

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">October 29, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Chesley Crosbie, Q.C... Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike, Q.C. NL Medical Association</p> <p>Jennifer Newbury Canadian Cancer Society (NL Division)</p> <p>Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p> <p>Barry Glaspell Counsel for Daniel Boone</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-3580 AND P-3581 Pg236</p> <p>EXHIBIT P-3584 Pg. 313</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>MR. DANIEL BOONE - SWORN</p> <p>Examination by Bernard Coffey, Q.C. Pgs. 4 - 235</p> <p>MR. JOSEPH WHITE - SWORN</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 235 - 313</p> <p>DR. DAVID SALTMAN - SWORN</p> <p>Examination by Bernard Coffey, Q.C. Pgs. 313 - 414</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER:</p> <p>2 Q. Please be seated. Mr. Coffey?</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Commissioner, the next witness is Daniel</p> <p>5 Boone.</p> <p>6 MR. DANIEL BOONE, SWORN, EXAMINATION BY BERNARD COFFEY,</p> <p>7 Q.C.</p> <p>8 REGISTRAR:</p> <p>9 Q. Would you please state and spell your complete</p> <p>10 name for the Commission?</p> <p>11 MR. BOONE:</p> <p>12 A. Daniel Boone, D-A-N-I-E-L B-O-O-N-E</p> <p>13 REGISTRAR:</p> <p>14 Q. Thank you.</p> <p>15 MR. BOONE:</p> <p>16 A. You're welcome.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Commissioner, Mr. Boone, there's counsel here</p> <p>19 in the room for Mr. Boone.</p> <p>20 MR. GLASPELL:</p> <p>21 Q. I'm Barry Glaspell from Borden Ladner Gervais.</p> <p>22 THE COMMISSIONER:</p> <p>23 Q. Welcome.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. And Mr. Boone, I understand you're a lawyer.</p>

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1 MR. BOONE:
 2 A. I am.
 3 COFFEY, Q.C.:
 4 Q. And Mr. Boone, can you tell the Commissioner,
 5 please, give her a brief overview of your
 6 educational and professional background,
 7 please?
 8 MR. BOONE:
 9 A. Yes. I graduated from the University of
 10 Ottawa Law School in 1988. I articulated with
 11 the firm then known as Sterling Ryan, which
 12 through a merger with other firms became the
 13 firm of Stewart McKelvey Sterling Scales in
 14 1990, and I've remained with that firm since
 15 that time. I became a partner in the firm in
 16 1994. I'm currently the regional managing
 17 partner for Newfoundland, and my practice, if
 18 you like, if you'd like to have a description
 19 of my practice?
 20 COFFEY, Q.C.:
 21 Q. Yes.
 22 MR. BOONE:
 23 A. It's been focused mainly in the field of
 24 insurance defence, but within that, even more
 25 so in respect of issues of hospital liability,

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

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1 the only person in our office functioning in
 2 that area, and then in around 1995, the
 3 practice started to accelerate, if you like,
 4 because of--well, for one thing, the
 5 Healthcare Insurance Reciprocal of Canada
 6 became the--provided insurance to most of the
 7 hospitals in St. John's and to many of the
 8 hospitals outside and then that's progressed
 9 over time, and we are counsel to that
 10 organization.
 11 COFFEY, Q.C.:
 12 Q. And that's the Health--I'm sorry, what is it?
 13 MR. BOONE:
 14 A. Healthcare Insurance Reciprocal of Canada.
 15 COFFEY, Q.C.:
 16 Q. Okay, and is that what has been referred to
 17 here as HIROC?
 18 MR. BOONE:
 19 A. You've referred to HIROC and I have no idea
 20 why this is the case. They prefer to
 21 pronounce it HIROC.
 22 COFFEY, Q.C.:
 23 Q. HIROC, okay, and I appreciate -
 24 MR. BOONE:
 25 A. But certainly that is an acronym and the

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1 acronym is for the Healthcare Insurance
 2 Reciprocal of Canada.
 3 COFFEY, Q.C.:
 4 Q. Okay, and you have been local counsel, local
 5 in the sense of provincial counsel for them,
 6 since approximately when?
 7 MR. BOONE:
 8 A. I can't recall exactly when, because the first
 9 hospital in the province to become a
 10 subscriber, and I can explain to you, if you
 11 like, what a subscriber is, in the HIROC
 12 system in Newfoundland was the Waterford
 13 Hospital in 1991.
 14 COFFEY, Q.C.:
 15 Q. Okay.
 16 MR. BOONE:
 17 A. And they were followed, I think, fairly
 18 closely by the Carbonear General Hospital and
 19 then by what was then the General Hospital,
 20 the Health Sciences Centre in St. John's, and
 21 then when the Health Care Corporation of St.
 22 John's was formed, they chose to place their
 23 insurance through the Reciprocal, and that of
 24 course is the biggest hospital, you know, the
 25 biggest organization and obviously most issues

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1 of insurance arise out of there. So we've
 2 been counsel, I guess, since the first claims
 3 arose with respect to that.
 4 COFFEY, Q.C.:
 5 Q. And could you tell the Commissioner then, from
 6 your perspective, what--I'm sorry, I want to
 7 get it right, HIROC?
 8 MR. BOONE:
 9 A. HIROC.
 10 COFFEY, Q.C.:
 11 Q. HIROC, okay. HIROC's role and/or roles and
 12 functions are?
 13 MR. BOONE:
 14 A. Sure, and there's obviously very long answers
 15 and very short answers to that and I'll keep
 16 it as short as possible. The Reciprocal was
 17 formed--and we often refer to it as the
 18 Reciprocal as well as HIROC. When I say we, I
 19 mean counsel who do work for both, for
 20 Reciprocal and hospitals, the Reciprocal
 21 itself, they often refer to themselves as the
 22 Reciprocal. The Reciprocal was formed in, as
 23 I understand it, the late '80s, in Ontario
 24 first, in response to a previous commission of
 25 inquiry that was dealing at the time with

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

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1 rata.
 2 COFFEY, Q.C.:
 3 Q. And Mr. Boone, are you aware of whether or not
 4 like the amount that this costs annually for
 5 any one subscriber varies based upon their
 6 kind of claims history?
 7 MR. BOONE:
 8 A. I would presume so. I mean, obviously that's
 9 not part of my role, but I would imagine that--
 10 -I really shouldn't speculate much. I know--
 11 it's a little bit more than imagine. I do
 12 know that the Reciprocal has an underwriting
 13 group and in determining what membership fees,
 14 if you like, or subscription fees must be paid
 15 by a member, they apply ordinary underwriting
 16 principles to that to determine what the
 17 overall Reciprocal's risks of loss are in the
 18 future and what the specific risks of loss
 19 would be for a particular subscriber, and
 20 these underwriting principles are applied
 21 because the Reciprocal is, although perhaps
 22 not a tradition insurance company, is yet
 23 regulated pursuant to most insurance acts. I
 24 know it's regulated under the Newfoundland
 25 Insurance Act, which refers to a reciprocal.

