doing something or they had a problem with a microscope or a microtome, they would stop me in the hall and ask me if they could make--if I could make a small adjustment or what do you think of this or what do you think of that? Under normal circumstances, I would do that.

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If it required a lot of work, I would go to Barry or Terry and tell them I needed a purchase order to spend an extended period of time to fix something.

CHAYTOR, Q.C.:

Q. And did you ever have occasion where you determined that the microtomes, for example, needed to be serviced and you brought that to the attention of Mr. Dyer, but was told, for example, like you've just indicated, that there's no funding, that they don't have any funding left in their current budget? Did that ever happen with respect to the microtomes?

MR. WHITE:

A. I'm not really sure, it's possible, not that I remember.

CHAYTOR, Q.C.:

Q. Okay. And in terms of--have you carried out maintenance on the microtomes over the years?

MR. WHITE:

A. I did maintenance on the microtomes twice a year since 1989, right up until last year, I guess, when this Inquiry started, the policies changed and I believe technical services at

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the University now, they're providing the maintenance on the microscopes and microtomes.

CHAYTOR, Q.C.:

Q. Okay. And what do you understand to be the importance of a microtome in the lab and the importance for it to be operating properly and well maintained?

MR. WHITE:

A. Just to give you a general idea, the pathology lab at the Health Sciences is, without question, the busiest lab in this province. I've been in every lab and there's no comparison. There's not enough room; there's not enough technologists; there's not enough equipment; and there's no enough money, in my humble opinion. Those microtomes are worked to death. Manufacturers will tell you that these instruments will last seven to ten years. Under normal circumstances, in a medium to low through put lab, sure, they will. At the Health Sciences, no, in my--they should be replaced every five years, whether they're working or not. They're just wore out basically and the tissue processors, the same thing. They shouldn't be over in those labs

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like in excess of five years. They're worked to death. Just to give you an example, an analogy about the tissue processors. They always have two, one for backup. Depending how busy they are, both may be running at the one time. It you take a family of 12 or a man and a woman who has 12 children and they have a washer and dryer. How long is that washer and dryer going to last in their house? Not very long. If you have a family of four, you'll probably get ten years out of it. A family of 12, you're not. Those instruments are wore out; they shouldn't be there any more than five years. I was listening to some of the testimony. You had two experts down here and they were talking about some filters that needed to be replaced on a tissue processor. And I think the lab techs were tasked to do this. In my opinion, that shouldn't be their job. They're just too busy to do that. They should have service technicians on staff--I know they use technical services at the University. That's great, 8--4, Monday to Friday, but I mean, you got to put in work orders and stuff like that. There should be a

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guy--and this is just not for pathology, this includes all the labs, chemistry, hematology, bactine (phonetic) and so on where you need general maintenance, daily routine maintenance. There should be somebody on staff who does that on a regular basis so the lab techs are not tasked to do it.

CHAYTOR, Q.C.:

Q. Okay. And Mr. White, in the circumstances where you did have occasion to speak to Mr. Dyer and/or Mr. Gulliver about feeling that maintenance needed to be carried out and they weren't in a position to do so because of funding issues, what happened in those circumstances?

MR. WHITE:

A. Two occasions and this would have been around 2003 to 2005, I provided service work to the lab, some minor service work, maybe an hour's labour. I was told beforehand that they had no money to pay for any maintenance and I don't know if this was Barry Dyer, it may have been Barry, there was no money to get any maintenance done and lab techs probably stopped me in the hall and asked me for

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maintenance and I mentioned it to them. They had no money to get it done. So, in any case, I would provide the service and wait until the first of April to get a purchase order.

CHAYTOR, Q.C.:

Q. And bill your services in their new fiscal year?

MR. WHITE:

A. Yeah.

CHAYTOR, Q.C.:

Q. And that happened on at least two occasions, you say, that you know of.

MR. WHITE:

A. At least one, maybe two occasions, yeah.

CHAYTOR, Q.C.:

Q. Now, Mr. White, there's a DAKO autostainer which is of interest to the subject matter of this Inquiry. Did you ever service the DAKO autostainer?

MR. WHITE:

A. No, I did no service on that, no.

CHAYTOR, Q.C.:

Q. Okay. And at some point, did the autostainer come into your possession?

MR. WHITE:

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A. Yes, it did.

CHAYTOR, Q.C.:

Q. Okay. And perhaps you can tell the Commissioner then when and under what circumstances you took possession of the DAKO autostainer.

MR. WHITE:

A. I believe it was in late 2004, early 2005 and that's just a general timeframe. I don't know exactly, somewhere between six and nine months timeframe. It may have been and I'm not absolutely positive. It may have been when the flood happened over at the Health Sciences, down at the pathology lab. It may have been, I remember that incident because I went in one morning and all the ceilings were down and the maintenance crews were there and so on. It was around that general timeframe. I had asked for that instrument on a couple of occasions and mainly because if I didn't ask for it, it was going to the landfill and it's not just the autostainer that would have went to the landfill. Basically everything that comes out of that institution goes to the landfill whether it's working or not.

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CHAYTOR, Q.C.:

Q. And so you have asked for it on a couple of occasions and what were you told?

MR. WHITE:

A. We don't know what we're doing with it yet.

CHAYTOR, Q.C.:

Q. Okay.

MR. WHITE:

A. And I think the last time I had asked Mr. Gulliver about it, I believe he said he was checking with the College of the North Atlantic to see if they could use it with their lab techs program. And some time after that I had asked him again because I knew they had their new instrument in and I knew it was going to the landfill. And I went in one morning and I had asked them again and he just said yeah, go take it, yeah, nobody wants it.

CHAYTOR, Q.C.:

Q. And did you also take possession of the computer that is used with the autostainer?

MR. WHITE:

A. I didn't think so. I don't mean to be funny about that, but I've been asked all these questions over the last month or so. I don't

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ever think I had a computer with that instrument, no.

CHAYTOR, Q.C.:

Q. Okay. Did you pay for the DAKO machine?

MR. WHITE:

A. Pay for it?

CHAYTOR, Q.C.:

Q. Yes, was any money exchanged hands?

MR. WHITE:

A. Absolutely not, no.

CHAYTOR, Q.C.:

Q. Okay. And was there any paperwork completed with respect to you taking it?

MR. WHITE:

A. No.

CHAYTOR, Q.C.:

Q. Okay. And perhaps we can look at P-3109. Now, it's going to come up on your screen, Mr. White.

MR. WHITE:

A. Okay.

CHAYTOR, Q.C.:

Q. And I just want to show you, we have some photographs attached. We have a letter here from you, but I'm going to take you to that in

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a minute. But this also has some photographs which we understand to be the condition of the lab after the flood that you mentioned.

MR. WHITE:

A. That's--yeah.

CHAYTOR, Q.C.:

Q. So, you remember being in the lab around the time and seeing it -

MR. WHITE:

A. Yeah, I believe there was a couple of weeks that it took to clean that place up.

CHAYTOR, Q.C.:

Q. Okay.

MR. WHITE:

A. It was a mess.

CHAYTOR, Q.C.:

Q. All right. And you've had a chance--I've shown you these photographs before.

MR. WHITE:

A. Yeah.

CHAYTOR, Q.C.:

Q. And was the DAKO autostainer in any of those photos?

MR. WHITE:

A. No, I don't see the autostainer, no.

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CHAYTOR, Q.C.:

Q. And when you saw the autostainer and was interested in taking it, was it in this part of the lab or where was it? Was it in a different part? I mean, you can flick through--do you want me to flick through it for you? Here's the third picture and I think that's it.

MR. WHITE:

A. It's very hard to tell by the pictures. It was in--as far as I can remember, it was in the main lab where the lab techs do their cuttings in the morning with the microtomes. There's normally maybe eight or ten lab techs there. And at the back of that lab, say, on the east side of that lab, there's a door and it joins onto another lab where they had, i believe, the new Ventana machine. I believe it sat on a desk, actually, it may have even been that desk that's right there. It probably straddled both of them. I'm not positive. That's just what I think.

CHAYTOR, Q.C.:

Q. It's hard to tell from the photos in terms of -

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MR. WHITE:

A. Yes, it is.

CHAYTOR, Q.C.:

Q. Okay. And when you removed the machine, I take it though, the lab wasn't in this condition. It was cleaned up from this condition?

MR. WHITE:

A. I'm not really sure. It might have been in this condition or it might have been cleaned up. I'm not positive.

CHAYTOR, Q.C.:

Q. So, there was no concern with you going into the lab with it in that condition or was there any -

MR. WHITE:

A. I wouldn't have been concerned about it, no.

CHAYTOR, Q.C.:

Q. Okay. And who was present when you removed the DAKO autostainer from the lab? You spoke to Mr. Gulliver and he said, yes--on this occasion when you asked him--he said it was okay for you to take it. And then did you take it that day or was it some period of time went by before you -

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MR. WHITE:
A. No, I would have taken it right away because I was concerned it was going to go to the landfill. And you got to keep in mind, I'm trying to make a living at this. So, my whole purpose for that instrument was to make money on it. I don't make any bones about it. I make a living as best I can. And I knew that instrument had some value and I didn't want to see it go to the landfill.
CHAYTOR, Q.C.:
Q. Okay. And so do you remember then who was present? Was Mr. Gulliver still there when you took it?
MR. WHITE:
A. No, I had spoke to Terry in his office.
CHAYTOR, Q.C.:
Q. Okay. And so in the lab that day did anyone else have to assist you, for example, in removing it?
MR. WHITE:
A. Oh absolutely, somebody would have assisted me. That instrument was just too big.
CHAYTOR, Q.C.:
Q. And do you know who did that? Do you know

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whether or not Mr. Dyer, for example, was involved?
MR. WHITE:
A. It definitely wasn't Barry. It was probably, if it was around this time when the flood was on the go, if I took it at that time, maybe one of the maintenance guys. There's a possibility, maybe one of the lab techs or maybe two. I mean, it was a pretty heavy instrument. So, somebody had to help me with it.
CHAYTOR, Q.C.:
Q. Okay. And did you have any discussions with anyone besides Mr. Gulliver and obviously, the people who physically helped you remove the machine, did you have discussions with anyone else at Eastern Health about the fact that you were going to be taking possession of the machine?
MR. WHITE:
A. No, I had asked Barry and Barry told me it wasn't in his power to do it. He said you have to check with Terry. Now, you have to keep in mind, Barry is a pack rat, that man keeps everything. He won't give anything away

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unless he gets permission from Terry.
CHAYTOR, Q.C.:
Q. And when you took the DAKO autostainer, when you received it, what condition was it in?
MR. WHITE:
A. The machine itself dispenses stains. These are all multi-colored, really, really dark and they're inks and so on. It was full of stains, a lot of them. You know, it was dusty. It needed tubing changed on it. It was just generally dirty. It wasn't really--I mean, it wasn't filthy or anything like that, it was just dirty.
CHAYTOR, Q.C.:
Q. And so other than having to clean it up basically, did you have to carry out any major repairs or any maintenance on it?
MR. WHITE:
A. The only maintenance I would have done besides cosmetic was I may have replace some tubing and if it was, it wasn't very much, and removed all of the excess drain tubing.
CHAYTOR, Q.C.:
Q. Okay. And prior to taking then possession of the machine, did you make any inquiries as to

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its conditions or whether or not it had any repairs carried out over the years?
MR. WHITE:
A. Yes, I did and I'm laughing at that again, sorry, I had spoken to you at some point after I had spoken to Mr. Gulliver. He called me one day and he asked me if there was a--and this was only like five weeks ago, before he came down to the Inquiry, and he asked me if there was a computer and I flat out told him no, there was no computer. He said, are you sure and I said, yeah, pretty sure. And it was only last week I went over and apologized to him because I know he told the Inquiry that there was no computer. He got that information directly from me, so what he told you is accurate based on the information that I gave him. And -
CHAYTOR, Q.C.:
Q. Yes.
MR. WHITE:
A. - I spoke to you probably a week later, maybe and I had just picked up my son at the university--when I had that DAKO autostainer, he had performed the self test diagnostics on

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it. So, anyway we were on our way home and I was speaking to you on my cell phone and you were asking me about the autostainer and you were asking me if there was a computer. So, just to confirm that there was no computer, my son had done the testing, so I turned to him and I said, do we have a computer with that instrument. He thought about it for two seconds and he said, oh yeah, we had to have a computer in order to run the self test diagnostics. He caught me by surprise because I was just after telling you second before there was no computer.

CHAYTOR, Q.C.:

Q. Yes.

MR. WHITE:

A. So, yeah, there was a computer with that instrument, yeah.

CHAYTOR, Q.C.:

Q. And I'll take you through that in a little more detail in a moment. I'm just wondering though, before you actually took possession of the autostainer, did you inquire of anyone as to its condition? You said you knew that there was a value in it.

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MR. WHITE:

A. I'm sorry, Ms. Chaytor, I got off topic that time.

CHAYTOR, Q.C.:

Q. No, no, that's okay, that's fine. And whether or not you contacted anyone to see if it had any repairs over the years.

MR. WHITE:

A. Right.

CHAYTOR, Q.C.:

Q. So, to assure yourself it did have value is basically what I'm asking.

MR. WHITE:

A. Right. I spoke to the guy who had performed the maintenance on it over a period of time from Tech Services. His name is Bruce. And I thought for sure I had asked him if any major parts had been replaced on that instrument. If that was the case, even if the instrument wasn't working, I could have made money on the parts. There's a worldwide industry for parts for lab equipment, just as there is in cars. And I thought he had told me that the robotic arm or the robotic head had been replaced at some point.

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CHAYTOR, Q.C.:

Q. And I take it the robotic arm is a significant component to this machine?

MR. WHITE:

A. It's about 30 percent of the value of the machine, I would say.

CHAYTOR, Q.C.:

Q. So, that would have made the machine more valuable to you to know it has a new robotic arm.

MR. WHITE:

A. If that machine was absolute garbage and there was a new robotic arm on it, I would have taken it anyway. I could have sold it for half the retail price.

CHAYTOR, Q.C.:

Q. And are you able to say if the robotic arm had failed at any point on the instrument? Do you have any knowledge as to whether or not the robotic arm had failed?

MR. WHITE:

A. I thought according to Bruce, at the time, I had questioned him on it just to see and I thought that's what he had told me. And as a matter of fact, last week, I called him and I

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asked him if he remembered the autostainer. He said he did. And I asked him when, not if, when he replaced the robotic arm and he says he never had replaced the robotic arm. So, I'm not sure where I got that -

CHAYTOR, Q.C.:

Q. So, if that were the case, he wasn't the person who did it or it wasn't done -

MR. WHITE:

A. Well, he told me somebody else was doing the service on it and I remember seeing work orders that myself and yourself looked at and his name is on the work orders and he told me that he hadn't done any service on that machine. Now, in the meantime, he may have misunderstood me, probably thought I was talking about the Ventana machine which is the new machine that's there. Because he's now in another building. I thought about it after and maybe that's what he thought at the time.