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1 And it's a fairly common way. This is a
 2 reasonably common way for health care
 3 insurance to be provided in the country. Now
 4 HIROC operates in, I think, six provinces now.
 5 Nova Scotia has its own reciprocal that
 6 effectively functions the same way.
 7 COFFEY, Q.C.:
 8 Q. And does HIROC do anything other than provide
 9 insurance services?
 10 MR. BOONE:
 11 A. It does a lot, and a lot of which I wouldn't
 12 necessarily be aware of, except obviously
 13 anecdotally and through hearsay. HIROC is
 14 member run and they--from the literature that
 15 I've read, from the meetings that I've
 16 attended with them, they pride themselves on
 17 the fact that they are member run, and what I
 18 mean by that is that the Board of Directors of
 19 HIROC are drawn from directors and executive
 20 of health care institutions across the
 21 country. So the board is essentially people
 22 who work in the health care industry. I think
 23 largely because of that, and largely because
 24 of the focus is on the members and their
 25 interests, HIROC has developed a fairly

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1 significant risk management program and
 2 they've done that internally. So internally,
 3 they have a risk management staff, which I
 4 think now numbers six or seven or eight, I
 5 think. They have a vice president of risk
 6 management who, you know, that might give some
 7 indication as to the importance that that
 8 seemed to have in the organization. And as
 9 well as that, they partner with other groups
 10 in respect of patient safety.
 11 If you go on the HIROC website, for
 12 instance, you'll find their vision statement
 13 includes that they wish to partner for a safer
 14 health care system, and in order to do that,
 15 they've partnered with many other groups who
 16 work within the system, for instance, the
 17 Canadian Medical Protective Association, the
 18 Canadian Patient Safety Institute, of which
 19 they're a voting member, and various other
 20 institutions, such as Ontario Hospital
 21 Association, with the Newfoundland and
 22 Labrador Risk Managers Association. They
 23 partner with groups of that sort to sponsor
 24 educational events and to have resources
 25 available for risk management, patient safety

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

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1 that members use that model. So there's a lot
 2 of activity in that respect.
 3 They also do some other activity in terms
 4 of--that I know less about, some brokerage of
 5 other types of insurance for members and those
 6 kinds of things, but I'm not very much aware
 7 of those.
 8 COFFEY, Q.C.:
 9 Q. Mr. Boone, so I take it then, from shortly
 10 after the inception of the Health Care
 11 Corporation of St. John's, which would be in
 12 the mid 1990s -
 13 MR. BOONE:
 14 A. 1995.
 15 COFFEY, Q.C.:
 16 Q. '95, that you, as the defacto lawyer in
 17 Newfoundland for HIROC, and I appreciate your
 18 firm acted for them, but -
 19 MR. BOONE:
 20 A. Sure.
 21 COFFEY, Q.C.:
 22 Q. - you in fact did most of the work, I take it,
 23 certainly in those days for your firm for that
 24 client.
 25 MR. BOONE:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Can you tell the Commissioner then, because to
 4 give her some sense of like throughout the
 5 late 1990s in through early 2000s, without of
 6 course getting into the nitty gritty of any
 7 one case, what sorts of interaction you found
 8 yourself having with representatives of the
 9 Health Care Corporation, or for that matter,
 10 any other organization, health care authority
 11 in Newfoundland at the time, in terms of
 12 dealing with matters on behalf of HIROC?
 13 Could you tell the Commissioner?
 14 MR. BOONE:
 15 A. Well, the interactions developed in practice
 16 over time, and as I understand it, my practice
 17 in this area is consistent with other people
 18 who do work for HIROC in other provinces.
 19 There are many interactions and these are
 20 encouraged, and many of these interactions are
 21 encouraged because, as I understand it,
 22 because of HIROC's vision for safer health
 23 care. As HIROC counsel, I understand that I
 24 am to make myself available. No one's ever
 25 told me this, but my understanding is I make

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1 myself available as a resource to subscriber
 2 hospitals within the province. So you know,
 3 one level of interaction that I would often
 4 get would be calls from--and these calls
 5 continue all the time, from hospitals within
 6 the province with issues that tend towards the
 7 legal and asking for input or a description as
 8 to perhaps what action they ought to take.
 9 Sometimes it involves a review of policies.
 10 Sometimes it involves directing towards
 11 resources or considerations they might take
 12 into account. Those interactions happen
 13 often, regularly and often. Very many times,
 14 no file is open in respect of those
 15 interactions, if you like. You know, a call
 16 is made, I'll give an answer and they'll
 17 proceed, you know, and that's often the case
 18 because the issue might be minor. The issue
 19 might not have significant ramifications. So
 20 we make ourselves available as a resource for
 21 hospitals in that kind of context.
 22 As well, when subscribers or hospitals
 23 call HIROC with an issue, sometimes that might
 24 get directed around back to me, and we get
 25 involved, and as I say, oftentimes, you know,

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1 really nobody is billed for that. It just--
 2 it's part of the service, I guess, if you
 3 like, that we're available as a resource.
 4 We also make ourselves available for
 5 educational events for hospitals within the
 6 province. You know, if somebody calls us and
 7 asks us to do an educational event on some
 8 aspect of legal liability, we just go and do
 9 it, and we get called about that as HIROC
 10 counsel. Sometimes we also have chats on a
 11 regular basis with the people who are involved
 12 in managing claims within the hospital. So
 13 we'll have, you know, quarterly meetings
 14 sometimes with some hospitals, less regular
 15 with others, just to get a feel for what's
 16 happening within their industry.
 17 And then there is also then the, I guess,
 18 the next level of involvement, which would be
 19 when a claim actually gets reported to HIROC,
 20 and when I say a claim, I don't mean a formal
 21 legal action, but when an actual claim is
 22 reported or an event of loss is considered to
 23 trigger a potential loss under the policy and
 24 a report is made to the insurer. Sometimes,
 25 depending on the nature of the file, and I

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1 couldn't really give you a definition as to
 2 that, we might get involved early in that
 3 file. Sometimes--I'm sorry, the paradigm
 4 situation rather is that HIROC will appoint an
 5 adjuster to investigate the claim, and that
 6 adjuster will sometimes report to me,
 7 sometimes copy me, sometimes just report
 8 directly to HIROC. So we do have a level of
 9 interaction that obviously grows and expands
 10 once a claim has been reported and especially
 11 once a statement of claim has been issued, and
 12 there's a formal legal action, then we get
 13 directly involved.
 14 COFFEY, Q.C.:
 15 Q. And I take it then that that, those
 16 relationships that you've just described,
 17 varying various ones, developed throughout the
 18 late '90s, into the 2000s, as time went on?
 19 MR. BOONE:
 20 A. Yeah.
 21 COFFEY, Q.C.:
 22 Q. You got more and more phone calls, for
 23 example, over time?
 24 MR. BOONE:
 25 A. Yes, absolutely.

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1 COFFEY, Q.C.:
 2 Q. And then I take it then, would it be fair to
 3 say that the relationships, such as you just
 4 described, existed by the beginning of July
 5 2005? By the time Eastern Health came along
 6 in the spring of 2005, that sort of
 7 interaction you would have either with Eastern
 8 Health or the other health authorities at the
 9 time, that existed by that point in time?
 10 MR. BOONE:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. Okay. Mr. Boone, can you tell the
 14 Commissioner when you first heard about--the
 15 circumstances under which you first heard
 16 about what is now referred to as the ER/PR
 17 matter?
 18 MR. BOONE:
 19 A. Okay. I can date it with reasonable certainty,
 20 because I know that I was on holidays out of
 21 the province with my family until, I think it
 22 was the 16th of July, which was a Saturday.
 23 On the 18th of July, I had some information
 24 provided to me by Heather Predham, who is the
 25 risk manager of Eastern Health, as it was at

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1 the time, and I can tell you what that is when
 2 we come to it, but I also had a voice mail
 3 sometime on the 18th, and I really can't
 4 recall when that was, from Eleanor Morton,
 5 who's the VP of risk management at HIROC, and
 6 Michael Boyce, who is the VP of claims at
 7 HIROC, to tell me that Eastern Health was
 8 facing a situation in respect of which they
 9 might need legal advice, among other things,
 10 and I don't recall much other than that in the
 11 voice mail.
 12 COFFEY, Q.C.:
 13 Q. And do you recall what Ms. Predham had to say
 14 to you?
 15 MR. BOONE:
 16 A. No, I didn't speak to her.
 17 COFFEY, Q.C.:
 18 Q. Oh, you didn't?
 19 MR. BOONE:
 20 A. No, she sent me material.
 21 COFFEY, Q.C.:
 22 Q. Oh, material.
 23 MR. BOONE:
 24 A. On the 18th. I spoke to her on the 19th.
 25 COFFEY, Q.C.:

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1 Q. And what do you recall about what was said
 2 then on the 19th?
 3 MR. BOONE:
 4 A. Yes, she called and asked me to come to a
 5 meeting. She told me no more than that.
 6 COFFEY, Q.C.:
 7 Q. And then what happened?
 8 MR. BOONE:
 9 A. I went to the meeting. Now, of course, just
 10 to--if I can just talk about this for a
 11 moment.
 12 COFFEY, Q.C.:
 13 Q. Sure.
 14 MR. BOONE:
 15 A. In attending the meeting, we're never sure
 16 when we're invited to a meeting of that sort
 17 whether what will develop will be, if you
 18 like, a HIROC file, in other words a claim
 19 file, or a matter in respect of which the
 20 hospital will need advice or anything of that
 21 sort, and it might never become a claim file,
 22 or if you like, speaking in a lawyer's
 23 parlance, may never become a file at all. In
 24 other words, it might be an issue that they'll
 25 never need to speak to us about again, and

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1 oftentimes when I'm called to go to meetings
 2 like that, and this was not the first time, I
 3 don't know what's going to be developing out
 4 of that meeting, and in fact, if I remember
 5 correctly, my first notation of any kind
 6 relating to ER/PR on the 19th, I recorded the
 7 client and the client part of my form is
 8 HCCSJ, which was the acronym for the Health
 9 Care Corporation of St. John's, which was
 10 force of habit because Eastern Health had only
 11 just been formed, and when I went to that
 12 meeting, that's what I wrote down. So I had
 13 no idea really what they were going to tell
 14 me, although I did know that HIROC had a
 15 feeling or a concern that there might be a
 16 claim that could arise out of the
 17 circumstances that were about to be described
 18 to me.
 19 COFFEY, Q.C.:
 20 Q. So what do you recall then happened? Do you
 21 recall who was at the meeting? Where the
 22 meeting was?
 23 MR. BOONE:
 24 A. Yeah, I do.
 25 COFFEY, Q.C.:

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1 Q. Or even what time of day it was?
 2 MR. BOONE:
 3 A. I actually recall not the exact time of day.
 4 I don't recall the starting time, but I do
 5 recall by when it had to finish, so it would
 6 have been around lunch time on the 19th, and
 7 the reason I know that is because at 2:00 on
 8 the 19th, Heather Predham and I were meeting
 9 with Colleen Simms, who is the manager for the
 10 Mental Health Program at the Waterford site,
 11 on a file, and that I had a 2:30 meeting then
 12 with Ms. Simms that wouldn't have included Ms.
 13 Predham. So I know that the meeting on the
 14 ER/PR issue ended in enough time for me to get
 15 to the General Hospital--from the General
 16 Hospital site to the Waterford site. So it's
 17 over lunch, and I remember that the meeting
 18 did take place in the General Hospital and I
 19 believe it took place in Dr. Williams' office,
 20 but I don't have a real recall of that. It
 21 was definitely a smaller room. It might have
 22 been an office near his office.
 23 COFFEY, Q.C.:
 24 Q. And do you recall who was there?
 25 MR. BOONE:

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1 A. Yeah. At the meeting was Dr. Williams, who
 2 was, I guess, the medical director or the VP
 3 Medical Services, who I had met before.
 4 Heather Predham was there, and Susan Bonnell,
 5 who was from communications within Eastern
 6 Health, who I think I had met before, but
 7 certainly I knew who she was. Dr. Donald Cook
 8 was there. I didn't--I don't think I
 9 understood this at the time, but he was the
 10 chief of pathology service, I believe, at that
 11 time, but I had known Dr. Cook from other
 12 files in which I'd been involved, just as a
 13 pathologist, and so I knew who he was. And
 14 Terry Gulliver was there, Terry was the lab
 15 director or presented to me as the lab
 16 director or the lab manager or some title of
 17 that sort.
 18 COFFEY, Q.C.:
 19 Q. Had you known Mr. Gulliver before that?
 20 MR. BOONE:
 21 A. No, I'd never met him.
 22 COFFEY, Q.C.:
 23 Q. Okay, and okay, what happened? What do you
 24 recall?
 25 MR. BOONE:

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1 A. The meeting started with a description by Dr.
 2 Cook of what had evolved over the course of
 3 time, since they first learned there might be
 4 an issue, and you'll recall that there's a
 5 memo--you'll recall it better than me, I
 6 think, that there's a memo that Dr. Cook
 7 prepared that's dated May 24th of 2005.
 8 COFFEY, Q.C.:
 9 Q. Yes.
 10 MR. BOONE:
 11 A. That was one of the things that Ms. Predham
 12 had sent to me on the 18th. So I actually had
 13 that memo, and the meeting started essentially
 14 with Dr. Cook giving a synopsis of what was in
 15 that memo, and so we heard from him with
 16 respect to that, and you know, he told us--I
 17 do recall he mentioned some, I guess, if you
 18 like, the highlights of that. The sentinel
 19 case was mentioned. The further investigation
 20 that had occurred up until that point of time.
 21 COFFEY, Q.C.:
 22 Q. That would be up until July?
 23 MR. BOONE:
 24 A. Up until the 19th.
 25 COFFEY, Q.C.:

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1 Q. Yes.
 2 MR. BOONE:
 3 A. And some other activity that they had had, and
 4 he also told me, because, of course, this is
 5 my first exposure to the ER/PR testing, to
 6 immunohistochemistry or any of the purposes
 7 for this. He also gave a description, which I
 8 think was meant for me more than anybody in
 9 the room, as to the test and its purpose, how
 10 it's done to some degree, and the things that
 11 I remember taking out of that were a couple of
 12 really important things. One was that, I
 13 remember he emphasized that the test was not
 14 diagnostic, which I would have took to mean
 15 that it was not a test to tell someone whether
 16 they do or don't have a disease. I recall
 17 that being part of the issues. He told me, or
 18 he told us, but again, I think it was mostly
 19 for me.
 20 COFFEY, Q.C.:
 21 Q. You felt it was directed mostly at yourself?
 22 MR. BOONE:
 23 A. Well, as everybody else already knew these
 24 things, because they already had their
 25 education at some point earlier than mine, and

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1 I was now getting mine. He told me, I
 2 remember that he mentioned that the purpose of
 3 the test is to be a guideline used in
 4 treatment by oncologists who are treating
 5 cancer patients, specifically I understood
 6 breast cancer patients. So I did have that
 7 understanding. And the word Tamoxifen was
 8 used, which was the first time I had ever
 9 heard the word, as being a drug or medication
 10 that could be available or made available,
 11 depending on some circumstances, including the
 12 outcome of the ER/PR test. I do recall at
 13 that time, that I was told, must have been by
 14 Dr. Cook, that ER/PR testing wouldn't be the
 15 sole indicator, I remember that discussion
 16 took place, for the use of Tamoxifen. That
 17 kind of discussion occurred.
 18 And I do recall a limited discussion, but
 19 I recall a much more expanded discussion at a
 20 later meeting, about the fact that everywhere
 21 where this test is done, there are issues.
 22 There was some notion of--I don't know if
 23 it's--probably going too far to say inherent
 24 unreliability, but some problem with inter-
 25 examiner variability with the test that was

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1 known. That was mostly Dr. Cook's
 2 contribution. That was essentially the
 3 beginning of the meeting for me, and then Mr.
 4 Gulliver spoke, and again as I said, it's the
 5 first time I'd met Mr. Gulliver, he was the
 6 lab manager and he talked more about the
 7 specifics of the test and the problems that
 8 they had encountered since May, or had been
 9 investigating since May, and the things that
 10 Mr. Gulliver told me that I considered to be
 11 important were the following--I do have a very
 12 good recall of these. Mr. Gulliver told us,
 13 people in the meeting, as well as me, that he
 14 himself--and I think he put it that he,
 15 himself, as manager for the area or something
 16 of that nature, was 100 percent certain that
 17 the staff were doing the test correctly.
 18 COFFEY, Q.C.:
 19 Q. Were doing it correctly. Did you understand
 20 from that, like, as in that day were doing it
 21 correctly, or had always done it correct?
 22 MR. BOONE:
 23 A. Always was my impression.
 24 COFFEY, Q.C.:
 25 Q. Okay.