CHAYTOR, Q.C.:

Q. And if the robotic arm had failed, do you know what might be the implications for any tests that were being run at the time of -

MR. WHITE:

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A. If the robotic arm had failed, there would be no test. That machine would not operate.
CHAYTOR, Q.C.:
Q. Okay. And how would someone operating the machine know whether or not the robotic arm had failed?
MR. WHITE:
A. Whether or not it had failed?
CHAYTOR, Q.C.:
Q. Yes.
MR. WHITE:
A. It would just stop.
CHAYTOR, Q.C.:
Q. Okay. And if it was causing any kind of difficulties like interruption in the runs, was there anything on the machine, any alarm system, anything, do you know that would trigger them to know there's an issue with the robotic arm?
MR. WHITE:
A. Generally speaking, not necessarily for that instrument, but generally speaking, any kind of a robotic instrument has stops and limits that if it goes outside of its stops and limits or it doesn't fall where it's supposed

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to fall on its XY axis you would get an error. I suspect that machine had something similar.
CHAYTOR, Q.C.:
Q. Okay. And do you know or did you have any discussions with anyone to indicate how it became if there was an issue with robotic arm, how it had been detected?
MR. WHITE:
A. The only discussions I had was with the service tech, Bruce.
CHAYTOR, Q.C.:
Q. Okay. And if we could look at P-3112 please.
THE COMMISSIONER:
Q. Excuse me, Ms. Chaytor, before you leave that, the Registrar tells me that when you were running through those photos, there, in fact, are two on each--so, if you want to run through them again just to make sure whatever point you were making in respect of the photographs was made.
CHAYTOR, Q.C.:
Q. Mr. White, then, I'll just show you--thank you, Commissioner--show you these photographs. We may not have seen them all. And -
THE COMMISSIONER:

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Q. And you're just looking at find out whether or not the location of the DAKO is shown here.
MR. WHITE:
A. Okay, excuse me, if you look at the bottom picture here and you see this sink.
CHAYTOR, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. Yes.
MR. WHITE:
A. That's up on the back of the lab on the east side of that lab, towards the front is where all the lab techs would perform their cuttings in the morning.
THE COMMISSIONER:
Q. Um-hm.
MR. WHITE:
A. To the left of that sink or just a bit further back, there would have been a desk and that's where the autostainer would have sat.
CHAYTOR, Q.C.:
Q. So, back this way from -
MR. WHITE:
A. Yes.
CHAYTOR, Q.C.:

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Q. Let's just see now, we'll look at the next page and see, is it in those photos.
MR. WHITE:
A. No, that's the front of the lab, no.
CHAYTOR, Q.C.:
Q. That's the front, no. And is this the sink?
MR. WHITE:
A. I don't--there's a couple of sinks there. If you go--right there behind that yellow bag, is that a yellow bag right there?
CHAYTOR, Q.C.:
Q. That looks like a yellow bag.
MR. WHITE:
A. Right behind that there, there's a shovel and there's another sink. It would have been just beyond that, I believe.
CHAYTOR, Q.C.:
Q. And let's just see, here's the other photos. Nothing in those? No?
MR. WHITE:
A. Actually, could you go back one, please
MR. WHITE:
A. Sure. No, that looks like the gross room.
CHAYTOR, Q.C.:
Q. Okay. And I think one more. Anything in any

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of those photos?
MR. WHITE:
A. No, I don't think so.
CHAYTOR, Q.C.:
Q. And if we could have, please Registrar, P-3112? Mr. White--and it'll come up on the screen--these are the maintenance records for the autostainer that we've been provided from Eastern Health.
MR. WHITE:
A. Okay.
CHAYTOR, Q.C.:
Q. Or certainly some maintenance records. It says, "there are maintenance records" -
MR. WHITE:
A. Right.
CHAYTOR, Q.C.:
Q. Attached are maintenance records. Whether or not it's all of them, I don't know if that's been determined, but, for example, here's the first one and it says, "Checked hose, cleaned drain filter".
MR. WHITE:
A. Right.
CHAYTOR, Q.C.:

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Q. Would that have anything to do -
MR. WHITE:
A. No, that's just--that's just basic maintenance. That would be part of a PM or a weekly check.
CHAYTOR, Q.C.:
Q. Okay, and then this one is 1999, March 18th, 1999, is the request date, and this says, "Fungus lines. Replace lines". What would that be referring to?
MR. WHITE:
A. That would be from lack of maintenance.
CHAYTOR, Q.C.:
Q. Okay.
MR. WHITE:
A. That's why those lines are changed on a regular basis is to prevent fungus from building up in them. So that might have been--maybe somebody overlooked it, or somebody--they may have been busy, but if they're left for any period of time, there's all kinds of weird and wonderful things that go through those lines, and if you don't replace them, you will get fungus.
MR. SIMMONS:

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Q. Excuse me, on that one, and I know I'll get a chance after, but I wonder looking at that particular record if you can identify maybe that is the autostainer? Would this be work on that one?
MR. WHITE:
A. It's a slide stainer.
CHAYTOR, Q.C.:
Q. It's the serial number -
MR. SIMMONS:
Q. See if we can match--okay, thank you.
CHAYTOR, Q.C.:
Q. Yes, we understood from your e-mail these all were related to the DAKO autostainer.
MR. SIMMONS:
Q. I just saw the reference to the (inaudible).
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Mr. Simmons, are you questioning that the serial number is the DAKO in concern?
MR. SIMMONS:
Q. No, I hadn't--I just saw a different reference (inaudible). For a moment there, I wasn't sure.

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THE COMMISSIONER:
Q. Okay, all right. Thank you.
CHAYTOR, Q.C.:
Q. Because there is--there is a discrepancy in the serial number, but we've had that discussion before and I understood this is the autostainer, though.
THE COMMISSIONER:
Q. Thank you.
CHAYTOR, Q.C.:
Q. There's one digit that was different, and my understanding is that that's perhaps an error in these maintenance records, yes. We're on page six now, sorry, Mr. White, of the exhibit.
MR. WHITE:
A. Sure.
CHAYTOR, Q.C.:
Q. And this is "tubing".
MR. WHITE:
A. Tygon tubing, that's correct.
CHAYTOR, Q.C.:
Q. Okay, and that's more--is that more just regular maintenance?
MR. WHITE:

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A. General maintenance, yeah.
CHAYTOR, Q.C.:
Q. Okay, I'm sorry, and the date on that one was into 2000 now, February 7th, 2000, and then the next one as well, February 17th, 2000, and this is tubing as well?
MR. WHITE:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And the next one, October 10th, 2000, and this is--we see, "B. Cocker". Is that Mr. Cocker?
MR. WHITE:
A. That would be Bruce, yeah.
CHAYTOR, Q.C.:
Q. Bruce Cocker, that you were speaking with.
CHAYTOR, Q.C.:
Q. And it says, "PM completed". So that's your preventative maintenance, I take it?
MR. WHITE:
A. Preventative maintenance, that's correct.
CHAYTOR, Q.C.:
Q. And then October 4th, 2001, I believe, and it's Mr. Cocker's name again?
MR. WHITE:
A. Uh-hm.

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CHAYTOR, Q.C.:
Q. "Probe not injecting, Due PM", what's that about?
MR. WHITE:
A. That a problem with the robotic head.
CHAYTOR, Q.C.:
Q. That is?
MR. WHITE:
A. That would be a problem with the robotic head, yes, as far as I can remember now.
CHAYTOR, Q.C.:
Q. Okay.
MR. WHITE:
A. But many years ago in Grand Falls, I serviced a similar instrument, and it was--it probably dispensed something else, I don't remember exactly, but if the probe is not injecting, there's not necessarily a problem with the robotic head, the probe sits in a robotic head, and there are pumps that would come on and off at certain segments and would force fluid up to the robotic head down to your syringe where it would actually deposit onto your slides.
CHAYTOR, Q.C.:

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Q. Okay, and so while you didn't service this particular autostainer, you did have experience in servicing another autostainer, a similar autostainer?
MR. WHITE:
A. It probably wasn't an autostainer. It was--it worked in a similar robotic fashion and it dispensed some fluids.
CHAYTOR, Q.C.:
Q. Okay, and this is October of 2001, and Mr. Cocker's name again is there, and then this one is February 7th, 2000, and tubing again, and in May of 2002--I don't see on this one--do you see anything on this one, Mr. White, that indicates what was carried out?
MR. WHITE:
A. Can I use this mouse here to scroll up?
CHAYTOR, Q.C.:
Q. Go right ahead, yeah, scroll up or down.
MR. WHITE:
A. Oops, I lost it.
CHAYTOR, Q.C.:
Q. That's okay, she'll bring it back up for you.
MR. WHITE:
A. This one here is too sensitive. Okay.

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There's nothing to indicate other than it says, "It must be down--they made a note that there that, "no". I'm not sure--there's nothing there to indicate that anything had been done to it.
CHAYTOR, Q.C.:
Q. Okay, and then December 19th, 2002, Mr. Cocker's name again, and again I don't see any particular description given of what happened on that date, and then July 29th, 2003, and I don't think -
MR. WHITE:
A. I don't know--spent five hours doing something.
CHAYTOR, Q.C.:
Q. Right here, yes, "Five hours doing something", okay. Then I believe, this is the last one we have is November 5th, 2003, and he spent it looks like seven hours doing something, is that right?
MR. WHITE:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Okay. So would any of those indicate that the robotic arm had been replaced?

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MR. WHITE:
A. If indeed it did, I mean, that's not something you replace in a short period of time. That would have taken several hours for sure.
CHAYTOR, Q.C.:
Q. So the one that we looked at--if we go back to, I think it was page--yes, page 12, please, Registrar. I don't think the--I think it looks like it's a two hours job, "The probe not injecting. Due PM", and there's a two hour and a six hour indicated there.
MR. WHITE:
A. Yeah, that could--well, I mean, the probe is not injecting, even if you know the instrument, it probably would have taken several hours to fix it if--if it was a person like me who had no specific experience on that particular instrument, I probably would have--and had no other information, I probably could have fixed it, but it would have taken me several hours more.
CHAYTOR, Q.C.:
Q. Okay, and the work dates here are indicated to be September 19th, September 24th. The request date is indicated to be October 4th,

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however, and completed September 24th. So the dates, there seems to be an issue with the dates.
MR. WHITE:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay. So, Mr. White, you took possession of the autostainer.
MR. WHITE:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And you now realize that it included both the autostainer and the accompanying computer. What did you do with it?
MR. WHITE:
A. What do you mean, when I disposed of it?
CHAYTOR, Q.C.:
Q. Yeah, once you got it, and you said you cleaned it up a bit, your son ran some sub-test diagnostics, I believe you called it?
MR. WHITE:
A. Self-test diagnostics.
CHAYTOR, Q.C.:
Q. Yes, and how long did you have it in your possession and then what happened to it?

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MR. WHITE:
A. I'm guessing it probably would have been no more than several weeks because I would have wanted to just get it in, get it out, generate some revenue from it, that's the only thing I was looking at.
CHAYTOR, Q.C.:
Q. And you would have gotten it either late 2004 or early 2005?
MR. WHITE:
A. That's just a guess on my part. I think it's around that general time frame.
CHAYTOR, Q.C.:
Q. Okay, so then you had it for several weeks?
MR. WHITE:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. So then what happened, where did it go from you?
MR. WHITE:
A. I sold it to a company down in North Carolina. They are a pathology broker, Southeast Pathology Instruments, and the guy's name is Michael Dietrich. He was the owner.
CHAYTOR, Q.C.:

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Q. Michael Dietrich, and, Mr. White, how much did you sell it for?
MR. WHITE:
A. I think about $4,000.00 including shipping.
CHAYTOR, Q.C.:
Q. Okay, US?
MR. WHITE:
A. US, absolutely.
CHAYTOR, Q.C.:
Q. Now, Mr. White, in the spring and summer of 2005, were you contacted by anyone from Eastern Health to inquire about the whereabouts of the DAKO machine and/or its computer?
MR. WHITE:
A. I don't think so, no.
CHAYTOR, Q.C.:
Q. And when were you first contacted by anyone from Eastern Health about the DAKO machine?
MR. WHITE:
A. I think Terry Gulliver phoned me--he never phoned me. I was walking by his office about five weeks ago, and he was on the phone, his door was open, and he waved to me more or less to say that he wanted to speak to me, and I

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waited for a second. He got off the phone and he asked me did I remember the autostainer, and I said, yeah, I do. He said was there a computer with it, and I told him, no, there was no computer. He said are you sure, and I said, yeah, I'm pretty sure.

CHAYTOR, Q.C.:

Q. Mr. White, would it surprise you if there was any issue as to the DAKO machine or whether or not it had been operating properly back in 2005 or whether or not it contained any records, would it surprise you that you weren't contacted back then?

MR. WHITE:

A. This is way before the inquiry. I don't know why somebody would even contact me.

CHAYTOR, Q.C.:

Q. Back in 2005, if--like, June, say, July, 2005, if there was any question within Eastern Health as to that DAKO machine, whether or not it was operating properly, or whether it had any records on the computer, if any question arose back then in that time period, shortly after you'd taken the machine -

MR. WHITE:

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A. Yeah.

CHAYTOR, Q.C.:

Q. Are you surprised that nobody would have contacted you then and said, well, Joe, do you have the computer or what condition was the machine in when you got it? The questions I'm asking you today, are you surprised if those questions had come up back in 2005, that you wouldn't have been asked back then about it?

MR. WHITE:

A. I don't think anybody asked me those questions, but if it had been important, why wouldn't they ask me.

CHAYTOR, Q.C.:

Q. And I take it, you were around as frequently as ever?

MR. WHITE:

A. No, actually there was a period of time there where I was in a traffic accident about four years ago, and it really did a number on me physically and I was in there infrequently.

CHAYTOR, Q.C.:

Q. Okay. So when would that have been?

MR. WHITE:

A. That would have been four years ago this

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January.

CHAYTOR, Q.C.:

Q. So back in the summer of 2005, would you have been around to be asked about -

MR. WHITE:

A. Possibly not.

CHAYTOR, Q.C.:

Q. And were you otherwise--had you moved, were you around? Like, if anyone from Eastern Health wanted to track you down, you know, Terry and Barry very well, would you have been around for them to be able to call?

MR. WHITE:

A. I had a cell phone.

CHAYTOR, Q.C.:

Q. And I take it they have your number?

MR. WHITE:

A. They know where to get me pretty well 24 hours a day if they need me.

CHAYTOR, Q.C.:

Q. Okay, and the first time you were asked any question about the DAKO machine was five weeks ago, around five weeks ago?

MR. WHITE:

A. Yeah, as far as I can remember, yeah.

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CHAYTOR, Q.C.:

Q. And did you ask Mr. Gulliver why this is an issue now, why he was asking you about it?

MR. WHITE:

A. I knew the inquiry was on the go. I thought if there was a computer, that the issue would have been a privacy issue, and that's why everybody was--everybody, well, you guys, and Terry was asking about the computer. I mean, fair enough, if it was a privacy issue, then I would have been concerned whether or not the hard drive was formatted, so if there was any patient files on it, then it wasn't easily accessible.

CHAYTOR, Q.C.:

Q. Yes, and so you had told Mr. Gulliver that. He'd asked you whether or not you also had the computer and you told him that you didn't think you had the computer?

MR. WHITE:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And you've told us about how you realized otherwise.

MR. WHITE:

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A. Right.
CHAYTOR, Q.C.:
Q. If we could look, please, at P-3110, and I'm just going to take you to page two, and this is--Mr. Gulliver then sends along this information about the DAKO autostainer, and how it came to be disposed of, and you'll see this is written on September 18th, 2008, and it's just going from the lawyer for Eastern Health to myself and Mr. Coffey.
MR. WHITE:
A. Right.
CHAYTOR, Q.C.:
Q. And you will see here that it's written, "In December, 2004, January, 2005, the old DAKO instrument was taken away by Mr. Joe White, General Technical Services, and Mr. White has dropped off a letter indicating that he indeed took away the old instrument, and the old computer with the DAKO machine, along with a fair bit of paper documentation, was discarded during the clean-up of the flood. The pathology laboratory, Barry Dyer, was given permission to enter the flooded area to identify information that could be saved. Mr.