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1 MR. BOONE:
 2 A. But whether or not--I can't say now whether
 3 I'm right or wrong, but that was certainly the
 4 impression I took.
 5 COFFEY, Q.C.:
 6 Q. That's what I'm getting at.
 7 MR. BOONE:
 8 A. No, I can't say that, but certainly my
 9 impression would have been over whatever
 10 period, and I didn't understand what period it
 11 was that they were looking at as being
 12 potentially problematic.
 13 COFFEY, Q.C.:
 14 Q. Okay, I'm sorry, go ahead.
 15 MR. BOONE:
 16 A. So this wasn't a recent or new development.
 17 Mr. Gulliver also told us -
 18 COFFEY, Q.C.:
 19 Q. So it was 100 percent.
 20 MR. BOONE:
 21 A. I remember those words, he was 100 percent
 22 certain that the staff were doing the test
 23 correctly, and I remember as well that he
 24 said--he also said that in doing the test, and
 25 I don't know if "doing the test" is an

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1 appropriate terminology, but in performing the
 2 test, the staff followed the instructions of
 3 the manufacturer, who I understood to be DAKO,
 4 the machine. So they followed the
 5 instructions. Another thing that was told to
 6 me, or told to us I should say, at the meeting
 7 by Mr. Gulliver was that not only were the
 8 staff and himself certain they were doing the
 9 test correctly and following instructions, but
 10 that there were also controls run, I can't
 11 recall if he said every day or every
 12 something. There was something like that.
 13 COFFEY, Q.C.:
 14 Q. Every run?
 15 MR. BOONE:
 16 A. I've heard--there's been so many descriptions
 17 of when controls are run. I can't be honest
 18 with you as to what he said at that time. I
 19 just can't recall. He spoke of controls and,
 20 of course, as a layperson without much of a
 21 scientific background, I didn't know what a
 22 control was. I had some vague, you know,
 23 Grade 11 impression as to what one would be,
 24 but I understood it to be a test or an
 25 assurance process that was done side by side

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1 with the test itself to ensure the test was
 2 done correctly. That's not how he described
 3 it to me, that was just what I understood in
 4 my own mind, but he did say, Mr. Gulliver,
 5 that these controls were run, and that if the
 6 controls were run and were--I can't remember
 7 what the words were--if the controls were run
 8 and were accurate, I think is what he said,
 9 then that would be an indication that the test
 10 itself was accurate, and that these were run
 11 all the time. That was my impression. Again
 12 it would be unfair of me to say whether he
 13 said every day, every run, every batch, I
 14 don't know. All the time is what I took out
 15 of it. And the next thing that Mr. Gulliver
 16 told us in the room was that in two to three
 17 days from that point forward--so that was the
 18 19th, I think, the 19th was a Tuesday?
 19 COFFEY, Q.C.:
 20 Q. This would be a Tuesday.
 21 MR. BOONE:
 22 A. In two to three days from that point forward,
 23 the lab would have all of its statistics for
 24 the years which were in question. At the
 25 time, I have to say I don't know what years

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

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1 notification, and that was ongoing. I know we
 2 talked about it because we were fairly active
 3 in that file at that time, it was ongoing over
 4 that period of 2005.
 5 COFFEY, Q.C.:
 6 Q. In fact, the Commissioner has seen in exhibits
 7 these media reports on--I think it's Judge
 8 Russell had just certified it as a class
 9 action earlier that month.
 10 MR. BOONE:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. That would be a matter of public record.
 14 MR. BOONE:
 15 A. And, of course, once certification occurs,
 16 there's an awful lot of activity that has to
 17 occur amongst the lawyers, so we were -
 18 COFFEY, Q.C.:
 19 Q. Okay, you were actively involved.
 20 MR. BOONE:
 21 A. It was occupying a fair bit of our time at
 22 that time.
 23 COFFEY, Q.C.:
 24 Q. And do you recall why that was raised, who
 25 raised it and why?

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

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1 service providers, other people who interact
 2 on a--put it this way, an intimate basis with
 3 the public, had had to make a notification and
 4 then had been sued in a class action process
 5 for that notification. In other words,
 6 leaving aside the question as to whether or
 7 not the underlying event caused any damage,
 8 the notification itself was felt either to be
 9 negligently done or the choice to do it was
 10 negligent, such that people were then claiming
 11 for damages for not physical harm, but rather
 12 the distress and the mental distress that
 13 occurred from the notification itself. So
 14 that would have been the essence of what I had
 15 said, but it went a little bit further than
 16 that because I do recall that Ms. Bonnell who
 17 was there said at the time that she had a file
 18 back in her office relating to Health Labrador
 19 communications issues, and she was going to go
 20 look at it. I never had any further
 21 discussion with her about that, but I
 22 understood that she had some other independent
 23 and perhaps a wholly different professional
 24 take on Health Labrador.
 25 COFFEY, Q.C.:

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

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

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1 Q. In relation to the positivity rates?
 2 MR. BOONE:
 3 A. That's what I -
 4 COFFEY, Q.C.:
 5 Q. That's what you understood?
 6 MR. BOONE:
 7 A. I don't--told you at the time, but that was my
 8 understanding that was what it was about,
 9 positivity rates, yeah.
 10 COFFEY, Q.C.:
 11 Q. Anything else about the meeting?
 12 MR. BOONE:
 13 A. No, I don't think so. I do recall--I can say
 14 this again because I suppose its come up, that
 15 Dr. Williams asked me, I think on the way out
 16 of the meeting, whether I was comfortable with
 17 that decision and I said yes.
 18 COFFEY, Q.C.:
 19 Q. The decision to wait to see the numbers,
 20 whatever Mr. Gulliver had to say?
 21 MR. BOONE:
 22 A. Yeah, I think so. I mean, that was the next
 23 step and they were going to make--essentially
 24 if I can put it this way, although it wasn't
 25 put that way at the meeting, further decision

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

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1 retests at that point in time, 16 had
 2 converted, and again I know the Commissioner
 3 and other people in this room have
 4 difficulties understanding what a conversion
 5 means, but at that time that word was used.
 6 COFFEY, Q.C.:
 7 Q. That's what I was going to ask you.
 8 MR. BOONE:
 9 A. Yeah, yeah.
 10 COFFEY, Q.C.:
 11 Q. Because you're a layperson in the medical
 12 world showing up, and the word you're hearing
 13 being used by these medical or technological
 14 people is "conversion".
 15 MR. BOONE:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. That's their word?
 19 MR. BOONE:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. What I'm getting at is you didn't show up and
 23 provide the word yourself, obviously?
 24 MR. BOONE:
 25 A. No.