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White has confirmed that he only took the DAKO instrument and not the old PC. There were no records kept with the DAKO machine's hard drive. There are also no records/discs from the old PC anywhere in the lab. We can only assume that when the PC was discarded after the flood, any disc/paper records went with it". So I take it, Mr. White, you told Mr. Gulliver that you only took the instrument, not the old computer, not the old PC?
MR. WHITE:
A. Yeah, see at the time, the only thing that would have been of any interest to me was the instrument itself, and not the accessories that went with it.
CHAYTOR, Q.C.:
Q. Okay.
MR. WHITE:
A. So I probably took--the computer was probably with it, it may have been physically plugged into it, but I--I still don't remember to this day having the computer with it.
CHAYTOR, Q.C.:
Q. Okay, and the--whether or not the--I take it you weren't the source of the information in

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terms of the old computer being thrown out, though, after the flood?
MR. WHITE:
A. What you have to understand is the way it works in pathology, anyway, and I suspect some of the other labs, when a piece of equipment becomes redundant and it has been replaced with another piece of equipment, generally speaking I think what they do, they'll keep the old equipment for several months to make sure that the new equipment is working properly, so they have some sort of a backup. When they determine that their new instrument is working properly, the other instrument basically just becomes--it's in the way and if the lab tech program at the college doesn't take it, it goes directly to the dump, and Mr. Gulliver would have just made the logical assumption that the computer would have went to the landfill as well because everything else does.
CHAYTOR, Q.C.:
Q. Okay, and if we just go to page--the first page is just an inquiry from myself on September 17th in the evening to Mr. Simmons

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asking about--to confirm the status of the machine, and then Mr. Simmons got back to me that evening indicating, "The latest information on the disposal of the DAKO autostainer was that it was given to Mr. Joe White, and that Mr. White apparently was interested in it for parts. It was not sold to him and there's no known paperwork related to the disposal of it. I have asked Barry Dyer to get in touch with Mr. White and find out what became of the unit, including the computer". So do you recall did Mr. Dyer get in touch with you and make any inquiries?
MR. WHITE:
A. Yes, Barry did. That was several days or maybe a week before Terry inquired about it, and Barry asked me to write a note saying that I had taken the instrument. Because Terry is the manager, I gave a copy of that same note to Terry as well.
CHAYTOR, Q.C.:
Q. So if we can just look then, please, at 3109. So your first--did your first contact come from Mr. Dyer asking you, or did it come from Mr. Gulliver flagging you down when you were

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in the lab?
MR. WHITE:
A. No, no, Barry Dyer would have asked me about it first.
CHAYTOR, Q.C.:
Q. Barry asked you about it first?
MR. WHITE:
A. Yeah.
CHAYTOR, Q.C.:
Q. And what did Mr. Dyer ask you when he contacted you? Was that a phone conversation or -
MR. WHITE:
A. No, no, I was walking by again one day.
CHAYTOR, Q.C.:
Q. Okay.
MR. WHITE:
A. And Barry had stopped me and he asked me--he told me got an e-mail, I guess from somebody at the inquiry, maybe it was yourself, and someone was looking for the whereabouts of the autostainer, or who took it, or something along those lines, and he asked me if I could write a note just saying that I had taken it at some point in time, whenever that might

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have been, and he may have asked me what I did with it at the time, but according to this note here, it was just--it's just the time frame in which I actually removed the instrument.
CHAYTOR, Q.C.:
Q. So Mr. Dyer asked you if you'd write a note?
MR. WHITE:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And what did you understand you had to write in your note?
MR. WHITE:
A. Just that I had taken it in a certain period of time.
CHAYTOR, Q.C.:
Q. And did he make any inquiries of you as to where did the machine go or what you did with it after having taken possession of it?
MR. WHITE:
A. No, I don't think so.
CHAYTOR, Q.C.:
Q. So it was just as to the fact you had taken it and the time period that you had taken it?
MR. WHITE:

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A. Yes.
CHAYTOR, Q.C.:
Q. So this is September 17th, 2008.
MR. WHITE:
A. Okay.
CHAYTOR, Q.C.:
Q. It's dated, and you write, "Hi, Barry, in response to your inquiry concerning the DAKO autostainer, I removed the instrument from the Health Science Complex somewhere in the general time frame of late 2004/early 2005, with the permission of the lab director, Mr. Terry Gulliver", and were you able to come up with those dates on your own or -
MR. WHITE:
A. It was just a guess on my part.
CHAYTOR, Q.C.:
Q. And did you have anything you could reference as to the time frame?
MR. WHITE:
A. Nothing really, because this is used equipment and it was several years old, I wouldn't keep any documentation on used equipment.
CHAYTOR, Q.C.:
Q. So your sale of the instrument, for example,

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to Southeast Pathology, did you have any records as to when that happened?
MR. WHITE:
A. No, I didn't, no.
CHAYTOR, Q.C.:
Q. Okay, and do you know--you thought you kept it for several weeks. Do you have any idea as to when that sale took place to Southeast Pathology?
MR. WHITE:
A. If I took it in late 2004, it would--depending on whether it was December or November, if I took it in November, I probably sold it in December, if I--if it was early 2005, say January, February, March, probably say within a month of either one of those months, and again, I'm only guessing. I don't know the exact time frame.
CHAYTOR, Q.C.:
Q. Okay, and when you were first contacted by Mr. Dyer about this, did he seem to have any knowledge about you having the machine or did it seem to be news to him that you had the machine?
MR. WHITE:

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A. I think he--I'm not sure.
CHAYTOR, Q.C.:
Q. And the date of the letter being September 17th, 2008, is that the same day that Mr. Dyer contacted you or -
MR. WHITE:
A. No, it probably would have been the day before.
CHAYTOR, Q.C.:
Q. So he probably contacted you on the 16th, you're saying?
MR. WHITE:
A. I think, well, that day I was in the lab was probably on the 16th, he had asked me for something or whatever, that I sent it to him, but I mean, I would have to go home to my computer and do it up and then the next day bring it back to him.
CHAYTOR, Q.C.:
Q. Okay, and you're sure though that's the date you wrote the letter, September 17th?
MR. WHITE:
A. Well, that should be accurate.
CHAYTOR, Q.C.:
Q. Okay, and then did you drop the letter off the

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same day that you wrote it?
MR. WHITE:
A. I probably did. It was either that day or the day before. It was like--if he asked me on the 16th, I probably did it up that night. That could have been the 16th or the 17th. In any case, it was within--I'm pretty sure it was within 24 hours of Barry asking me about it.
CHAYTOR, Q.C.:
Q. Okay, and when you had your discussion with Mr. Gulliver and so that came--your discussion with Mr. Gulliver came after your discussion with Mr. Dyer?
MR. WHITE:
A. Right.
CHAYTOR, Q.C.:
Q. Did Mr. Gulliver--he remembered, I take it, that you're the person who had the DAKO machine. Was there any confusion on his part or did he indicate whether or not he'd forgotten for a period of time that you had the machine?
MR. WHITE:
A. No. What he said to me was, he said "do you

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remember the DAKO autostainer?" I said "yes, I do" and then he asked me about the computer and I told him there was no computer. It was a very short conversation that we had.
CHAYTOR, Q.C.:
Q. Okay, and then your letter, you dropped the letter off. Who did you give the letter to?
MR. WHITE:
A. I gave a copy to Barry and I gave a copy to Terry.
CHAYTOR, Q.C.:
Q. And was there any discussion then around the letter when you dropped it off or any further discussion about the DAKO machine?
MR. WHITE:
A. I don't think there was any discussion at all.
CHAYTOR, Q.C.:
Q. And if we could go back to 3110, please? And just on page three then, you'll see page two is the summary from Mr. Gulliver, and then on page three, a few days later, Monday, September 22nd, "here is Terry Gulliver's reply to the question about what Joe White did with the autostainer. 'When Joe came in with the letter, I asked him that question. He

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said that when he took it, he cleaned it up, a few minor repairs, performed diagnostic check and preventive maintenance. At some point, he sold it to a surplus equipment place and he thinks it is in Bermuda/Bahamas.'" Do you recall giving that information to Mr. Gulliver?
MR. WHITE:
A. I don't recall it. That's not to say that I didn't give it to him. I don't remember giving anybody that information.
CHAYTOR, Q.C.:
Q. And this would have just been, well, a month ago, September 22nd. So you don't remember telling that to Mr. Gulliver?
MR. WHITE:
A. I may have. I don't recall a conversation, but he may have asked me some questions about it.
CHAYTOR, Q.C.:
Q. Is there any reason why you would tell him Bermuda or Bahamas?
MR. WHITE:
A. Absolutely not, no.
CHAYTOR, Q.C.:

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Q. Okay, and -
MR. WHITE:
A. No, because I wouldn't have--I wouldn't have known. I had to go back and check when you called me, I think the next day I had to phone to find out where it actually went to.
CHAYTOR, Q.C.:
Q. Where it went after you--you sold it to the States. I take it you remembered that?
MR. WHITE:
A. Yes.
CHAYTOR, Q.C.:
Q. And Southeast Pathology, you knew that?
MR. WHITE:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Okay, all right, and then you had to go and check and do what, after I phoned and asked you about it?
MR. WHITE:
A. After I spoke to you on the phone that day on my way home, I phoned Southeast Pathology the next day. I spoke to Michael Dietrich, he was the owner. I asked him if he remembered me, because I hadn't spoken to him since I sold

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that autostainer. He said he did. I asked him if there was a computer with that instrument. He said he didn't know. I told him what was going on with the Inquiry and so on and it was important that we try to locate it. I asked him if he remembered where he sold it, and he said he thinks he knew where he sold it at the time, and I asked him if he had any paperwork on it, and at the time, he was on his cell phone and he wasn't in his office. So I asked him if when he got back to his office, if he would check, and I sent him an e-mail to remind him and asked him some questions, basically whether or not it was formatted, because at the time I thought it was a privacy issue. I had asked him some other questions about any maintenance that he may have done to it and so on.

After I sent him the e-mail, I had no---I waited for 48 hours. There was no response. So I called him back again, and at the time, he was in his office, and I asked him if he could take a look to see if he had any paperwork, and he did. He told me had a purchase order from the University of West

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Virginia and I asked him if there was anything on the purchase order that would indicate there was a computer. He said no. So I still wasn't convinced there was a computer, even though my son told me it was there. I asked him if he had a contact name, e-mail, telephone number for the University of Western Virginia where it was sold to. He gave me that information.

The same day, I believe this was on a Friday, I called the University of Western Virginia with the number that I had and I got someone's voice mail. I left a message. I waited for 48 hours, which brought us up to a Tuesday or a Wednesday, can't remember exactly, and I had no response. So I had an e-mail address. I sent off an e-mail to this same guy, and within an hour, he responded to my e-mail and he said, yeah, they did have the autostainer and yes, they had the original computer that was sent with it.
CHAYTOR, Q.C.:
Q. And there's a couple of e-mails that I'll take you to about that.
MR. WHITE:

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A. Sure.
CHAYTOR, Q.C.:
Q. And Mr. White, in terms of the issue of it being a privacy issue, I take it you're referring to the document I showed you when you were in, and I don't know if I have the number handy, but is it 2154, page eight? It's the one with the computer document. Do you remember, Registrar? If not, 2140 maybe. No, it's not this one.
REGISTRAR:
Q. The other number?
CHAYTOR, Q.C.:
Q. Maybe 2140? Does anyone else remember that?
COFFEY, Q.C.:
Q. 2147.
CHAYTOR, Q.C.:
Q. 2147, thank you. Do you think? Maybe.
THE COMMISSIONER:
Q. No memory of it either, no.
REGISTRAR:
Q. No.
CHAYTOR, Q.C.:
Q. No, okay. Anyhow, there was a form that--I know it's page eight of 23 -

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REGISTRAR:
Q. 2152.
CHAYTOR, Q.C.:
Q. 2152, thank you. Now, and page eight, please, Registrar. This is the document that we were looking for, Mr. White. Is this what you're referring to, the type of information that we were looking to see if it's on the DAKO machine?
MR. WHITE:
A. This is the information that you guys were looking to retrieve?
CHAYTOR, Q.C.:
Q. Yes.
MR. WHITE:
A. This is the information that I thought you wanted to get rid of. That's why I thought it was the privacy issue.
CHAYTOR, Q.C.:
Q. To get rid of?
MR. WHITE:
A. When I say it was a privacy issue -
CHAYTOR, Q.C.:
Q. Okay.
MR. WHITE:

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A. - just say I sent this computer and there was patient information on it.
CHAYTOR, Q.C.:
Q. Oh, okay.
MR. WHITE:
A. I thought it was a privacy issue that you didn't want anybody -
CHAYTOR, Q.C.:
Q. Oh, I see what you mean.
MR. WHITE:
A. - retrieving this information or looking at it, you know, that type of thing.
CHAYTOR, Q.C.:
Q. Okay, I see what you mean.
MR. WHITE:
A. When I spoke to you, you told me that you were trying to retrieve the documentation -
CHAYTOR, Q.C.:
Q. Yes.
MR. WHITE:
A. - that's a different issue altogether. I mean, the privacy issue was important, but I mean, I had no idea you were looking to retrieve information.
CHAYTOR, Q.C.:

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Q. Oh, okay.
MR. WHITE:
A. And that's why I spent all the time trying to find that instrument.
CHAYTOR, Q.C.:
Q. Okay, and you were trying to find the information because you thought--you were concerned that this documentation could be out there and it could be a privacy issue, or because we wanted to retrieve the information?
MR. WHITE:
A. Because you wanted to retrieve the information and obviously it was very important to like this whole inquiry about what happened to, you know, I guess the victims or however you want to put it, for lack of a better word.
CHAYTOR, Q.C.:
Q. Yes, and we appreciate your efforts in that regard, and thank you very much, and if we look then at your e-mail, it's P-3580, and this is an e-mail then from yourself to me, October 9th, 2008, and you're forwarding on your e-mail to--and his name is taken out here, but we know that it was Michael Dietrich.

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MR. WHITE:
A. Right.
CHAYTOR, Q.C.:
Q. And he's the owner of the company you sold the machine to?
MR. WHITE:
A. That's correct.
CHAYTOR, Q.C.:
Q. "Nice chatting with you this morning. As I indicated, there is a local legal inquiry ongoing in our province and one of the items of interest is the DAKO autostainer that I sold to you several years ago. I was asked if I had the computer for that instrument and I honestly do not remember if indeed I had one and shipped it to you with the autostainer. Can you confirm whether or not the instrument came with a computer? If so, was the hard drive formatted at the time or did you format the drive yourself? Can you tell me the condition of the autostainer when you received it? Did it require parts and/or adjustments before you resold the instrument? And finally, can you tell me where you sold the instrument and if indeed the instrument is

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still in service. A contact name and number will be greatly appreciated. Thanks, Joe."
And did you receive a response back from Mr. Dietrich?
MR. WHITE:
A. No, he never responded. This was the first e-mail that I had sent him, and before he replied to the e-mail, I had called him back for the second time, and the second time he told me that his computer was down and that's why he never responded.
CHAYTOR, Q.C.:
Q. And so you got the information over the phone instead?
MR. WHITE:
A. Yes, the information as to who had the instrument, yeah.
CHAYTOR, Q.C.:
Q. Okay, and if we could then look, please, at P-3581? And then this is an e-mail exchange. I think it starts at the bottom, and you'll see Mr. White, these black marks are just where we have redacted or taken out information so that anything that might be contact information basically for people.

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MR. WHITE:
A. Okay.
CHAYTOR, Q.C.:
Q. Or other private information. This is your e-mail then on October 14th you wrote, and this time you're writing to Dan Heffron, and who did you understand Mr. Heffron to be?
MR. WHITE:
A. He was the end user of that instrument at the University of West Virginia.
CHAYTOR, Q.C.:
Q. And he's the technical person, I take it, at the University?
MR. WHITE:
A. I guess so.
CHAYTOR, Q.C.:
Q. Okay. "My name is Joe White. About four years ago, I sold a DAKO autostainer to Michael Dietrich from Southeast Pathology Instruments. I'm interested to know whether or not you still have that instrument. We have a local commission of inquiry ongoing and the original computer that came with that instrument is of some interest. Please respond as soon as possible. Many thanks,

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Joe."
And then he got back to you and said--I'm sorry, he got back to you and said "Hello, we still have the machine here in the lab with original computer." And then you went back to him again and said "thanks, Dan. Do you know if there was or still is any patient information on the hard drive? Was the hard drive ever formatted? Thanks, Joe." And he said "looks like no to both. There are old files back to 2001, but nothing that includes patient info. The only user files of any kind anywhere on the autostainer log files are the"--sorry, "autostainer log files, some of which with the pg extension lists the names of antibodies used but not anything else. The computer is not networked. I'd be happy to erase these old files, if you like," and then you pass that on to us.
MR. WHITE:
A. Yes, and at that time, again, I thought it was a privacy issue, and this guy, Dan, must have thought it was a privacy issue because he wanted to remove the files.
CHAYTOR, Q.C.:

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Q. He was prepared to delete them for you if you wanted that.
MR. WHITE:
A. Yeah.
CHAYTOR, Q.C.:
Q. Yes, okay, and then we--and we were also at the same time, in contact with the University at this time period, and happy to tell you that we received the information today that we were looking for, but we're not in a--we haven't read it yet, in terms of seeing how much is actually there and whether or not it's the documents that -
MR. WHITE:
A. You actually have the computer now?
CHAYTOR, Q.C.:
Q. No, we have the data off the computer.
MR. WHITE:
A. Oh, okay.
CHAYTOR, Q.C.:
Q. Whatever was there, we have.
MR. WHITE:
A. All right.
CHAYTOR, Q.C.:
Q. We've received it. So thank you for your

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efforts in that regard.
MR. WHITE:
A. Well, no problem. The other thing is you received data from the computer, I think we discussed this before, just the data that you got from the computer, I would have thought that you would have asked for the whole computer.
CHAYTOR, Q.C.:
Q. Yes. Would that be of benefit, do you think?
MR. WHITE:
A. If there was information on that hard drive--and I have an intimate understanding of computers. If there was information on the hard drive on that computer that was deleted at some time in the past, if it was formatted at some time in the past, that information is retrievable by an IT expert or even someone like my son. He has to ability to do that if he wanted to get that information. Just because you ask for the information that's on the hard drive, if it was deleted or formatted, you'll never get the information that you're looking for.
CHAYTOR, Q.C.:

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Q. Okay. So if there's anything missing or anything else that we think we might need, it could still be on the computer and it would be worthwhile getting the computer?
MR. WHITE:
A. I think I even suggested to you at one time if you wanted that computer, I would have had it here.
CHAYTOR, Q.C.:
Q. To get the computer?
MR. WHITE:
A. And have a forensic analysis done to that computer.
CHAYTOR, Q.C.:
Q. Yes.
MR. WHITE:
A. Because if it was formatted--a lot of people think that if you format a hard drive on a computer, all that information is gone and nothing can be further from the truth. There's still a small compacted file that you can retrieve where you can get information if that information is missing.
CHAYTOR, Q.C.:
Q. That's good to know. Thank you. Those are my

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questions. Thank you, Commissioner.
THE COMMISSIONER:
Q. All right then. Mr. Pritchard, do you have any questions for Mr. White?
MR. PRITCHARD:
Q. I don't, Commissioner. Thank you for your evidence, Mr. White.
THE COMMISSIONER:
Q. Mr. Simmons?
MR. SIMMONS:
Q. Thank you, Commissioner. No, I don't have any questions for Mr. White.
THE COMMISSIONER:
Q. Mr. Browne?
BROWNE, Q.C.:
Q. No questions, but I was wondering if Mr. White has a business card.
THE COMMISSIONER:
Q. You think Mr. White has interesting information.
BROWNE, Q.C.:
Q. I think he could be quite handy.
THE COMMISSIONER:
Q. Mr. Pritchett?
MR. PRITCHETT:

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Q. No questions, Commissioner.
THE COMMISSIONER:
Q. Ms. Newbury?
MS. NEWBURY:
Q. No questions.
THE COMMISSIONER:
Q. Mr. Crosbie?
CROSBIE, Q.C.:
Q. No questions, thank you.
THE COMMISSIONER:
Q. Oh, twice in one day, no questions. Mr. White, I want to add to Ms. Chaytor's thanks on behalf of the Commission for your efforts on our behalf in locating what we hope will be valuable information, and I'm sure we'll let you know what we find.
MR. WHITE:
A. You're welcome.
THE COMMISSIONER:
Q. Thank you very much. I suggest we take the afternoon break before we continue with the next witness.
CHAYTOR, Q.C.:
Q. Thank you.
(BREAK)

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THE COMMISSIONER:
Q. Please be seated.
COFFEY, Q.C.:
Q. Commissioner, the next witness is Dr. David Saltman.
DR. DAVID SALTMAN, SWORN, EXAMINATION BY BERNARD COFFEY, Q.C.
REGISTRAR:
Q. Would you please state and spell your complete name for the Commission?
DR. SALTMAN:
A. My name is David Saltman, S-A-L-T-M-A-N.
REGISTRAR:
Q. Thank you.
COFFEY, Q.C.:
Q. First of all, Commissioner, I'm going to ask that Exhibit P-3584 be entered, please.
THE COMMISSIONER:
Q. Entered.
EXHIBIT ENTERED AND MARKED P-3584
COFFEY, Q.C.:
Q. And if we could bring it up on the screen, please, Registrar? Dr. Saltman, I take it that--of course you'd understand that the black parts are redacted because they're

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personal information. This is a copy of your CV?
DR. SALTMAN:
A. It is.
COFFEY, Q.C.:
Q. Doctor, could you give the Commissioner, please, an overview of your educational and professional background?
DR. SALTMAN:
A. I'll start--well, I'll start from the beginning. I grew up in Conception Bay North where I went to high school, went to university at Memorial in St. John's, and I went to medical school and I graduated in 1982. From there, I went to Montreal where I studied internal medicine. Followed that by more internal medicine in Vancouver and hematology, and then I received a Medical Research Council of Canada fellowship and went to Edinburgh in Scotland where I did a PhD in cancer cell biology, which I completed in 1989, and then I went to Stanford Medical Centre in Stanford, California, where I was a post-doctoral fellow in molecular cytogenetics, also interested in cancer, and

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that I guess was completion of my education. From then, I worked in either industry or more recently as a clinician in medical oncology.
COFFEY, Q.C.:
Q. And can you tell the Commissioner, please, where you've worked as a physician per se, as a clinician?
DR. SALTMAN:
A. Well, I've worked many places, mostly in Canada as an oncologist, which is probably the most relevant to this Commission. I trained in hematology, but more recently I've worked as an oncologist and most of my experience is with the B.C. Cancer Agency, and I've also worked for Cancer Care Ontario and worked at the Juravinski Cancer Centre, which is in Hamilton in Ontario.
COFFEY, Q.C.:
Q. And you worked there as an oncologist?
DR. SALTMAN:
A. Yes.
COFFEY, Q.C.:
Q. And most recently, before coming to St. John's, you worked--where were you located?
DR. SALTMAN:

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A. I worked for the B.C. Cancer Agency, which has four, I think soon to be five, radiation oncology centres and one of these was in the interior of the province, in a place called Kelowna and that was one of the B.C. Cancer Agency's radiation oncology sites. We had a catchment area of about a million people and covering the geographic area, probably about two and a half sizes times the size of Newfoundland, the island of Newfoundland, so actually quite a lot of similarities in terms of the province and how the cancer care program is run in Newfoundland.
COFFEY, Q.C.:
Q. And that would be in relation to the Kelowna centre?
DR. SALTMAN:
A. That's right, there was one centre and then we had satellite clinics. We had actually board certified oncologists, which is different, in some of these centres and then we had community centres and we also did visiting clinics, and we also had a tele-oncology program which is also similar to what they have in Newfoundland.

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COFFEY, Q.C.:
Q. And Doctor, how long were you in Kelowna?
DR. SALTMAN:
A. I was in Kelowna since 2004, and before then, I was in Hamilton, but I had worked in British Columbia on and off since 19--the 1990s. At one point, I had been a private practice oncologist, but then the clinic I worked in was incorporated into the B.C. Cancer Centre.
COFFEY, Q.C.:
Q. And from 2004, I take it through 2008, the beginning of 2008, you were in Kelowna and that centre is part of the B.C. Cancer Agency?
DR. SALTMAN:
A. That's right.
COFFEY, Q.C.:
Q. And you've indicated as well that you worked in Hamilton for a while?
DR. SALTMAN:
A. Yes.
COFFEY, Q.C.:
Q. And what was the centre there?
DR. SALTMAN:
A. It was called the Hamilton Regional Cancer Centre, and then somebody gave them, I think,

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16 or 20 million dollars and got naming rights. That person was called Juravinski, and so now it's called the Juravinski Cancer Centre. Probably at that time, it was the busiest cancer centre in Canada, in terms of total number of people treated in terms of chemotherapy and radiation.
COFFEY, Q.C.:
Q. And Doctor, how long were you in Hamilton?
DR. SALTMAN:
A. I was there for about three years, yeah.
COFFEY, Q.C.:
Q. And that would have been what time period?
DR. SALTMAN:
A. That would have been around 2001-2002 to 2004.
COFFEY, Q.C.:
Q. Okay, so you went from Hamilton to Kelowna?
DR. SALTMAN:
A. That's right.
COFFEY, Q.C.:
Q. Okay. Doctor, could you tell the Commissioner, please, then--because well, first of all, I'll ask you, where are you now located?
DR. SALTMAN:

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A. I now work in St. John's. I have an appointment, I'm the chair and professor of oncology at the University. This is a brand new discipline within the Faculty of Medicine. I also have a clinical appointment with Eastern Health at the Bliss Murphy Cancer Centre.
COFFEY, Q.C.:
Q. And when did you take up that post, Doctor?
DR. SALTMAN:
A. I arrived in--well, I shouldn't--I started working in March of 2008.
COFFEY, Q.C.:
Q. And so you have a clinical appointment as an oncologist with Eastern Health?
DR. SALTMAN:
A. Um-hm.
COFFEY, Q.C.:
Q. And you're a professor of oncology with Memorial University's Medical School?
DR. SALTMAN:
A. That's right.
COFFEY, Q.C.:
Q. And is there any understanding, formal or informal, about the amount of time you're

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supposed to devote to--or what percentage of your time is supposed to be devoted to either?
DR. SALTMAN:
A. I think this is a brand new venture and I think there's--I haven't looked at my contract recently, but the understanding is essentially that I would be expected to see less patients than an oncologist who doesn't have as much responsibility in terms of administrative or academic. I don't think there's any set number of patients, but the expectations would be I would do a considerable amount of non-direct patient care as part of my appointment. As it turns out, I do a considerable amount of clinical care. It's not onerous, but probably more so than somebody with a similar appointment in another institution.
COFFEY, Q.C.:
Q. And Doctor, you've indicated that this is, you understand, as professor of oncology, chair and professor of oncology with the medical school that this is a new position?
DR. SALTMAN:
A. Yes. The idea of having a discipline of oncology within the Faculty of Medicine is

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relatively new in Canada, and there's very few of them, and in the United States and in Europe, there are some, but it's a relatively new idea to actually have a separate discipline. Historically, oncology has been included within the discipline of internal medicine. I think the feeling is or was, and is here, is that due to the complexity of oncology and the number of different people involved, medical oncologists, radiation oncologists, radiation physicists, nursing, pharmacy, researchers, that there might be some utility in creating a discipline of oncology and that, I think, was the feeling here at Memorial.

COFFEY, Q.C.:

Q. What do you understand then your role is?

DR. SALTMAN:

A. Well -

COFFEY, Q.C.:

Q. First of all, I'll ask you because you have different roles, I take it.

DR. SALTMAN:

A. Yeah.

COFFEY, Q.C.:

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Q. One is your clinical appointment as an oncologist per se. I'll deal with that first.

DR. SALTMAN:

A. Yeah.

COFFEY, Q.C.:

Q. I take it that that involves you providing clinical services to oncology patients?

DR. SALTMAN:

A. Right. So I'm a medical oncologist and so I have two clinics a week. I have a clinic on Wednesday afternoon where I see new patients, and I have a clinic on Friday mornings where I will generally see follow up patients, and those are not fixed. I can see new patients on Friday, whatever, but that's generally what happens. I also do visiting clinics to Corner Brook as part of a rotation. There's three oncologists, medical oncologists, and radiation oncologists that rotate to Corner Brook, and I also actively participate in the tele-oncology program, and that's where actually a lot of my patient load actually is generated. I really don't like patients driving all the way from Corner Brook or Grand Falls to see me for an hour, only to turn

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around and drive right back. So I do a lot of new patient consultation, follow up visits, actually through the video link, which we refer to as tele-oncology, and I do those--I don't really have a fixed day, but I'll do those on the days I don't have--usually on the days I don't have clinics within the cancer program.

COFFEY, Q.C.:

Q. And then within medical oncology, as you indicated you practise as a medical oncologist, is there any particular area of medical oncology that you--I won't say specialize in, but spend more time at?

DR. SALTMAN:

A. My interest have been, in the past, have been gastrointestinal malignancies, hematological malignancies like leukemias and lymphomas and that's where I've done most of my research, and in neuro-oncology or brain tumours. In Newfoundland, I do almost exclusively gastrointestinal malignancies, but if someone comes in the door and they need to be seen with kidney cancer, whatever, I will see them, and when we go to Corner Brook, we have to

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follow people who have breast cancer, lung cancer, again whatever has to be seen. But primarily, I do gastrointestinal malignancies, such as bowel cancer or stomach cancer.

COFFEY, Q.C.:

Q. And Doctor, I'm going to ask you then about your role as a professor of oncology, as the professor of oncology and the discipline chair, which I take it is in effect the same thing, or are they?

DR. SALTMAN:

A. The professor is an academic appointment. You could be discipline chair and be an associate professor or whatever. So that's just based on your research experience, your publication experience, and the chair of oncology is the appointment itself. As I mentioned, this is a new venture for the University and so it's a bit open as to how this is going to evolve. I have spent a fair amount of my time actually trying to establish my practice as a medical oncologist and also trying to assess with some of the processes within the cancer care program, trying to make sure that this is a place I feel comfortable practising medicine

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and doing the best for my patients.

At the same time, I've been working to try to help the various potential members of the discipline, in terms of getting more involved with research, making connections between the other disciplines. We're very interested in working with the cancer genetic group at the Terry Fox lab. So there's been a lot of meetings with various disciplines, trying to get this venture off the ground.

COFFEY, Q.C.:

Q. Okay, and in relation to some of those and what sorts of initiatives in those regards have you been involved in, I take it in the past seven to eight months since you started in March? Perhaps--well, I'll ask you first of all about tele-oncology, first of all, and the usage of tele-oncology and perhaps communications devices?

DR. SALTMAN:

A. Yes. Well, tele-oncology is very important for a province like Newfoundland and I have a fair amount of experience with this in British Columbia because, as I mentioned earlier, we have similar situations. We have a single

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radiation oncology centre in B.C. within the centre of the province, and we service areas which may be eight hour drive by car. You may have to go across several mountain passes. The idea is to provide care closer to home and this is very similar to Newfoundland.

What's different in B.C. is that we have satellite clinics, which may have oncologists in them or we have what are called general practice oncologists, and these people are often full-time employees of the cancer program, and they look after patients who are currently on treatment, whereas our job may be to mostly look after new patients and do new patient consultations.

In Newfoundland, a lot of patients, despite the tele-oncology program, are still being asked to travel to St. John's to have initial consultation, whereas the visiting clinics are almost exclusively to follow up patients. So in terms of participating in the tele-oncology program, I have probably been busier than I was in British Columbia, because I'm trying to see new patients here and to prevent them having to travel to St. John's.

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That is not really a research project in itself. We have some people within the cancer care program, such as Dr. Greenland, who's been very, very active in this.

One of the areas that I'm interested in, I'm interested in community oncology and I'm interested in also communication, and I've been working a lot with Dr. Max House, who's really a pioneer in this field. He's got the Order of Canada for his work in tele-medicine, and he's been very interested in taking this a step further about using even the internet to be able to provide oncology services and other tele-health services around the province.

I think he's been a bit frustrated by some of the regulations within the health care system, within Eastern Health. He attempted to initiate a project a couple of years ago using handheld devices, such as Blackberrys, to look at efficiency within the cancer care program, and I think he wanted to target the pharmacists, and unfortunately Eastern Health would not give the go ahead to this project. So when I came to Newfoundland and met with Dr. House, this is something he wanted to

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pursue, so I've been working with Eastern Health IT people and we've been able to resurrect this as a research project and I have a very good medical student who is working on this.

It's really a study to look at efficiency, but it's also an attempt to convince the health authorities that these devices are not harmful, but in fact, very, very useful. 46 percent of all oncologists in Canada use handheld devices in their daily practices. You're talking about, you know, prestigious institutions within the country, Sunnybrook, Princess Margaret, the B.C. Cancer Agency, the Ottawa Cancer Centre. Oncologists all use these devices as a daily practice to do radiation planning, to do sign off charts, to communicate with patients, with other health care faculties. So we're really behind here and this project is really an attempt to get some information to determine the utility of this, but also to convince the health authorities that these--that communication is really, really important.

COFFEY, Q.C.:

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Q. And why is that sort of communication important, Doctor, in your experience?

DR. SALTMAN:

A. Well, I'll give you someone else's experience because evidence based results are what you're looking for. There's been very few formal studies, but there was one from Mississauga Hospital where they looked at efficiency within their intensive care unit. They had a couple of near misses of patients almost had severe adverse events and they determined that the problem was lack of effective communication between doctors and ICU nurses, that the traditional paging system just wasn't doing the trick, and so they gave nurses and doctors Blackberries. They did a study over 12 months and they were able to demonstrate a 16 percent reduction in adverse events and they've gone from a pilot project to put this as part of their standard of care, and they certainly didn't see any of the concerns that some of the health authorities such as here in Newfoundland are concerned about, interference with other medical devices, those sort of things. So my interest is in that it can

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provide better efficiency, but also help with safety issues.

COFFEY, Q.C.:

Q. And, doctor, the idea of community medicine, community oncology, in particular, that you referred to, in your experience, have you found or encountered situations where information can be made available and is made available to oncologists, for example, via the internet from some centralized server?