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1 COFFEY, Q.C.:
 2 Q. So you hear the word conversion, and 16 out of
 3 25?
 4 MR. BOONE:
 5 A. Yes, and I was told at that time, by the way,
 6 because it went a little bit further than
 7 that, that 12 of the 16 had been notified and
 8 it was told to me in such a way, because I'll
 9 anticipate your next question, that the others
 10 just hadn't been yet, but were going to be,
 11 and notified means their doctors had spoken to
 12 them and said that they had previously been
 13 considered--I don't know if it was ER/PR or
 14 just ER negative, and now they were being
 15 considered to be ER positive and that there,
 16 therefore, might be some change in their test
 17 that could occur.
 18 COFFEY, Q.C.:
 19 Q. Mr. Boone, at that first meeting, did you get
 20 any sense or were you told about--having come
 21 away with any understanding at the time that
 22 this ER/PR testing not only involved the
 23 Health Care Corporation, but involved patients
 24 outside St. John's?
 25 MR. BOONE:

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1 A. Not in that first meeting, no. I had no
 2 understanding of that at that time.
 3 COFFEY, Q.C.:
 4 Q. So coming away--attending the first meeting
 5 and coming away from it, you thought, well,
 6 this is a St. John's problem, as it were?
 7 MR. BOONE:
 8 A. That was my impression, rightly or wrongly.
 9 Someone might have said something that I
 10 should have taken a different way, but that
 11 was what I came away with.
 12 COFFEY, Q.C.:
 13 Q. And what then happened, what next, do you
 14 recall?
 15 MR. BOONE:
 16 A. The next day was the 20th. I know that I had
 17 no interactions at all with the people from
 18 the hospital on the 20th. The 21st, I had an
 19 e-mail from Heather Predham, and the e-mail
 20 said that here is the latest statistics. So I
 21 presume--you know, as soon as I read it, I
 22 thought, well, this is what Terry was working
 23 on, here's the latest statistics and with
 24 these new statistics, we appear to be moving
 25 back into the best case scenario again. That

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1 was the words that she used, and she said the
 2 plan now is to retest all the patient is what
 3 she said, meet with the oncologists and inform
 4 the attending. Now what I understood that to
 5 mean was that they were going to meet with the
 6 oncologists--I wasn't necessarily sure as to
 7 what that was about at that time, but I did
 8 get--I read some material she sent and I got
 9 an impression as to what that meant. Inform
 10 the attending meant tell the attending or
 11 responsible or most responsible physician that
 12 there had been a change in the test. She sent
 13 to me at that time--I noted there are
 14 statistics that were prepared by Mr. Gulliver
 15 on the 21st, sort of a spreadsheet.
 16 COFFEY, Q.C.:
 17 Q. Uh-hm.
 18 MR. BOONE:
 19 A. I really don't know if I got those that day. I
 20 got those around that time, so I don't know if
 21 that was attached, but I do know what she did
 22 send me was a summary, as I understood it. I
 23 later learned, because I had no idea ever what
 24 a briefing note was, I later learned that this
 25 was some work in progress briefing note that

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1 had been prepared and updated often, but--so
 2 she sent me this briefing note as up to the
 3 21st of July, I think it was, and you have
 4 that briefing note because--I actually took
 5 pains to go look for it because I know there's
 6 been a lot of briefing notes introduced into
 7 evidence, and I wanted to make sure that the
 8 one that I got was, in fact, one that you've
 9 seen and the exhibit is P-0075.

10 COFFEY, Q.C.:
 11 Q. P-0075, yes.

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

18 COFFEY, Q.C.:
 19 Q. So she sent you that. Go ahead. That's
 20 Thursday.

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

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1 it?

2 COFFEY, Q.C.:
 3 Q. P-0075, please, yes. You'll see the exhibit
 4 come up now, Mr. Boone. As well you have
 5 control of the mouse.

6 MR. BOONE:
 7 A. Okay. The first thing I'll say is again, and I
 8 think I said it before, but what you have here
 9 in all its essential terms, all words used are
 10 the ones that I have in my file, but it looks
 11 slightly different. What was important to me
 12 is if we go down to--I think it might be page
 13 two, I'm not sure. The first thing, July
 14 18th, 2005, it says, "Laboratory managers in
 15 St. John's began reviewing the statistical
 16 data for 2000 to 2004 to see if there are any
 17 inconsistencies in the findings of positive
 18 conversions, or this could be just a matter of
 19 the sensitivity of the Ventana System being
 20 more accurate with its findings". I had been
 21 told something in my 19th meeting that they'd
 22 switched testing platforms from DAKO to
 23 Ventana. I didn't understand the significance
 24 of that. Then the next thing is July 20th,
 25 '05, which occurred before Ms. Predham e-

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

9 COFFEY, Q.C.:
 10 Q. So it was those two entries, the 18th and the
 11 20th.

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

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

20 THE COMMISSIONER:
 21 Q. Excuse me -

22 MR. BOONE:
 23 A. Sure.

24 THE COMMISSIONER:
 25 Q. You quoted there from the portion in which it

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1 said that they would be going ahead with
 2 retesting of specimens.
 3 MR. BOONE:
 4 A. Yes.
 5 THE COMMISSIONER:
 6 Q. Did you know at that time how--what specimens
 7 were being retested or how large that project
 8 was? Did you have any understanding of that?
 9 MR. BOONE:
 10 A. I have no independent recollection, and having
 11 prepared for here, I can't tell you. I just
 12 don't know. I know the words were used. I do
 13 believe I left the meeting--I think I had an
 14 idea that they weren't stopping at the 25 that
 15 they told me about, that they were continuing
 16 to do some testing. There was some indication
 17 somewhere along the way, and I don't know if
 18 it was this early or later, that the 25 chosen
 19 might not have been random for some reason.
 20 In other words, they might not have been a
 21 randomized survey, that they might not give
 22 them a good idea of what conversion rates
 23 would be.
 24 THE COMMISSIONER:
 25 Q. Okay.

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1 MR. BOONE:
 2 A. But I really don't know if I came up with that
 3 around this time or that was later.
 4 THE COMMISSIONER:
 5 Q. Thank you.
 6 MR. BOONE:
 7 A. So at that time, I certainly didn't know the
 8 extent, if you like, of the retesting program.
 9 COFFEY, Q.C.:
 10 Q. And here at the bottom of the first page of
 11 this memorandum, there's a reference to 16 out
 12 of the 25, and testing on 33 more patients.
 13 Go back up.
 14 MR. BOONE:
 15 A. Is that the last page?
 16 COFFEY, Q.C.:
 17 Q. No, actually, if you'll go back up to the
 18 first page.
 19 MR. BOONE:
 20 A. The last of the first page?
 21 COFFEY, Q.C.:
 22 Q. Right there.
 23 MR. BOONE:
 24 A. Oh, yeah, okay.
 25 COFFEY, Q.C.:

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1 Q. For some reason it's grouped under May 17th,
 2 2005, and I gather that's probably just a poor
 3 grouping of the information in question, but
 4 testing on 33 more patients found 25 converted
 5 to positive. So there was the initial 25, and
 6 by the time this was prepared, there was
 7 another 33. See that?
 8 MR. BOONE:
 9 A. Yeah.
 10 COFFEY, Q.C.:
 11 Q. And 12, as you point out, had been informed by
 12 their oncologist.
 13 MR. BOONE:
 14 A. Yeah, for what it's worth, I have no doubt
 15 that what's recorded here is more accurate,
 16 but my impression was 16 of 25.
 17 COFFEY, Q.C.:
 18 Q. Yeah, here, "Specimens collected from 25
 19 initially tested as negative were retested and
 20 16 came back -
 21 MR. BOONE:
 22 A. Right, and in my understanding at that point--
 23 again I can't quibble with what anybody else
 24 wrote because I'm only going on my
 25 recollection. My recollection was there had

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1 been 25 retested, 16 of those had come back
 2 positive, and of those 12 had been told. So
 3 the 12 was of the 16.
 4 COFFEY, Q.C.:
 5 Q. And that's certainly there, but there's
 6 another 33 apparently here, testing on 33
 7 more, found 25 converted to positive.
 8 MR. BOONE:
 9 A. Yeah, I knew that at some point in time. I
 10 don't know if I knew that that date.
 11 COFFEY, Q.C.:
 12 Q. No, this is on--I'm talking about when you got
 13 the memo itself.
 14 MR. BOONE:
 15 A. I would have read it, but beyond that--it
 16 wasn't present to my mind on the 19th that
 17 that was another group. I didn't--I remember
 18 16 of 25 was what I had been told.
 19 COFFEY, Q.C.:
 20 Q. And so in terms of best case scenario, you
 21 said there had been a reference in the e-mail.
 22 In this context, and bearing in mind what you
 23 were reading here, that meant what?
 24 MR. BOONE:
 25 A. Well, bearing in mind--if I can just put it