DR. SALTMAN:

A. Absolutely, yes. I think one of the strengths of the BC Cancer Agency is its website. It's probably one of the best in the world and gets one of the largest numbers of hits worldwide for a cancer website. One of the deficiencies of the Cancer Care Program in Newfoundland is we're the only cancer care program in the country that doesn't actually have a website. There was, I think, under the old Newfoundland Cancer Treatment Foundation, a website, and my understanding is in 2005 when they amalgamated, this was not carried forward. I've had various discussions about the importance of this, and about resurrecting

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this, but three years after, you know, the takeover of the Cancer Care Program by Eastern Health, we still don't have a website. Now this just isn't important because of direct patient care by radiation and medical oncologists, or nurses, or family doctors. It has implications even for surgeons, pathologists--many of the other larger cancer care programs such as BC will have directives on how to process surgical specimens for testing, how much tissue to take, what's the proper way to take it, directives on how to treat various types of cancers, how to treat patients if they become sick in your community. We don't have any guidelines in Newfoundland for how to treat people if they get fevers due to chemotherapy treatments and they end up in the hospital in Stephenville. There really isn't any directives for that, and that's one of the utilities of a website that a physician in that community can go to the website and look up what's the most appropriate way to treat patients. So these things are invaluable in this day and age, and it's one of the big deficiencies of our

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program here.

COFFEY, Q.C.:

Q. Have you made any inquiries in that regard?

DR. SALTMAN:

A. I have, yes.

COFFEY, Q.C.:

Q. What happened?

DR. SALTMAN:

A. Well, I spoke to our management team about this, and unless I'm mistaken, I don't think there's been much progress on this. I think from the perspective of Eastern Health IT, they don't design a website, they put it up, probably it would be linked to the Eastern Health website, so it means that somebody in this program, in the clinical care program, has to create this website. It's a lot of work, but you need to--somebody needs to do it and somebody needs to be delegated to do this. It really is quite important. I have started designing a website which will be the Discipline of Oncology website, but that's going to serve a different function, although there's some overlap. I can't emphasize how important this would be to what is not just

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Eastern Health program, this is a provincial program.

COFFEY, Q.C.:

Q. The Cancer Care Program?

DR. SALTMAN:

A. Yes, it has a provincial focus, and the website would be invaluable for physicians, nurses, pharmacists, patients across the province.

COFFEY, Q.C.:

Q. Doctor, in relation to--you just referred to the idea that, and you recognized that this could be a fair amount of work.

DR. SALTMAN:

A. Uh-hm.

COFFEY, Q.C.:

Q. And it would require knowledgeable people, people knowledgeable in the area to design it. This sort of work, I take it at times is done by committees. What has been your experience in relation to that compared to elsewhere in terms of participation on committees?

DR. SALTMAN:

A. I mean, every cancer centre is structured different and there's many ways to skin a cat,

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but my experience here is different than other places I've worked, not just in clinical medicine, but also in industry and in research. I think what makes the BC Cancer Agency one of the best cancer care programs in the world, not only the delivery of care, but also to work in, is that it's a very democratic socialist organization where a lot of ideas filter up from the bottom. So whether you are a pharmacy technician, or you work in health records, or you're an IT technician, or an oncologist, you have the opportunity to be innovative and to take things forward and actually get things done, and so in BC, I sat on multiple committees and I was not part of the administrative team there, I worked as a clinical oncologist and clinical researcher, but I was required--you know, it wasn't I volunteered, I was required to sit on multiple committees with not just oncologists, but people from all aspects of the cancer care, and that gave you an opportunity to really appreciate what other people did, how they did their jobs, and it was a networking thing. So you had a problem,

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somebody had a solution, and it got done. What we didn't have is a middle management structure where things sort of either started there or had to percolate up there first before they, you know, actually got underway, and here it's a bit of a different structure. I think we have what's called a--and I'm talking about the clinical care program now, I'm not talking my discipline, oncology. I think we have what's called a leadership team, and I'm sure there's other committees within the cancer care program, but this is a committee where a lot of decisions which could be made at a lower level and actually implemented to go into that structure, and I think--I think it's not a structure that maybe is the most conducive for creativity or getting things done.

COFFEY, Q.C.:

Q. In terms of--what has been your experience in terms of your observations here locally in terms of the amount of participation or lack thereof of doctors on committees?

DR. SALTMAN:

A. Again I will -

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COFFEY, Q.C.:

Q. And I'm saying, of course, in comparison to elsewhere.

DR. SALTMAN:

A. Yes, and I stand corrected, but my impression is that a number of physicians who sit on a committee or multiple committees is not what it should be. That's my personal opinion. It's certainly less than what I'm used to working in other places, such as British Columbia and in Ontario, and I think that's very important--most of us are not going to volunteer for working on committees, and I think that has to come from management to say that you're expect to be on "x" number of committees, and again it's a way of networking, you should be expected to be on committees not just within the cancer care program, but within your host hospital. So again it's a way of networking with other people in different disciplines.

COFFEY, Q.C.:

Q. And what if any are the implications for patient care if doctors are not required and do not participate in such committee work?

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Are there any possible implications for patient care?

DR. SALTMAN:

A. Well, I don't know if there's been any studies, but intuitively, you would think indirectly there would be. I mean, I think, you know--I think in our system here, not only are people not participating in enough committees, but there probably aren't enough committees, and again there's different management structures and maybe people feel that they don't need a lot of committees, but again I think the more people you have talking about the same problem or different problems, the more opportunity you get to find out what's going on, and it is a quality assurance thing as well.

COFFEY, Q.C.:

Q. And why is that, doctor?

DR. SALTMAN:

A. Well, I think the more cross-talk you have, I think the less likely you're going to--you're going to pick up--somebody is going to say something in a committee or a meeting and you're going to say, well, I think we should

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look at this in a bit more detail or a bit more depth, or someone will say, well, I've seen something similar in my area and that's something we need to look at, and sometimes a lot of these things are very serendipitous, but that's--what's different about the BC Cancer Agency is multiple levels of redundancy. The chances that something is going to fall through the cracks is much less because you have these multiple people involved in the system rather than a very top down sort of approach to running a cancer care program.

COFFEY, Q.C.:

Q. And you refer to serendipity. I take it that--just people are required to have a certain amount of contact with each other, clinicians of various sorts, and of the same sort, on a routine and regular basis, that the chances are better that new ideas or problems being identified are more likely to occur?

DR. SALTMAN:

A. Yes.

COFFEY, Q.C.:

Q. Likely to be better education of each other?

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DR. SALTMAN:

A. Yes, yeah.

COFFEY, Q.C.:

Q. And problems potentially identified?

DR. SALTMAN:

A. Sure. I mean, one of the things -

COFFEY, Q.C.:

Q. If I could, doctor -

DR. SALTMAN:

A. Yes.

COFFEY, Q.C.:

Q. Otherwise, what's the effect? If you don't take part in committees, and you're just doing your clinical work, what can happen?

DR. SALTMAN:

A. Well, again I think that's very intuitive as well in that I think you're not aware of what's happening in the other disciplines. Within oncology now, we work often in multi-disciplinary teams. Now they may not be formal teams, but many of our treatments are multi-modality where we're giving chemotherapy, radiation, or immuno therapies, and this cross-talk between health care professionals, I think, is very, very

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important. Within the Cancer Care Program in Newfoundland, we have a Division of Medical Oncology, which all the oncologists in Newfoundland are in St. John's, so that's obviously centred here. We have a Division of Radiation Oncology, and they meet on a regular basis, but we don't actually have a structure where radiation oncologists and medical oncologists meet on a regular basis. So if problems arise in these multi-modality therapies, you can talk about them in the hallways or over coffee, or in the clinic, but in most institutions you will have on a regular basis, whether it's every two or three months, an opportunity for both disciplines to actually sit in the same room and formally talk about any concerns that they may have, and again this is how you--this is how you pick up these problems and sometimes avert some of these problems.

THE COMMISSIONER:

Q. Mr. Coffey, if you're going to address this with the witness, by all means, we'll wait, but I'm interested in the relationship with other centres in that in that issue we're

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dealing with here, you would have had pathologists from other regions feeding into Eastern Health, and then information going back and the oncologist might be still back in St. John's. So there seemed to be a lot of movement back and forth, and I'm concerned about how good the communications might be between--I know all oncologists are in St. John's, so it would have to be between the oncologists and, for example, pathologists who were in other centres, and frankly up to date I've not seen something which causes me to have a lot of confidence that that communication is very good. So could you tell me what your experience has been about the communication and what your view is--if you don't think it's up to scratch, what your view is of ways of improving that kind of communication?

DR. SALTMAN:

A. Again I'll preface it by saying I've been here eight months, I don't profess to know everything about this program, and everything about how health care works in the province, but it is also a concern of mine that the

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communication between oncologists and--this cancer program here is Radiation and Medical Oncology where within the same institution within St. John's, we have hematologists and they treat cancer, we have paediatric oncologists, we have gynecology oncologists which do work in our clinic, but are part of a different discipline, this is in some ways a little bit of an unusual structure and the communication between some of these various disciplines within oncology is not great, let alone the communication between other specialists, such as pathologists. As you're probably aware from your Commission, in many other centres pathologists are incorporated into a Cancer Care Program, they actually have an office in there. They may not necessarily have a lab in there, but a significant part of the week they're in that office, which has a lot of advantages. In Kelowna, we had our own pathologist who was hired by the BC Cancer Agency, and he reviewed slides for all our patients that were coming. He came to our rounds, he was an invaluable member of the team. We had surgical oncologists, as we did

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in Hamilton, who were part of the Cancer Care Program. They actually had an office within the centre. My impression when I came to Newfoundland is that communication between pathologists within the province and the oncologists had lots of room for improvement, and when I came here--even before I came here, I asked members of the Cancer Care Program to put me in touch with an oncology pathologist or an oncological pathologist or somebody who had an interest in oncology, and I was put in touch with Dr. Bev Carter, and while Bev was here before she resigned from Eastern Health, we established a very good relationship. I think she had found it frustrating that she didn't have the funding to start to go out to different centres, to talk to other pathologists, or to bring the pathologists to St. John's for educational sessions, updates on management.

So we worked very closely together and I got her money and I brought every pathologist in Newfoundland, except for one, everyone and that's easy to do because there's only about 23 of them and brought them to the Murray

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Premises and it was an opportunity for me to meet them all, so I knew them by face and by name and we specifically wanted to look at the issue of what's called synoptic template reporting and to make sure that they adopted the College of--the American College of Pathology recommendations, which they endorsed. And just that meeting alone, even for my own practice as a gastrointestinal oncologist has had actually quite profound effects, even in a short period of time and I'll give you an example. One of the concerns about treating colon cancer and getting specimens from the surgeon is the number of lymph glands that are recovered. It's also an issue for breast cancer pathology as well. It's like estrogen receptors is an important prognostic marker and there are guidelines on how many lymph glands you require, how many you should recover and there are also recommendations about how you can recover more nodes. And the--there are various solutions a pathologist can use and I did a study in British Columbia looking at over a thousand cases in several different peripheral

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hospitals and I presented that study here at this meeting that was in June of this year, and I told the pathologists about some ways they could improve their practice which has direct effects on my practice in patient care. Does someone get treatment for the colon cancer or don't they? And do visiting clinics in Corner Brook. Four or five weeks after this meeting I went to Corner Brook and I went to see their pathologist, the pathologist unfortunately are usually in the basement, so I wandered down in the basement and they very proudly took me into this room and said, look what we've done. They purchased all these reagents, mixed the solution and I called the pathologist from Corner Brook now, I called him yesterday after doing a tele-oncology consultation and I said, you're getting an incredible amount of lymph glands, are you using those solutions, and they said of course we are. And now their lymph node recovery is probably the best in the province. So this is communication with people in the periphery, the Cancer Care Program is not just St. John's, it's all these--it's Gander, Grand

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Falls, Corner Brook, but just networking, bringing people together, even for one day and then you know who they are and you can call them up and speak to them by their first name and within a relatively short period, and that was not an executive decision, that didn't go to a committee, they went back to Corner Brook and said it sounds like a good idea, they did it and now that's really going to affect the quality of care that they're providing their patients. The only other communication that I know of formally is with pathologists outside of St. John's, with the oncologists, are two mechanisms, there's an informal one where you call someone up and say, you know, can you take a second look at this, and then there's the tumour board which is every Wednesday morning where, up until recently the only tumour board was all-comers, if we had to present a case with breast cancer, lung cancer, whatever, this was all done within one hour, once a week. As of this Monday, I've initiated a tumour board which is a joint surgical and oncology round, specifically for gastrointestinal malignancies because I wasn't

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happy with having such a large number of cases presented. Over an hour, once a week, I didn't think it was doing justice to my gastrointestinal patients and there was certainly a lot of support from the surgeons, pathologists, both within St. John's and outside, so that's linked to a video link, so a pathologist or surgeon in Gander, Grand Falls--and again, this is talking about cases, not only about specific cases, but talking about we've got something funny going on in Grand Falls with this and that and that sort of networking where you can say, well, you know, we think as oncologists you had better do something about that. So again, the more dialogue you have, whether it's with oncologists or pathologists, I think the better quality system and there's nothing stopping anybody really within the system of doing that for lung or a specific--breast or some of the other sites. These are the sort of things we, people should take the initiative to do or if not, the management should be requiring people to do this, we're all public employees and that should be part

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of your job.

COFFEY, Q.C.:

Q. And so, Doctor, I take it then in addressing the Commissioner's question, responding to it, that there are very few formal mechanisms right now in place where there is interaction between, like groups of pathologists and groups of oncologists or groups of surgeons on a routine basis. I mean, there's the tumour board of Wednesday, tumour board rounds of Wednesdays and this one you've initiated. And that, because it involves video conferencing, it can involve people from outside St. John's itself. What about even within St. John's, is there anything more within St. John's itself, in terms of kind of routine regular meetings between physicians where these sorts of things can be discussed?

DR. SALTMAN:

A. Yes, I think there is, I mean because it's, the medical school there, there are lots of rounds occurring, there's weekly surgical rounds and I don't know, I've been asked to participate in their lecture series, I'm not sure about the participation in these

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meetings, who goes and who doesn't go, but there are formal mechanisms there.

COFFEY, Q.C.:

Q. What ones do oncologists now routinely participate in, that's what I'm -

DR. SALTMAN:

A. Well I don't know, I know that oncologists are sometimes asked to, say, give lectures in the surgical, weekly surgical rounds or they may be asked to give some lectures to the gynecologist. I think those sort of things are happening. The oncologists are asked to give lectures to surgeons in training and other physicians, but getting back to the original question, I think there is lots of room to have more dialogue between oncologists and other people treating cancer, such as hematologists and surgeons and pathologists and I think, again, there's lots of good things about this program, but there are some deficits and I think it's, the care here is very centralized and I think there needs to be a serious look at decentralizing some of the services and I think, for example, there should be a real push to have a oncologist,

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possibly two oncologists but certainly an oncologist in Corner Brook and what that does, is it automatically starts that connection, so if you've got somebody in-house, that person is giving talks in the Corner Brook hospital, they are talking informally, but possibly formally, they're sitting on committees. It's one thing for an oncologist to go for a few days to Corner Brook once a month, but it's never the same as having someone in-house and I think you have the referral base there that you could easily support two oncologists. Now we have a competitive funding within this province for oncologists, I would hope it would not be too difficult to actually recruit oncologists to that area. And again, then you're going to start to get those dialogues between pathologists and surgeons. I think our program should really look at having surgical oncologists and pathologists as actually members of the Cancer Care Program, formal members.

COFFEY, Q.C.:

Q. I take it, if you could explain that to the Commissioner, I take it right now they're not

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formal members?

DR. SALTMAN:

A. There's nobody with an office or actually formally who are part of the Cancer Care Program. We certainly interact on a daily basis with pathologists in St. John's, but when Dr. Carter first expressed her desire to leave Eastern Health, I met with her and I was very candid, I said what would it take to keep you in this program, to keep you in Eastern Health and keep you in the province and she trained as an oncological pathologist, she was a breast cancer oncological pathologist, she did a fellowship and she didn't want to be a general pathologist, she wanted to work primarily in cancer care. And I approached the CEO of Eastern Health, Louise Jones, I sent an e-mail out to the Dean of Medicine, Ms. Jones to a number of other people saying we can't--we can't let this person go. If that's what she wants, we have to try to see if that's something we can facilitate and unfortunately that didn't come to fruition and Dr. Carter is now an oncological pathologist in a cancer centre in Vancouver. And this is

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somebody I think could have been the moving force for bringing pathologists, oncologists, surgeons and the like together in the Cancer Care Program within Newfoundland. So this would not be a precedent here, I mean, this is something that's common throughout Cancer Care Programs throughout the world. My understanding that if they don't have someone in-house, they may actually ask somebody within a host hospital to be an oncological pathologist. I think Nova Scotia has looked at this Commissioner of Inquiry and are dedicating a breast pathologist, realizing that that is an important part of their Cancer Care Program that they have an oncological pathologist dedicated to breast cancer.

COFFEY, Q.C.:

Q. And do you recall what the problem was or the challenges encountered in relation to what Dr. Carter wanted? What, if anything, did you know about it?

DR. SALTMAN:

A. Well I wasn't involved in the sort of discussions with medical directors of Eastern Health, but I think it came down to a job

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description and again, I wasn't part of the intimate sort of one-on-one discussions, but I think there was some reluctance on, not just on part of the Cancer Care Program, but also on the part of the Pathology Program of having a member who would be dedicated specifically to oncology, and again, you would have to speak to Dr. Denic about the nuances of those discussions. But I don't think we did enough, I think this was a big loss for this, for cancer care in Newfoundland, not just losing Dr. Carter, but I think it was an opportunity for us to finally come of age and say that oncology isn't just radiation and medical oncology, that many other disciplines now are--our surgeons are making a career out of oncology and they're often not fee-for-service physicians, they want to take a salary and they want to teach, they want to set guidelines, that's why it's important that they are physically within the centre. They want to work hand in hand with their hematology and oncology colleagues.

COFFEY, Q.C.:

Q. And I take it that the position, she described

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it to you, pathological oncologist -

DR. SALTMAN:

A. Oncological pathologist, yeah.

COFFEY, Q.C.:

Q. Was in fact, when you first thought about it or were considering coming to Newfoundland, when you contacted St. John's, you asked to be put in touch with whomever he or she happened to be.

DR. SALTMAN:

A. Right.

COFFEY, Q.C.:

Q. And you were told, well there's no such position here.

DR. SALTMAN:

A. Right.

COFFEY, Q.C.:

Q. But then eventually your inquiries led you to Dr. Carter.

DR. SALTMAN:

A. Right.

COFFEY, Q.C.:

Q. And I gather Dr. Carter, you understood then was interested in creating in effect such a position?

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DR. SALTMAN:

A. Yes. You know, I think Bev was generally interested and being in a role within the province of not just looking at slides, but to be an educator, to, like we co-chaired this meeting on synoptic templates, we sat down and within a couple of months we had every pathologist in a room and as a result of that, as I already told you, that has had impacts on patient care and practices.

COFFEY, Q.C.:

Q. What, in the context of a Cancer Care Program, what is the advantage of having an oncological pathologist or the reverse?

DR. SALTMAN:

A. Well many cancer care programs, I mean, it all has to do with size, it has to do with structure, but many programs will require, especially breast because of the complexity, colon cancer is very simple in the terms of pathology there isn't the need for immunohistochemistry. Usually 95 percent of all the cancers are one type, adnocarcinoma and it's fairly straightforward, although there are some nuances and--but breast and

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prostate are complex of the number of prognostic markers that you're looking at and this is only going to increase in breast as we start to look at gene profile and these sort of things. And so many cancer centres will require that all patients referred into the cancer centre have a secondary review because and certainly we know if you talked to experts in those fields that there are enough errors made that it may make a difference in how you decide to treat the patient. We know from hematology that this is really important. Every hematological malignancy, such as a lymphoma, really should be reviewed by a hematopathologist because of the error rate by general pathologists. But certainly in B.C., in Ontario, in the larger cancer centres, if you're referred into the cancer centre, you automatically have secondary review, meaning that if someone has colon cancer resected or breast cancer and they're sent in to see an oncologist in St. John's from St. Anthony, then as part of that referral they'll have their pathology reviewed. Now, the BC Cancer Agency and in Ontario does not have enough

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pathologists to do that, so what they do is they accredit external pathologists and they say that this person has developed the necessary expertise that they will do secondary review for us.

So, that's one real advantage is to have that confidence, that somebody that you're very comfortable with. It's a very personal thing and you develop a relationship with a pathologist. You feel comfortable the same way you do with a radiologist and you say--I get this report back and I say, well, I feel comfortable because I know who did the report. I know that they're skilled and I trust that report. And so it's very important for oncologists and so having someone in house is important. It's also important that you can walk down the hallway and say, listen, you know, I'm not happy about this. Now, you can pick up the phone and in St. John's, it's only a little bit more of a walk because we're all in the same building, but I think as a program gets bigger and because we have a lot of patients referred from outside, I think an in-house person is an important thing. That if

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we can't do it at this point because there's not enough pathologists, fine, but that's something the program should be striving for in the future.

COFFEY, Q.C.:

Q. And Doctor, in relation to the issue of routine or regularly scheduled meetings between physicians and other clinical staff, potentially, at Eastern Health, to your knowledge, are there any mortality or morbidity rounds?

DR. SALTMAN:

A. I can't speak for Eastern Health for all the disciplines. I know that the Emergency Department at Eastern Health at the Health Science Complex has morbidity and mortality rounds and what that means is that someone comes into Emergency, they're in bay number 5 and they're sitting there comfortably and next thing they've died and it's unexpected. And so that gets put into a file and at the end of the week or the month, all the doctors and medical students and residents sit down and say, right, that was an unexpected death or side effect. How can we learn from it? It

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may have been caused by human error, but the idea is not to blame, but to learn from that. Within the cancer care program, within radiation oncology, I met with the head of radiation oncology last night and they have a mechanism where they have delegated one of their members, a general practice associate, to collect charts and to review them on a regular basis. Within medical oncology, to the best of my knowledge and again, I talked to my colleagues yesterday, that we do not have morbidity and mortality rounds within the program as a provincial cancer care program; we do not have morbidity and mortality rounds per se.

Which means if Mrs. Browne, who is my patient, comes into Stephenville, who is on chemotherapy, she's young, she's otherwise well and she gets seriously ill or dies, then if that's not directly due to her cancer, we need to know about that. We need to learn about that, not just as an individual case, but we need to sort of say, well, we se a trend here. We see that maybe there's something going on in Stephenville or maybe

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there's something going on with the treatment. Are people not getting the most appropriate treatment of follow-up?

So, these are--this is not a new concept. Morbidity/mortality rounds should be an integral part of any program, whether it's oncology or cardiology.

COFFEY, Q.C.:

Q. And you're indicating, I take it, in this context, in particular, just don't, Mr. Coffey, just don't focus on St. John's. In fact, this should be a province wide -

DR. SALTMAN:

A. We're a provincial program. If I see somebody here and they go back to St. Anthony, unless I sign off on my chart that I'm no longer responsible which is what's called a most responsible person, MRP, I'm assuming it's the same in Newfoundland and B.C., but until I put that in the patient's chart, that patient is mine forever, as long as I'm in practice. And so if something happens to them in Stephenville or Corner Brook, even though I'm in St. John's, I'm ultimately responsible and that's why I need to know why they got sick;

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why they were admitted and why they could have died.

THE COMMISSIONER:

Q. Mr. Coffey, it's quite near to 5.

COFFEY, Q.C.:

Q. It's a good point to break, Commissioner. I understand we're going to break for an hour and a half and come back at 6:30.

MR. SIMMONS:

Q. Commissioner, if I might throw my (inaudible) out to the room (inaudible) get knocked down. I don't know how long Mr. Coffey thinks he might be, but if it was only an hour or so -

COFFEY, Q.C.:

Q. I prefer to break, myself, if I could, and come back 6:30 and come back. I just would.

THE COMMISSIONER:

Q. All right, if that's the plan, that's the plan. I think that was the one that was announced

COFFEY, Q.C.:

Q. Yes, it was.

THE COMMISSIONER:

Q. All right then, we'll break until 6:30. Thank you.

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(SUPPER BREAK)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

Q. Doctor, in relation to initiatives on your behalf that you've started out on, have you been involved in the development of any forms?

DR. SALTMAN:

A. One of the--let me back up. We talked about the strengths and weaknesses of the cancer program and the strengths are its people, its nurses, its pharmacists, physicians.

COFFEY, Q.C.:

Q. Um-hm.

DR. SALTMAN:

A. But one of the weaknesses of this program and I think of big concern and one that differs from most provincial cancer care programs is that we don't have our own pharmacy program. In fact our pharmacy manager does double duty with Eastern Health management in non-oncology business, are two very well trained oncology pharmacists are, at least, one of them is having to rotate through the regular general hospital service. So, this is an unusual

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situation, but of equal concern is that we have a big discrepancy on how chemotherapy is ordered in this province. Within the cancer care program in St. John's, we order it electronically for most patients, that's for what's called parental therapy, IV therapy, as you know, in this province, non-parental therapy is not covered usually by the government except for exceptional circumstances. If you go within the same hospital, within the Health Science Complex, if you go up to the cancer ward where patients with lymphomas, leukemias, breast cancer, are treated an is-patients, how chemotherapy is ordered up there is different than it is ordered in the cancer centre in the same building. And there's some real advantages of electronic ordering in terms of reducing clerical errors. Once you start writing out chemotherapy errors, you introduce the possibility of errors. And there's lots of checks and balances, they get checked by pharmacists, pharmacy technicians, nurses, but the more times you're handwriting things out, the more times you're going to increase the

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risk of an error.

Now, if you go to clinic in Grand Falls or Corner Brook or if you have a patient in Stephenville, you have a different system yet again of, again, more handwritten, then typing, then faxing, then more typing, then more computer entering. So, there's no common system in what is a provincial program.

So, when I arrived in Newfoundland, I asked the leadership about this and we did talk about some potential solutions. I asked about why don't we have electronic ordering in the same building, in the same Health Science Complex and I'm not quite sure, to this day, why that's not the case. I was told by IT people that within a relatively short period of time in the other centres, but to my knowledge, this has not been done as of yet.

So, one of the solutions I propose is what many other centres does and certainly what the BC Cancer Agency does, and that's the next best thing which are pre-printed orders. And these can be very comprehensive. Not only do they give you the actual chemotherapeutic agents, but they can give you the medications

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for nausea, what we call antiemetics. It's very useful for clerical staff in that they can book the patients. So, it's one-stop shopping using one form. And again, there's different ways to do things, but I proposed this as a potential intermediate step to, sort of help to bridge the period until we had the same common system whether electronic or paper throughout the whole province. And I even put them all together for each disease site group, for every type of cancer, and I spoke with the in-patient head nurse, with physicians and I even spoke to my hematology colleagues and there seemed to be a lot of support for this, but again, this never really got off the ground when it went to management.

COFFEY, Q.C.:

Q. And management in this context is whom?

DR. SALTMAN:

A. Management in the cancer care program is--again, I'm sure there's other committees within the centre, but management is what's called a leadership committee. And this cancer centre has a structured, has a clinical chief which is Doctor Laing. There's an

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operational head which is--it's called a director of oncology which is part of the operational team of the Eastern Health and I think you're going to speak with Ms. Smith at some point during this Inquiry. She can explain her role in the cancer care program and then there's various other members of that leadership team including myself and that's where these, as I talked before, a lot of decisions, a lot of ideas, filter into this committee and in my opinion, a lot of them stay there. These are often not executive type decisions. These are decisions that should really be generated from nurses, doctors, pharmacy technicians, whoever and communicate with each other, work on these things. It's something leadership has to know about, but it's not something that leadership actually has to rubber stamp.

COFFEY, Q.C.:

Q. Now, these forms, for example, the form for different disease sites that you developed, you did so, I take it, with a view to making them available to physicians, just within Eastern Health or throughout the province in

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terms of cancer care.

DR. SALTMAN:

A. Yes, anybody in the cancer care program, I discussed this with the clinics in Grand Falls, the doctors that work there; they thought it was a great idea, doctors in Corner Brook and there's just some real advantage to it. You either have an electronic system which most cancer centres don't have. Most people either have pre-printed orders. I'm sure there's probably still some places that hand write out orders which I don't think is a good thing to be doing anymore, but certainly, this would have been a province wide thing and in my opinion, would have added another element of safety into the system.

COFFEY, Q.C.:

Q. So, when you started to speak about this, you had gone to some IT people and spoken to them about the possibility of, I take it, putting in electronic or communicating electronically between, for example, St. John's and elsewhere, in relation to the pharmacy orders. Is that -

DR. SALTMAN:

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A. We have a system called OPIS which is used quite a lot in Ontario and it's electronic, there's an electronic ordering system. There's also a way of collecting--it's not really a true electronic chart, but it's a place you can store dictation, follow-up notes. Cancer care program really doesn't have an electronic chart and in my opinion, the paper chart is not a full paper chart as well, but chemotherapy can be ordered electronically through there. I spoke to the IT people who work with the cancer centre and I was told that certainly on the wards in the Health Science Complex, this was something that could be rectified very quickly. Even in places like Corner Brook, this is something that, you know, could happen within a matter of days, not weeks or months.

COFFEY, Q.C.:

Q. So, I take it the ward was within hours or days and it could be addressed -

DR. SALTMAN:

A. Yes.

COFFEY, Q.C.:

Q. - the IT people indicated. And outside St.

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John's within days or weeks.
DR. SALTMAN:
A. Yes, this is--a good IT person can sit down and do this relatively quickly and certainly in British Columbia because we deal primarily with pre-printed orders, we don't have electronic ordering, that we had this commonality. In fact, you didn't have to be in a cancer centre. You could be in Stephenville, the equivalent of Stephenville, Grand Falls, Twillingate. You can go to your computer and you download a pre-printed order which is accompanied by a protocol. And we have a system that if we wanted to treat someone with chemotherapy in Clarenville or Stephenville, there's a lot of, sort of, back and forth of handwriting, then transcribing, then entering into a computer. It seems to work, but it's--there's a much easier and I think safer solution.
THE COMMISSIONER:
Q. Excuse me, Mr. Coffey, but it's a case of just asking questions when they run through your head, Dr. Saltman, you talked about OPIS?
DR. SALTMAN:

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A. Yes.
THE COMMISSIONER:
Q. And we've heard numerous references to the existence of Meditech.
DR. SALTMAN:
A. Right.
THE COMMISSIONER:
Q. Which I understand is not necessarily the same--they're not--the Meditech System, at least within the city, are not capable of talking to each other, so I would assume that the Meditech Systems that exist in other parts of the province don't talk to each other either, at least for the moment. If you are in the Cancer Centre, can you pull up both OPIS and the Meditech System? Do you have to do that and get a large paper chart? How do you deal with a patient who walks through the door who's got some history?
DR. SALTMAN:
A. Yeah. So the Meditech System is a clinical information system and can store dictations, lab tests, x-ray reports. It's been difficult sometimes to link Meditech with x-ray archiving system in some cases. I think we

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have a real problem in the province with the Meditech System, but I can't--it depends who you talk to, and again this is going back to the leadership of--not the leadership, but the way decisions are made in the Cancer Care Program in Newfoundland. I arrived here from British Columbia. I can sit in my office in Kelowna, I have an electronic, a true electronic chart because all my dictations are there, and although Meditech doesn't talk with electronic chart, the BC Cancer Agency scans everything in. So we have an electronic chart, we still keep a paper chart, but when I go into a visiting clinic or sit in my office, I would no longer use paper, even though it's there, I can all do it electronically, and the x-rays are fused in too. So everything is there. I can look at the pathology report, the x-rays, blood tests. What happened here in 2005 when they amalgamated all the health care regions into four, I think it's four health care regions, and even within Eastern Health, which I don't know, had "x" number of facilities, they did not--each Meditech System in Carbonear, Clarenville, whatever, had its

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own database, and in order for these to talk to each other, they would have had to have been fused together. In St. John's, the one from St. Clare's and the Health Science are fused together, I can sit at my desk and if someone had a blood test done in St. Clare's, I can pick it up. So when I arrived here, I just assumed because you had Meditech and this is within Eastern Health, the same health authority, and because it's a provincial Cancer Care Program, when I got my first call from Clarenville and talked to a doctor, he said I have a difficult problem, and I said, well, let me look up the patient, I realized that I can't look up their blood work, I can't look up their pathology report, or surgical report. If they already have an existing chart, I can try to get it, but as I mentioned, our charts--our paper charts are not up to date and, in my opinion, not complete. So I spoke to Meditech in Montreal. I said what's the problem. They said, well, it's not a technically difficult problem, it's a lot of work to fuse all these databases, but it can be done, but there is a step that you

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can take as an intermediary step, and I met with the IT people in Eastern Health and I said this is a big problem for us, it's a major problem, we can't--we're coming back again to communication, and I said, you know, can this be fixed because it just doesn't affect doctors, we have booking clerks who spend days upon days getting faxes and phone calls to put together a paper chart where as in the BC Cancer Agency it takes them an hour because they sit in the front of the computer and they go "path report, surgical report, blood tests, x-rays, here's your chart", not just a paper chart, but that's made into an electronic chart. I said we have two very hard working new patient booking clerks, we have doctors who want to be able to access people's results so they can communicate effectively, and I was told that it could be done. I said, well, why hasn't it been done, why hasn't anybody addressed this, and they said because nobody has asked us. I said, well, could you do it, and they've done it, and, you know, I approached the management and this is something that did happen relatively

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quickly. I came back from holidays last week, I spoke to the booking clerks, and they said our job is exponentially easier because now they can put together a chart and now--I don't know if the physicians have access, but the plan is this is--they haven't fused the databases, but they've somehow been able to give the people here in the Cancer Centre the various icons for Meditech. So Meditech and OPIS are different, and we have Meditech for lab results, we can store x-ray reports, and if a surgeon or pathologist has a dictation, that's stored in there, but I can't access Grand Falls, I can't access Corner Brook. Where I have a great number of patients, I spend an awful lot of time on the phone trying to get lab tests directly from the nurse or have them faxed, or whatever. So we don't really have a true--one electronic charting here. OPIS is for collecting our dictations within the Cancer Centre, but there's something called OPIS 2000, which is an electronic ordering system.