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

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1 done all those things, that the expectation
 2 would be that there likely would not be many
 3 more conversions, but I have to say, though,
 4 that's my assessment. No one said that to me
 5 in that way.
 6 COFFEY, Q.C.:
 7 Q. And here the second last paragraph in the
 8 memorandum refers to Dr. Williams, his title.
 9 MR. BOONE:
 10 A. Yeah.
 11 COFFEY, Q.C.:
 12 Q. "Has also asked that an investigation be
 13 conducted into the five week stoppage of
 14 immunoperoxidase staining for ER/PR receptors
 15 in 2003 by Dr. Ejeckam".
 16 MR. BOONE:
 17 A. Right.
 18 COFFEY, Q.C.:
 19 Q. Prior to getting this memorandum, a copy of it
 20 on the 21st, had you heard any reference to -
 21 MR. BOONE:
 22 A. I hadn't heard, but I read. Dr. Ejeckam's
 23 work, if you like, was not discussion on the
 24 19th of July meeting, but I had read Dr.
 25 Cook's memo of May of '05 which mentioned--I

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1 can almost quote from it. I think he said
 2 something to the effect that in the spring of
 3 2003 our point man on immunoperoxidase
 4 staining, Dr. Gershon Ejeckam, had stopped the
 5 staining for a period of time. So I was aware
 6 that that was out there and an issue, and that
 7 was in Dr. Cook's memo.
 8 COFFEY, Q.C.:
 9 Q. And you--and it didn't--you have no
 10 recollection of it coming up on the 19th
 11 itself during the meeting? I'm not suggesting
 12 it did. I take it you have no recollection of
 13 it?
 14 MR. BOONE:
 15 A. I don't remember. I think I might if it did,
 16 but I don't remember.
 17 COFFEY, Q.C.:
 18 Q. If it did.
 19 MR. BOONE:
 20 A. It came up later in later meetings.
 21 COFFEY, Q.C.:
 22 Q. Yes. Here there's a reference in the last
 23 paragraph to, "Dr. Williams has also asked if
 24 we could repeat any of the negative tested
 25 specimens again on the old DAKO System to

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1 confirm it was indeed the system and not a lab
 2 error", and Mr. Gulliver said it is unlikely
 3 we will be able to obtain such a system at
 4 this time to retest on that method. Had that
 5 come up on the 19th, do you know?
 6 MR. BOONE:
 7 A. No. Well, not within my recollection.
 8 COFFEY, Q.C.:
 9 Q. And again I don't want -
 10 MR. BOONE:
 11 A. I don't even remember it making an impression
 12 on me when I read this summary back at that
 13 time, and it didn't resonate with me.
 14 COFFEY, Q.C.:
 15 Q. What then happened? Up to the 21st, you had
 16 Ms. Predham's e-mail and you read the material
 17 she sent.
 18 MR. BOONE:
 19 A. If I recall correctly, when you say what next
 20 happened, the next thing that happened didn't
 21 involve me, but it was an event, I suppose of
 22 significance. I understood by some point--if
 23 I remember correctly, and I'm trying to
 24 remember the times, the 22nd was a Friday,
 25 that week.

1 COFFEY, Q.C.:

2 Q. Yes, it would be.

3 MR. BOONE:

4 A. I had an understanding by the 22nd that there

5 had been some meeting between or among

6 officials from Eastern Health and officials

7 from the Department of Health.

8 COFFEY, Q.C.:

9 Q. Uh-hm.

10 MR. BOONE:

11 A. And that at that meeting there was further

12 discussion as to the question--discussion,

13 because I don't know if they ever discussed it

14 before, discussion about the question as to

15 whether or not there should be a direct and

16 broadbased communication to patients, and I'll

17 use that as a shorthand for either a public

18 notice or a general mail out, some kind of

19 broad communication, that that had been the

20 subject of discussion, but my understanding

21 was that it was left inconclusive, and I got

22 that understanding on the 22nd, I believe from

23 Ms. Bonnell, but I'm not sure. On the 22nd,

24 later in that day, I got a call from Denise

25 Dunn, who is Dr. Williams' assistant, asking

1 meeting took place there.

2 COFFEY, Q.C.:

3 Q. And what do you recall about who was there?

4 We do have--if it would assist, we do have at

5 least some notes that were taken.

6 MR. BOONE:

7 A. Okay, that's fine.

8 COFFEY, Q.C.:

9 Q. If we could bring up, please--and this may be

10 of some assistance because this is a larger

11 group.

12 MR. BOONE:

13 A. Actually, I can tell you that because I can

14 picture that meeting.

15 COFFEY, Q.C.:

16 Q. Okay, well -

17 MR. BOONE:

18 A. I remember a lot about that meeting.

19 COFFEY, Q.C.:

20 Q. Okay, without bringing it up, we'll see what -

21 MR. BOONE:

22 A. It's not a test, I know, but, I mean, just so

23 I can tell you that this is my recollection.

24 I remember that, well, obviously I was there,

25 Heather Predham was present, Susan Bonnell was

1 me to go to a meeting on the 24th on a Sunday

2 morning, which stuck out with me because I

3 don't go to many meetings on Sunday mornings.

4 COFFEY, Q.C.:

5 Q. And then what happened?

6 MR. BOONE:

7 A. I went to the meeting.

8 COFFEY, Q.C.:

9 Q. That's on the 24th, Sunday.

10 MR. BOONE:

11 A. Yeah.

12 COFFEY, Q.C.:

13 Q. Do you recall where that was and who was

14 there?

15 MR. BOONE:

16 A. Yeah, the meeting was in--there's a large

17 boardroom--at the Health Sciences Centre, the

18 administration is based mainly in the

19 basement.

20 COFFEY, Q.C.:

21 Q. Go ahead--I'm sorry, Mr. Boone, go ahead.

22 MR. BOONE:

23 A. The basement is where most of the

24 administrative offices are, and there's a

25 large boardroom in the basement and the

1 present and she had someone who I didn't know

2 very well, if at all, from her Communications

3 Department, whose name, I think, was Deborah

4 Thomas, or maybe she had a married name as

5 well. Dr. Williams was there. I recall

6 George Tilley being there, the CEO, for some

7 part of that meeting, but my recollection is

8 not that he was there for the whole time, for

9 what that's worth. I remember that Dr. Laing

10 was there, and that was the first time I had

11 met her, and I came to know that she was a

12 medical oncologist. Dr. Kwan was there, and I

13 didn't--I remember at one point in time I

14 referenced him in a note or something as "Dr.

15 Kwa". I actually had known who Dr. Kwan was

16 by reputation, but I didn't realize this was

17 the same man, that he was a surgeon. So he

18 was there. I think that that's--no, Terry

19 Gulliver was there, and Dr. Cook was there.

20 So those were the people who were there.

21 COFFEY, Q.C.:

22 Q. Paul Gardiner?

23 MR. BOONE:

24 A. I don't remember Dr. Gardiner.

25 COFFEY, Q.C.:

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

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

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

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

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

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1 might be going into far more detail than you
 2 really -
 3 COFFEY, Q.C.:
 4 Q. No, no, what you can recall.
 5 MR. BOONE:
 6 A. This is it, unfortunately it's a lot, but -
 7 THE COMMISSIONER:
 8 Q. Not from my standpoint.
 9 COFFEY, Q.C.:
 10 Q. Not from the Commissioner's perspective.
 11 MR. BOONE:
 12 A. Really? Okay, all right. In any event, so I
 13 recall that discussion. I did recall that Dr.
 14 Kwan went--I think he went from that
 15 description to a reference to Dr. Ejeckam and
 16 what he said was, well, you know, we don't
 17 really know--sorry, what he said was "We need
 18 to know whether the new results we're getting
 19 are a consequence of an error in our old
 20 system or the consequences of the new system."
 21 And that's how he spoke to it and then Dr.
 22 Laing said something again about the
 23 overcalling the positivity because this was
 24 circling around the room. And a lot of these
 25 conversations weren't of the sort that were