THE COMMISSIONER:

Q. This sounds oddly (unintelligible) complicated.

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DR. SALTMAN:

A. It doesn't need to be, it doesn't need to be. Now in British Columbia, we did the same thing in 2002. I don't know how many health care regions, but within the Interior Health, 30 health facilities came together the same way they did in Newfoundland, and within one year, and you can follow--all this is on the web, the progress of fusing these databases because it was a priority for the health authority because they realized not just for oncologists, but for thoracic surgeons, everybody, that this was a--this had to be done so that we put all our clinical information into one site. Here we are now three years, going on four years, since the health care regions amalgamated within Newfoundland, we still don't have a provincial one stop shopping, but we don't even have it within Eastern Health, that the majority of physicians, if you're an ICU physician, a thoracic surgeon, a respirologist, you cannot access valuable clinical information outside of St. Clare's and the Health Science Complex.

COFFEY, Q.C.:

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Q. Doctor, I take it in terms of the form, or your suggested form or forms, you still haven't heard back about those?

DR. SALTMAN:

A. No, I'm not sure I--you know, after a point, you just say, I'll do it for you, I'll try to facilitate this, people seem to be interested in it, but if it doesn't go anywhere, then that's fine, you know, I--that's all I can do is try to initiate these things.

COFFEY, Q.C.:

Q. Was any difficulty with your suggestion communicated to you? Did anybody say, well, that won't work, doctor, for the following reason or reasons?

DR. SALTMAN:

A. I don't remember specific comments, but I just felt that this was--you know, I just felt any initiatives like these were to try to get them to where they needed to go was a very difficult process because again it seem all filtered into a senior management team, and that's where it stayed. That decision really should have been a Head of Medical Oncology decision, and then going to operational people

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to make it happen. Really it's a clinical decision, from my point of view, and to use the operational management to facilitate that, not to decide whether or not it's a good thing. If the oncologists and the physicians around the province say we don't want to do that, fair enough, but I didn't get the impression that was the case.

COFFEY, Q.C.:

Q. And from your perspective, it should be the decision of the people who would actually be utilizing it, which is the physicians themselves?

DR. SALTMAN:

A. Yes. There's a very important role for operations and operational management, but this to me was do the clinical people feel that this would be useful; if so, yes, how can we facilitate it in a timely manner.

COFFEY, Q.C.:

Q. Doctor, you did--before we broke for supper, you did speak of electronic communication, particularly cell phones, e-mail, Blackberrys, that sort of thing as being, from your perspective, a useful tool for a clinician. I

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did want to ask you about that in relation to the idea of utilizing, in effect, an e-mail system as the potential for it to be utilized as, what I'll refer to, as a virtual tumour board. Is there a possibility of that, and if so, how might it work?

DR. SALTMAN:

A. Again we're going back to communication and how this can be very useful. It's not an esoteric thing, it's a real thing, and it's a patient care thing. So I'll go back to the BC Cancer Agency. You have four radiation oncology centres which--a lot of the cancer care given in BC, including seeing new patients, is done by internal medicine specialists, and a lot of administration of chemotherapy is given by family doctors, in some cases nurses, and once you're part of that system, you get a BC Cancer Agency e-mail address, and then you can communicate--I can be an oncologist anywhere and somebody can say, listen, I've got a little bit of a problem here, what do you think. I can be sitting in my office seeing patients, and I have my screen up, and between patients I can

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access my e-mail. So that's a very effective way of problem solving and helping colleagues and referring physicians outside the Cancer Centre, but we also used it as a virtual tumour board. So rather than having a fixed--we had fixed tumour boards for all the disease sites, which were videolinked throughout the whole province, but we also had disease site groups that what we did is--I was on the GI group, the neuro oncology group, the skin group, the lymphoma group, and if someone in Victoria had a difficult case, they sent an e-mail that went out to 30 people within the GI group, and within an hour or so seven or eight people responded to say, yeah, I saw one last week, or I'm concerned about--let's take your breast cancer, why we're here, lobular carcinoma that was ER negative; gosh, I haven't seen that for a while, maybe I should get--these are the sort of things that you can do virtually, and you may have a difficult case that you can't wait until Friday to the actual fixed tumour board rounds. Now there's no reason why we can't do this here. I found when I came here there were no distribution

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lists within the Cancer Centre for a GI group, for a neuro group, and these don't--these are not just people within the Cancer Centre, they would include the neurosurgeons, the neuropathologists--there are no distribution groups--e-mail distribution lists for those groups, and I've created those since I came and I've sent them to all the oncologists, and so it's a very effective way of communicating and it's certainly something that could be advocated here, but again we have an IT problem. Even if I want to access my e-mail, my Eastern Health e-mail in the clinic, I have to go into the web to access that. I just can't type in David Saltman and my password, and that screen comes up and that's mine, and my e-mail is there. Again there's a level of complexity, which I think a reasonable IT person, I would be able to approach them and between us we would be able to make a decision how to fix this, and then it filters up eventually to an executive committee to say, you know, this is what we've done.

COFFEY, Q.C.:

Q. And in terms of--this, of course, would

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involve sitting at a computer terminal?
DR. SALTMAN:
A. Yes.
COFFEY, Q.C.:
Q. If Blackberrys were, for example, able to be utilized throughout the facilities, the physical facilities, I take it that if someone at least who was familiar with the usage of Blackberry or a similar device, the text messaging would allow you to do that, in effect carry on this virtual tumour board?
DR. SALTMAN:
A. Absolutely, and we're about to start this study, again I think to prove to Eastern Health and Newfoundland health authorities that somehow we're not different than the rest of the world, but that's it, you sit there with your Blackberry or you can even sit with a patient because they're--we've been doing now for 40 years, you go in a room and your pager goes off and you have to leave the room to find a phone; well, you can sit in the room and this thing doesn't ring, it gives a little red signal--you probably have a Blackberry, or it gives a little buzz, and you can quickly

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take a peak at it and say, well, that's an e-mail, I don't need--if I'm a nurse in Corner Brook, I don't need to answer it right away, but when I leave the room, I'll quickly contact her back. Yes, there is a computer terminal outside in the clinic, yes, there is a phone, but at least we should give health care workers the option of utilizing these technologies. That's not a possibility except through this clinical trial that we're going to be doing in the Cancer Care Program. There is another problem that there's a lot of dead zones within hospitals. In basements, we have lead lined rooms, these things, but, in fact, it turns out that you can get good reception in most of the clinical areas within the Cancer Centre.
COFFEY, Q.C.:
Q. Doctor, you had spoken or told the Commissioner about this--in dealing with Dr. Carter, you'd been able to arrange for one meeting, I believe it was back earlier this year, of all pathologists, all but one pathologist, and that I take it--would it be right, June?

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DR. SALTMAN:
A. This was, I think, June 18th through the 20th, something like that.
COFFEY, Q.C.:
Q. Are there any plans for any more?
DR. SALTMAN:
A. Yeah, there was tremendous excitement by the pathologists about the idea that you could bring a group of people together like that, and, you know, you just don't chat about synoptic templates, there was a lot of discussion about a number of issues, and so the idea is actually to--I'm working with--as you know, Dr. Carter has moved on to the BC Cancer Agency in Vancouver, but I'm working with Dr. Ford Elms and we thought it would be a good idea to bring in an expert to talk about immunohistochemistry, and this time actually even invite the laboratory technologists to come as well. We would bring another speaker in to talk about quality in pathology, and again, pharmaceutical company--the Department of Pathology and I don't know about Eastern Health's budget, but certainly Pathology doesn't have the budget to do this,

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and I have approached pharmaceutical companies for unrestricted educational grants, and they're very, very interested in pathologists these days and because of these new targeted therapies and immunohistochemistry and all these things, they take a great interest. So getting monies from the private sector to do these educational sessions is not that difficult. We were going to do that actually in October and because of commitments with this Commission of Inquiry, Dr. Elms thought that we would delay that probably to the spring.
COFFEY, Q.C.:
Q. And had there been any discussion about who that expert might be?
DR. SALTMAN:
A. I've forgotten the names, because I'm not a pathologist, but there was somebody from Ontario and then there was somebody who was an expert with the--expert advisor, I think from Florida, a pathologist who's done a lot of work on quality within the field of pathology.
COFFEY, Q.C.:
Q. And if I was to say Bryan Hewlett?

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DR. SALTMAN:
A. This is one person that came up, and then there's another person who has an East Indian name, who's an American expert in the field of quality.
COFFEY, Q.C.:
Q. And this was the--why I'm bringing this out is this, asking you about this is that you're involved in this because this generally will involve pathologists and, in this context, technologists.
DR. SALTMAN:
A. Right.
COFFEY, Q.C.:
Q. And you are neither of those.
DR. SALTMAN:
A. Yes.
COFFEY, Q.C.:
Q. So how is it that you've gotten involved in it? Just if you could explain kind of why you feel the need or see the need to get involved.
DR. SALTMAN:
A. I see it as a role of somebody who's going to be part of the discipline of oncology. I worked as a scientist for a number of years.

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I have done a lot of these techniques, immunohistochemistry, fluorescent in situ hybridization, and so I have an interest in it, but for--I do it also for a very selfish reason, because I'm a practising medical oncologist and I want to make sure it's safe to practise in Newfoundland. I want the best practice and I want--if I get a report from Corner Brook, I want it as a synoptic template. I don't want to spend all day reading through paragraphs of pathology jargon. I want a concise report and I want them to look at the things that are important for prognostication, and if it's breast, it has to do with nodes and ER receptors. In colon, it's a number of other things. And so I have a vested interest as a physician, but also as somebody who's interested in education as well.
COFFEY, Q.C.:
Q. Doctor, in relation to matters relating to patient safety, you, in the past, but you've been here now eight months or almost eight months, has issues involving public safety ever come up in the way of, I'll refer to it as involving controversy? Have you ever been involved?

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DR. SALTMAN:
A. Can you rephrase the question?
COFFEY, Q.C.:
Q. Okay. Well, in terms of have you ever had to deal with any situations where you've gotten into a disagreement about whether or not you should be involved in certain things involving patient safety, or from your perspective, involved patient safety potentially?
DR. SALTMAN:
A. As I mentioned earlier, I'm the academic head and then I'm a medical oncologist. I sit on the leadership committee, and this is a new venture and it's rather nebulous how the two fit together, but let me give you--try to answer your question.
Recently, there's been a very good review talking--as a cautionary review about oral chemotherapy and how its dispensed, and this is from the context of the United States where most chemotherapies are dispensed through the retail sector, but they have multiple other ways that they're dispensed, and this was a

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good review saying "we need to be careful because these are not just chemotherapeutic agents any more. These have types of side effects which are unusual and we need to take a look at this."
Now this was a very relevant article for Newfoundland because of the way chemotherapy is dispensed in this province. Anything that's not pumped in through an IV is what calls non-parental. It could be intramuscular; it could be subcutaneous; it could be oral, and we use more and more oral chemotherapies every year, and these are dispensed in Newfoundland primarily through the retail sector. We would dispense some from the Cancer Centre in St. John's, but primarily it's through the retail sector, and I have tremendous confidence in pharmacists and appreciate their job. They're very professional people, but you can appreciate, if you're given a prescription for a new oral chemotherapy that has potentially life threatening side effects, complex--some of these are very complex agents, and you send the patient back to Labrador City and it's

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dispensed at Shopper's in Labrador City, and I just picked Shopper's. I should say pharmacy X. And although that person can go online and look up something, they may have never dispensed it and they may not do it for another year or two, because cancer, although we think it's common, compared to diabetes or health disease, it's not that common.

And so it's not just a concern in Newfoundland. Most of the western provinces, chemotherapy is dispensed through cancer centres or hospitals. You don't get it from a retail sector or very rarely, and so this is a safety concern for me and that when I--even before I got here, I was talking to Mr. Rick Abbott, who's the manager for the Cancer Care Pharmacy program, about this issue and he had some concerns as well, and we reviewed the Pharmacy Act. We looked and said well, maybe a starting ground is maybe we should see if we can eventually start dispensing chemotherapy, oral chemotherapies through hospitals and cancer centres.

This would require a change in the Pharmacy Act, and I drafted a letter when I

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got here. I sent it to the Minister of Health, never had a reply, but on the suggestion of Mr. Abbott, he thought I should get in touch with the registrar of the College of Pharmacy of Newfoundland. I called and he was out of town. I tried to arrange for a meeting. I wrote a letter, the same letter that I wrote to Mr. Wiseman. I wrote again, e-mailed again, spoke to a friend who is a friend of the registrar, and after about ten weeks or so, I e-mailed him and said "I want to write about this concern. I want to talk about it publicly," that may be also in the media, whatever, but I think there has to be transparency about these issues, and to talk about them openly. I got eventually an e-mail response from the registrar of the College of Pharmacy and said that "sorry for the delay. I wasn't quite sure who you were, if you really should be poking your nose around here," and that wasn't his words, that's my words, and this was copied to the head of Eastern Health's pharmacy and to the director of oncology at our Cancer Centre, and I received an e-mail shortly after that from the

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director of oncology cautioning me that I should not be talking about safety in public.

COFFEY, Q.C.:

Q. And the director of oncology in this, you're using that phrase in this context, that's not Dr. Laing?

DR. SALTMAN:

A. No, that's Ms. Smith, yeah.

COFFEY, Q.C.:

Q. And did anything else then transpire in relation to that?

DR. SALTMAN:

A. Well, I was a bit flabbergasted that as a chair of oncology, even as a physician, that you can't talk about safety in public. Anyway, that -

COFFEY, Q.C.:

Q. And if I could, in public in this context was what?

DR. SALTMAN:

A. Well, in public, could have meant that I could have talked to--given a talk about this, written a paper. I don't think Ms. Smith really knew, and I mentioned that I may want to talk, to write an article in the media or

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whatever, to--I get asked by the media or other people to write reviews, these sort of things. You'll have to ask her what she meant by public, but this to me was an outstanding really thing to say, regardless of the context, you must not talk about safety in public.

Anyway, I was quite concerned about this. I'm here since March. I have an appointment with the University. I think it's my job to talk publicly, to be an advocate for patient care and for safety and so, I approached the university. I approached the person I report to, the Dean of Medicine, and I said I was quite concerned about this, and I told him that I was actually--I have had an office in the administrative suite within the Cancer Center and I said "I would like to have an office within the University." I'm concerned about these comments, and I'm in the process of getting an office in the Medical School.

I don't think it's the role of the operational management of Eastern Health to get involved in these issues, and quite happy to talk to people about them, but for the

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operational management to be telling physicians or other health care workers they can't talk in public--not about a specific case in the Cancer Centre, we're not talking. We're talking about something that's of concern in the United States, the rest of Canada and Europe, about the safety concerns of dispensing oral chemotherapy.

COFFEY, Q.C.:

Q. And Doctor, I want to ask you about your contact with, you know, other bodies that affect your work or potentially affect the work of oncologists and, for that matter, in some instances, pathologists and other people, and I'll refer to them as kind of non-clinical partners, in terms of cancer care. In relation to the NLMA, have you had any dealings with the NLMA here?

DR. SALTMAN:

A. That's the Newfoundland -

COFFEY, Q.C.:

Q. Newfoundland and Labrador Medical Association.

DR. SALTMAN:

A. My only real relationship, other than to be in Newfoundland, you have to become a member and

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some other provinces, you don't have to become a member. You have to be a member of the College of Physicians and Surgeons, but you don't necessarily have to be a member of the medical association, but in Newfoundland, you do, so I'm a member. As you may remember, earlier this year, we had some pathologists resign. We had some threatened to resign and as oncologists, as you know, we work very closely with them, and so not just me, Dr. Laing and the entire group decided to advocate on their behalf and so we worked with the Newfoundland Medical Association, with Mr. Ritter from that organization, and worked with the government to try to save our pathologists.

COFFEY, Q.C.:

Q. And in the course of meeting with the NLMA, have you gotten any feedback from your own cancer care program arising out of your contact with the NLMA?

DR. SALTMAN:

A. There were a lot of sessions. Well, I didn't attend a lot of them. Almost on a weekly basis, the Newfoundland Medical Association

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was briefing the physicians about what was happening in the Inquiry, what was happening with negotiations with the government, for the pathologists, and at the same time, there was negotiations about a new salary package for the oncologists.

When I first came to Newfoundland, I made a point of going to visit the head of MCP, who was an old classmate of mine, and to have an informal discussion about how physicians are remunerated in this province and not the actual amount, but the actual structure. Most oncologists in Canada are paid a straight salary, sort of alternative funding plan, and it's done differently in each province, and the actual amount of money that they get is comparable to what the physicians were paid in Newfoundland. The way physicians are paid in Newfoundland is very complex, but I wanted to talk to her about creating an alternative funding plan so that all oncologists and hematologists, gyneoncologists, pediatric oncologists, could all fit into the same salary structure and be paid equitably.

And so one specific meeting we had with

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the Newfoundland Medical Association, we were, I think, in late stages of negotiation with the Government about potentially getting an alternative funding plan. There were also some talks about continuing the current funding mechanism, which pays oncologists a certain stipend and then an extra amount of money per patient.

And I was concerned about the tone of the meeting and I did mention to the oncologists and maybe I said it a bit too strongly, but I said you need to be more focused on this Cancer Care Program, I said, well I'll say it, it's the worse cancer care program--no, I didn't say program, managed program that I've worked in and that was not a reflection on the patient care, not a reflection on the program itself, but the management and I said you need to get more involved in committees, you need to be thinking about how we work more effectively with pharmacists, nurses--anyway, I regret using such a tone at the meeting, but I got a few vitriolic e-mails after that, which is fine, that's part of having a discussion and those people I worked very

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effectively with. But one of those was copied to Ms. Smith and again, I was sent an e-mail that in no way I would even within the Cancer Centre was I to criticize their program and again, I met with Smith after that and we discussed a number of issues, but there's a real reluctance, even for sort of the normal back and forth, even if there's confrontation, out of that usually comes a consensus and I think that's a healthy thing and I think that's something lacking in the system, that sort of dialogue.

COFFEY, Q.C.:

Q. Doctor, and I take it then from that perspective in terms of--why I'm canvassing this with you is this, it's your view, I take it, based upon your own experience that such a dialogue ultimately can be beneficial to the patients that you treat?

DR. SALTMAN:

A. I think saying some of the worse managed cancer program is inappropriate and I apologize for that, but I think having a lively discussion, whether it's in the management and having a different point of

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view is a very healthy thing. You've got to come out of it with consensus or it's a waste of time, but no, it's a very healthy process.

COFFEY, Q.C.:

Q. Doctor, the Canadian Cancer Society, in particular here in Newfoundland, the most public figure in terms of being identified with the society, I wouldn't be remiss, I think, in saying it's perhaps Mr. Dawe, Peter Dawe. Have you had any dealings with Mr. Dawe since you came to Newfoundland--or I should say came back to Newfoundland?

DR. SALTMAN:

A. Came back to Newfoundland, yes. I met Peter Dawe and I didn't know him before I left Newfoundland. I left in 1982 and I've never worked in the province up until recently, but I went to meet Peter Dawe and the reason I went to meet Peter Dawe is that the Canadian Cancer Society is one of the biggest funders of cancer research in Canada. And as a medical oncologist interested in research, as Chair of oncology at the university, this is an invaluable partner, so Peter and I met at his office and we talked for a couple of hours

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and we agreed to work together and we have been working together, I don't know when we met, it was sometime in the spring, and Peter and his organization is very relentless in trying to get people to stop smoking and we've been working together to try to get Eastern Health to ban smoking on their premises. This, I think, is a huge disgrace for such an institution, the largest health care facility in the province, the home of the medical school, the home of the cancer centre and yet at any one time there's five to 20 people smoking and littering with cigarette butts and within Newfoundland, the Labrador Health Authority, the Western Health Authority have taken the lead of a comprehensive ban and here we are, the biggest hospital in the province and the home of the cancer care program and this does not seem to be an issue for the management. It doesn't seem to be an issue for the Cancer Care Program. So I've been working with Peter, we've been advocating, we've been sending letters to Eastern Health and so far, nothing has happened, but we've had a few indications that something may

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happen in the future.

COFFEY, Q.C.:

Q. Now with respect to your dealings with Mr. Dawe, has that given rise to any problems or concerns?

DR. SALTMAN:

A. I've only met with Peter once during that meeting, we communicate frequently by e-mail and I have been working primarily with one of his managers who is dealing with the smoking advocacy, but I've had no problems working with Peter Dawe or the Canadian Cancer Society. I think their initiative, the Daffodil Place is a fantastic thing. I'm not from St. John's, I know what it's like to have to come in here to stay for a week or two, if you're coming from Labrador or anywhere in Newfoundland, right now it's very expensive for our patients and this is a tremendous initiative that's been done in a relatively short period of time and his organization and Peter should be commended for it.

COFFEY, Q.C.:

Q. Have you discussed your working with Mr. Dawe in the Cancer Care Program, have you discussed

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it with others?
DR. SALTMAN:
A. I haven't.
COFFEY, Q.C.:
Q. And is there any reason that you haven't?
DR. SALTMAN:
A. I think the relationship between the Cancer Care Program in Newfoundland and the Canadian Cancer Society is very, very strained. Now historically there may be reasons for that, it may not be just a one-sided affair, but this is a very, very, very important relationship where you've got to put your differences aside and work together because we're talking about two organizations which are very, very similar in their mandate and I think, I don't--I haven't sat in on any meetings at the Canadian Cancer Society, but certainly at the Cancer centre itself, I think the attitude towards Mr. Dawe is not a very professional one.
COFFEY, Q.C.:
Q. And why do you feel that?
DR. SALTMAN:
A. Well I think there have been some derogatory comments made. Now what people say in their

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offices or in the privacy of their office or in the hallway, that's their business, but I've attended leadership meetings, this is the most important committee within the Cancer Care Program where comments have been made about Mr. Dawe which I just thought were very unprofessional and especially within this atmosphere of the Commission, the breast cancer inquiry, I just thought those were very inappropriate.
COFFEY, Q.C.:
Q. Doctor, is there anything that you wanted--anything else that you wanted to tell the Commissioner in terms of, you know, better or best practices. I appreciate you've outlined a number and I suspect that you could list a lot more, but in terms of is there anything else in terms of the ER/PR, the relationship of oncologists with pathologists and with other people involved in treating breast cancer that we haven't covered that you think the Commissioner should know from yourself?
DR. SALTMAN:
A. Well what I, this is a very personal thing for me, this isn't me as Chair of the Oncology, as

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an oncologist. My mother was diagnosed with breast cancer in 2000 and the luck of the draw she was ER positive and that's in Newfoundland. She got treated with Tamoxifen, she's alive and very well at this time, but it could have been a very different story. I have friends in this province who have had a mastectomy because they were told they were ER negative when--and because of concerns about getting cancer in the other breast, have had a mastectomy on an unaffected breast. You know, I know people, it's a very personal thing for me. I can't go back retrospectively, it's very easy to do that and say what would have happened in 1997 or 2003, but to me, there seems--it comes back to communication, it just seems that the communication between oncologists and other people working in cancer care has not been optimum. There has been a huge turnover of physicians, oncologists, pathologists, other types of physicians, that's Newfoundland, we're always going to have that problem. But if you have a system in place that you have these meetings, you have these ways of communicating, even in the

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times when you're short two or three pathologists or oncologists, that at least you have that system in place that you have your meetings, your way of communicating. Back then we may not have had the same electronic capabilities, but now we do and I'm just concerned what has happened to women with breast cancer is just a symptom of a system that is not working as optimally as we could. We have the potential to be a good cancer centre. We have very good oncologists. For the first time, I think in the history of Newfoundland, we almost have the full complement or radiation oncologists. We have medical oncologists who are coming back here, who are in training or coming back and so we'll have a good complement of medical oncologists. And my hope is that the Cancer Care Program will start to think about having oncologists in other centres, not just everything is centred around St. John's, but I think to avoid these sort of things, we've got to have better communication, we've got to have, in my opinion and I haven't discussed this with anybody else or very few people, I

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think we need a different management structure. I think to incorporate the Cancer Care Program into a regional health care authority simply because they were in the same building in 2005 was a bit short-sighted. Maybe they were forced to do that, maybe there were financial considerations, but we have an organization with a provincial mandate which is incorporated into a regional centre without the proper communication tools. We talked about Meditech, we talked about ordering systems and here we are, three years later, and a lot of these things have not really come to fruition that would be very, very helpful. I'm not sure if this is the right management structure. I'm not sure it's the right idea to have this Cancer Program incorporated into a regional authority. The old Newfoundland Cancer Treatment Foundation was not perfect, it was an autonomous or semi-autonomous organization and it had problems as well. There's many different models, but I think there has to be a provincial organization, either if it continues within Eastern Health, it has to have more of a say at the table, at

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the executive table and less middle management to stifle all these ideas about IT and communication and communicating with each other and ideas filtering from below and things getting done in a timely fashion. I think that's where we need to get people working together and this middle management needs to be pared down or re-defined, so to have someone, whether that's Dr. Laing or whatever, at that very top who is making key decisions with the government and then a different management structure within the provincial Cancer Care Program. And that's going to help lessen the chance of these sort of tragedies happening, okay.

There was a very good letter, a very short letter put on the BC Cancer Agency Breast Website before I left BC. It was put on there by a colleague of mine in the breast cancer group and basically what it said was to the patients and the families in BC because they were getting a lot of calls, this is not just, as you know a provincial story, it's a national or international story, getting a lot of calls, what about BC, what about my

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estrogen receptors? We put a letter there explaining why this was unlikely, it's always possible, but unlikely to happen in BC because of that level of redundancy, because of pathology review, because of the way that cancer centre is structured and because they were participating in a quality assurance program for a number of years in the United Kingdom.

So I think we need a different management structure. I think the breast cancer tragedy is a symptom of a system that really needs a lot of work, and again, this is no reflection on the people working in the system. Great nurses, great pharmacists, health care records workers, nurses who work in the periphery, fantastic radiation and medical oncologists, physicists, whatever, we have great people but the system really needs, I think, an overhaul and people need to be participating more in the decision-making process.

COFFEY, Q.C.:

Q. Thank you, Doctor. Those are the questions I have, Commissioner, thank you.

THE COMMISSIONER:

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Q. Thank you. Ms. Brazil?

BRAZIL, Q.C.:

Q. No questions, Commissioner.

THE COMMISSIONER:

Q. Mr. Simmons?

MR. SIMMONS:

Q. I know we're back on leaving, but I wonder if we might have a five or ten minute break, I'd like to consult with my constructive clients in order to -

THE COMMISSIONER:

Q. Yes, of course, we can do that. We'll take ten minutes. Mr. Simmons, if you need longer, you can just let -

(RECESS)

THE COMMISSIONER:

Q. Mr. Simmons.

MR. SIMMONS:

Q. Thank you, Commissioner. We just had notice yesterday that Dr. Saltman would be appearing here. His notice of anticipated evidence we received lunch time and it didn't have any of the particulars of much of the evidence that we heard from Dr. Saltman, it's a lot of new information that hasn't been particulars of

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incidents and so on that haven't been previously addressed in evidence and that we haven't had an opportunity to consider. And in particular, I haven't had an opportunity to prepare to be able to cross-examine Dr. Saltman on much of what he has said and I think I would like an opportunity to do that. I'm going to propose that we can proceed with the other witnesses that are scheduled for tomorrow, in particular Ms. Smith and it may be after Ms. Smith has given her evidence I will be able to give you an idea if it would be necessary to bring Dr. Saltman back, but if it is, I would ask that my examination be deferred until I've had an opportunity to do a proper preparation in order to be able to deal with these issues.

THE COMMISSIONER:

Q. How long a deferral are you looking at? You know that we think we're going to close on Friday morning.

MR. SIMMONS:

Q. Yes, Commissioner, I don't think I could do it justice to be prepared to proceed tomorrow. There are many issues that require some

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investigation, there will be documents that may have to be--e-mails and so on that have been referred to by Dr. Saltman that I want an opportunity to review and investigate. That's not going to happen between now and tomorrow. We can make some headway with it tomorrow, but it may be that after we hear from Ms. Smith that some of these issues may have another perspective on them and that may eliminate the need to examine Dr. Saltman on some of these issues.

THE COMMISSIONER:

Q. Okay, have you and Mr. Coffey had a conversation about the availability of the witness.

MR. SIMMONS:

Q. I've just informed Mr. Coffey that this would be my request, Commissioner.

THE COMMISSIONER:

Q. In the US, this would be called a sidebar.

MR. SIMMONS:

Q. Mr. Coffey advises me that Dr. Saltman has understandable commitments that would mean that if I can't proceed tomorrow, it would have to be at some later time to be

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determined.

THE COMMISSIONER:

Q. Uh-hm.

MR. SIMMONS:

Q. Which is satisfactory to me. I don't think, as I said, I could do this justice if we had to proceed tomorrow morning and as I said, it may be that after Ms. Smith, that may reduce the necessity or even eliminate the necessity of examining Dr. Saltman. I can't say that for sure, but that's my preference, Commissioner.

THE COMMISSIONER:

Q. Well I take your point about the timing in terms of the information provided in respect of what Dr. Saltman might say because he is a recent addition to our witness list, so I do have some sympathy for your request. Where I don't have some sympathy, you might recall would be--or agreement that all submissions to the Commission have to be in 30 days from the last day of our hearings, which I think is Friday.

MR. SIMMONS:

Q. I'm quite willing, Commissioner, to agree that

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the clock will start to tick then and if Dr. Saltman has to come back, it will not postpone those 30 days, so I have no difficulty with that.

THE COMMISSIONER:

Q. All right and in the meantime, let's find out from the others in the room whether or not they have a similar problem or are in a position to tell me whether or not they want further questions of Dr. Saltman. Mr. Browne, are you in a position?

BROWNE, Q.C.:

Q. Commissioner, at this point I have no questions for Dr. Saltman, there may be something arising from Mr. Simmons' cross-examination, but at this point, I have no (inaudible).

THE COMMISSIONER:

Q. Mr. Pritchard?

MR. PRITCHARD:

Q. We have no questions for Dr. Saltman and in respect of Mr. Simmons' comment about submissions, we're certainly in agreement with that as well.

THE COMMISSIONER:

Q. Well as you realize, my deadline isn't going to move, so that's what I'm being very firm on Friday. Ms. Newbury?

MS. NEWBURY:

Q. My position is the same as Mr. Browne, is that I don't anticipate any questions, unless it's something that arises and we're also agreeable to -

THE COMMISSIONER:

Q. The clock running from Friday?

MS. NEWBURY:

Q. I have no problem with that, yes.

BROWNE, Q.C.:

Q. Sorry, Commissioner, I didn't address--I have no problem with the 30 days from Friday.

THE COMMISSIONER:

Q. Okay, do you have a similar position on the clock, Ms. Brazil?

BRAZIL, Q.C.:

Q. That's fine with the with the province with respect to the matter, Commissioner.

THE COMMISSIONER:

Q. All right, thank you. All right, Mr. Simmons, I will leave it to you to advise counsel following the evidence tomorrow of Mrs. Smith,

what your position is in respect of that and then we will do our best to accommodate whatever that is and communicate it to the witness as well.

MR. SIMMONS:

Q. Thank you, Commissioner.

THE COMMISSIONER:

Q. So I guess that ends the session for this evening and I will see you all at 9:30 tomorrow morning, thank you.

Upon conclusion at 7:50 p.m.

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 29th day of October, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 29th day of October, A.D., 2008

Judy Moss

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