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

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

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1 was paying for a system that was supposed to
 2 be better, it got it. Then there was a--Dr.
 3 Williams at some point in time mentioned, and
 4 I think again he was addressing Dr. Laing's
 5 concerns about the Ventana overcalling. He
 6 said that they should duplicate conversions in
 7 an outside lab before they went back to the
 8 patients who had converted on Ventana. I
 9 don't think I really realized myself the
 10 significance of that at that time, but I think
 11 looking back on it, it meant that they weren't
 12 necessarily going to tell the people who had
 13 converted on Ventana if there were any left
 14 who hadn't been told
 15 COFFEY, Q.C.:
 16 Q. Hadn't been told yet?
 17 MR. BOONE:
 18 A. Who had not been told.
 19 THE COMMISSIONER:
 20 Q. I'm sorry, I missed who suggested that.
 21 MR. BOONE:
 22 A. Dr. Williams, he said it because I remember he
 23 said duplicate positive conversions, is what
 24 he said, which, you know, in the context of
 25 the meeting would have made sense because

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1 people were saying Ventana might be
 2 overcalling and then Dr. Laing had expressed
 3 this fairly significant concern about her
 4 patients and whenever I encountered Dr. Laing,
 5 she always spoke about her patients, you know,
 6 it always came from the perspective that she
 7 was speaking for concern for her patients and
 8 she spoke fairly strongly about the fact that
 9 she didn't want to put her patients in a
 10 situation where their treatment was going to
 11 be switched inappropriately or for an
 12 inappropriate reason. So I think what Dr.
 13 Williams was trying to do was to account for
 14 that concern on her part. But they were going
 15 to continue to retest was another part of the
 16 plan--sorry, not retest, they were going to
 17 continue to investigate, that was part of
 18 their plan. I don't know what retesting was
 19 going to take place, I don't have a
 20 recollection of any discussion of that on the
 21 24th and that they were going to get someone
 22 in from Ventana, and that was the essential
 23 plan. Oh, and one other thing was that they
 24 were going to talk about, they were going to
 25 talk to other hospitals across the country to

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1 see what their experience was. So those were
 2 all the things that occurred in that meeting
 3 of the 24th--in my recollection.
 4 COFFEY, Q.C.:
 5 Q. Did Dr. Laing, do you recall explain the basis
 6 for her concern about Ventana overcalling?
 7 MR. BOONE:
 8 A. No, well she very well may have, I never--in
 9 never stuck with me if she did.
 10 COFFEY, Q.C.:
 11 Q. Because Mr. Gulliver was there as well on
 12 behalf of the lab and I take it you had gotten
 13 the impression from him, well the machinery is
 14 working properly, the technologists -
 15 MR. BOONE:
 16 A. Oh no, I think you're taking too much out of
 17 that because in fact, Mr. Gulliver was talking
 18 about DAKO, he wasn't talking about Ventana.
 19 Those comments that he made to me on the 19th
 20 had nothing to do with Ventana.
 21 COFFEY, Q.C.:
 22 Q. Okay, well at the 21st--the 24th, I'm sorry,
 23 this is a Sunday morning, when Dr. Laing is
 24 expressing this concern about the Ventana
 25 possibly overcalling, overcalling in the sense

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1 of showing too many positives or producing too
 2 many positives, was there any response from
 3 the technologists' side of the meeting, which
 4 would be Mr. Gulliver, about that, to address
 5 that?
 6 MR. BOONE:
 7 A. There may have been -
 8 COFFEY, Q.C.:
 9 Q. You don't recall and -
 10 MR. BOONE:
 11 A. Of course, and again, I don't want to give any
 12 kind of impression that the meeting was
 13 chaotic, but as big meetings around great big
 14 boardroom tables often transpire such that you
 15 have a lot of side conversations,
 16 conversations amongst small groups and those
 17 things happen.
 18 COFFEY, Q.C.:
 19 Q. Sure.
 20 MR. BOONE:
 21 A. You know, and so I really can't say whether or
 22 not there was any address by Mr. Gulliver of
 23 that or Dr. Cook.
 24 COFFEY, Q.C.:
 25 Q. You don't recall any and you're saying that's

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1 not to mean it didn't happen, Mr. Coffey -
 2 MR. BOONE:
 3 A. Absolutely not because that meeting, if I
 4 remember correctly, it was certainly more than
 5 a hour long, I don't know if it was two hours
 6 and quite obviously what I've just recounted
 7 for you can only be a part of what happened at
 8 the meeting, it's only what I remember.
 9 COFFEY, Q.C.:
 10 Q. What then happened, Mr. Boone? This is Sunday
 11 morning meeting ends, what's next?
 12 MR. BOONE:
 13 A. The next interaction, if you like that I had
 14 with Eastern Health on this issue was when I
 15 attended a meeting on the 27th and a similar
 16 meeting, if you like.
 17 COFFEY, Q.C.:
 18 Q. How is it you came to go to the meeting on the
 19 27th?
 20 MR. BOONE:
 21 A. I don't remember. I really don't remember, I
 22 can't remember who called me about that
 23 meeting, I know I went to it.
 24 COFFEY, Q.C.:
 25 Q. Do you recall where the meeting was?

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

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

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

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

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1 Montreal Jewish, Sloan-Kettering, various
 2 hospitals were spoken of through the course of
 3 the meeting.
 4 COFFEY, Q.C.:
 5 Q. Who was providing that information?
 6 MR. BOONE:
 7 A. I remember Dr. Cook had called hospitals
 8 himself. I had some impression that Terry
 9 Gulliver had as well and certainly I remember
 10 him talking about it, about what other labs
 11 were doing. I don't know if that was because
 12 of recent calls or just some knowledge that he
 13 had. And something tells me and somebody else
 14 spoke to it, but I don't recall them having
 15 done an investigation and someone else, might
 16 have been Dr. Laing or someone knew what other
 17 labs were doing, but again, it's too hazy, so
 18 that kind of discussion was going on but the
 19 impression that came out of it, at least for
 20 me sitting as an observer and trying to take
 21 something out of this, a science that I truly
 22 didn't understand, the impression that came
 23 out of it for me was that St. John's was
 24 really doing nothing different than anybody
 25 else, that everybody is doing the same thing.

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

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1 COFFEY, Q.C.:
 2 Q. And anything else about the meeting?
 3 MR. BOONE:
 4 A. The first two components of it, you know, as
 5 I've conceptualized, I've described to you.
 6 The third was well what are we going to do,
 7 and my understanding as to what we are going
 8 to do was Dr. Williams was summing this up at
 9 this point in time and again, this notion that
 10 we are getting closer and closer to concluding
 11 that what we are seeing, meaning the
 12 conversions in the earlier conversions, was
 13 the consequences of new technology, as opposed
 14 to something wrong in the manner in which we
 15 were proceeding before. And that there would
 16 be--there would not be any, again, some kind
 17 of a broad disclosure at that point in time
 18 and that--but they would meet, "they" being
 19 the group of people who were at that table, I
 20 suppose, would continue to meet. And when I
 21 say "they", I think mostly the scientific
 22 people, if you like, the people who truly
 23 should have had something to contribute to it,
 24 you know, the doctors and the techs and those
 25 people, they were going to continue to meet

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1 and continue to investigate and this was going
 2 to be going on for some time, that's my
 3 understanding.
 4 COFFEY, Q.C.:
 5 Q. Did you have any sense of the -
 6 MR. BOONE:
 7 A. No, actually there's one other thing I should
 8 say.
 9 COFFEY, Q.C.:
 10 Q. Yes, fine.
 11 MR. BOONE:
 12 A. The only other thing that came out of it in my
 13 recollection was that retesting was ongoing on
 14 Ventana at that time and -
 15 COFFEY, Q.C.:
 16 Q. Using the Ventana.
 17 MR. BOONE:
 18 A. Using the Ventana and, because it was being
 19 done in St. John's and of course, they only
 20 had Ventana at that time, DAKO was gone. And
 21 Terry Gulliver said that in two to three
 22 weeks, they would have all the retests done,
 23 you know, which again was some indication as
 24 to when they could act or when they'd act or
 25 something like that. That was as much as I

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1 remember.
 2 COFFEY, Q.C.:
 3 Q. This is -
 4 THE COMMISSIONER:
 5 Q. Excuse me, at this phase was your
 6 understanding of what all the retests meant
 7 any greater than it had been before, or did
 8 you even think about what they were talking
 9 about when they said they would have them all
 10 done?
 11 MR. BOONE:
 12 A. I had no real good perception as to whether or
 13 not they were retesting, you know, I can use
 14 these terms now because I know, '97 to 2004,
 15 '97 to 2003, all negatives, all positives, I
 16 just didn't know. Retesting was going to
 17 continue, that was what I remember.
 18 THE COMMISSIONER:
 19 Q. All right, thank you.
 20 COFFEY, Q.C.:
 21 Q. This is Wednesday, July 28th and according to
 22 the note here, it's a conference call
 23 beginning around 5 p.m. in the day which is
 24 towards the end of the day.
 25 MR. BOONE:

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1 A. Well it wasn't a conference call.
 2 COFFEY, Q.C.:
 3 Q. No, I appreciate it wasn't a conference call,
 4 it's styled here on the particular note, I
 5 should take it the conference call aspect
 6 probably refers to Drs. Laing and McCarthy.
 7 MR. BOONE:
 8 A. Oh sure, it says there by phone.
 9 COFFEY, Q.C.:
 10 Q. But Mr. Boone, by the end of that meeting, on
 11 Wednesday the 27th, had you heard anything
 12 about Bev Carter?
 13 MR. BOONE:
 14 A. Yes, because in that meeting I remember--she
 15 wasn't there, but I remember Dr. Williams
 16 recounted a conversation that he had with Dr.
 17 Carter where she mentioned--I'm trying to
 18 remember, she mentioned a statistical range of
 19 68 to 80 percent. I think that was in
 20 reference as to what they should be achieving,
 21 as opposed to what anybody was achieving.
 22 That's the only thing I heard about Dr.
 23 Carter.
 24 COFFEY, Q.C.:
 25 Q. That was it, so the idea that she might have

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1 been about to embark or having embarked upon a
 2 large scale examination of what had gone on
 3 before or looking at the old slides and
 4 results and so on, and the Commissioner has
 5 heard evidence of this, Mr. Boone, so I just
 6 want to ask -
 7 MR. BOONE:
 8 A. I have a vague recollection of someone saying
 9 that Dr. Carter had sent slides somewhere, but
 10 if you're saying large scale, it doesn't
 11 accord with my recollection because I remember
 12 some talk of five slides out somewhere.
 13 COFFEY, Q.C.:
 14 Q. Yes, and we've heard about evidence that she
 15 sent some slides to Mount Sinai.
 16 MR. BOONE:
 17 A. Yeah, I don't remember anything else, that's
 18 it.
 19 COFFEY, Q.C.:
 20 Q. But in terms of, kind of there's a large scale
 21 review set out in a letter in mid July, just
 22 to let you know this, okay, it's referred to,
 23 it's in an exhibit here, the Commissioner has
 24 heard of it, and she spells out what she--her
 25 plan of action, as it were and I'm just asking

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1 you, you have no recollection of that ever
 2 having been brought to your attention during
 3 this timeframe?
 4 MR. BOONE:
 5 A. I can't say it wasn't and again, these are
 6 long meetings and what I've described to you
 7 is really probably snippets that I happen to
 8 recall as being significant.
 9 COFFEY, Q.C.:
 10 Q. Do you think you would recall if you had been
 11 told, like in these early meetings, look,
 12 there's a large scale review going on by a
 13 local breast pathologist, do you think -
 14 MR. BOONE:
 15 A. I can't say whether I would or wouldn't have,
 16 I really don't, you know.
 17 COFFEY, Q.C.:
 18 Q. Because again, there's no suggestion -
 19 MR. BOONE:
 20 A. You have to remember that this is the 27th and
 21 the first I heard of it was the 18th of July,
 22 I never knew anything about the science, so in
 23 nine days, I don't think I would have enough
 24 appreciation to really know what was
 25 important. When I considered something to be

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1 important, it was because somebody else
 2 attached an importance to it, you know, if you
 3 like, because I would have had no other basis
 4 upon which to do so.
 5 COFFEY, Q.C.:
 6 Q. And did the topic come up, up to this point,
 7 at the end of this meeting or prior to this,
 8 did the topic come up, well why are we using
 9 the Ventana to use the retesting if there's a
 10 concern about the Ventana?
 11 MR. BOONE:
 12 A. I don't recall it coming up.
 13 COFFEY, Q.C.:
 14 Q. What then happened, Mr. Boone?
 15 MR. BOONE:
 16 A. That was the 27th of July. I had one--if
 17 you're asking what then happened -
 18 COFFEY, Q.C.:
 19 Q. Yes.
 20 MR. BOONE:
 21 A. I presume you're asking what then happened
 22 that involved me.
 23 COFFEY, Q.C.:
 24 Q. That involved yourself, yes--or that you were
 25 informed of that had some relevance to you.

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

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

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1 report and I'll describe that for you in a
 2 second, and the other was that the oncologists
 3 felt that their patients would be too stressed
 4 by such a disclosure. And when she told me
 5 that there was nothing to report, I think what
 6 that meant and maybe I'm thinking too much,
 7 but I think what that meant was there was
 8 nothing to report to individual patients until
 9 the results came back. So I think that was
 10 less to do with a broad-based disclosure than
 11 an individual discussion with patients, but
 12 that with respect to the overall public
 13 disclosure, that the corporation--and I wrote
 14 it that way in a place where I wrote it, that
 15 they would--they had resisted the Minister's
 16 overtures in respect of disclosure because
 17 mainly this ground that their patients would
 18 be too stressed by it. The oncologists felt
 19 their patients would be too stressed by it.
 20 That was a phone call, that was it, I can't
 21 imagine how long it was, I don't remember if
 22 it took place in my office, somewhere else, I
 23 have no idea.
 24 COFFEY, Q.C.:
 25 Q. And so then from the 27th of July to the 19th

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1 of August, in terms of your own interaction
 2 with, in relation to this ER/PR matter, there
 3 was nothing else that you recall, in terms of
 4 this whole disclosure issue that you can
 5 recall?
 6 MR. BOONE:
 7 A. I think you've asked a lot of questions in
 8 one. Maybe you should -
 9 COFFEY, Q.C.:
 10 Q. I appreciate that, but the disclosure issue in
 11 terms of the disclosure to the patients or
 12 disclosure to the public, because -
 13 MR. BOONE:
 14 A. I'll tell you, I'll put it to you this way
 15 because maybe it's the easiest way to answer
 16 your question, from the 27th of July until the
 17 19th of August, I had no interaction with
 18 Eastern Health on any aspect of the ER/PR
 19 issue.
 20 COFFEY, Q.C.:
 21 Q. Okay, well on that and at the end of the
 22 meeting on the 27th of July of 2005, your
 23 understanding was what in relation to
 24 informing the patients about this or informing
 25 the public about this, going away from that

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1 meeting?
 2 MR. BOONE:
 3 A. Going away on the 27th, my impression would
 4 have been that they were still thinking about
 5 it because this was part of the work that was
 6 going to done, I mean, the impression I had
 7 through these meetings, if you like, was that
 8 this was going to be--they were going to stick
 9 with this until it got done, whatever got done
 10 meant and that these people were going to
 11 work, these people at Eastern Health were
 12 going to work through this, that amongst the
 13 things that they were working through were
 14 essentially the investigative aspects of the
 15 case and the question of disclosure and
 16 communication. So I would have taken it that
 17 they would have continued to discuss that
 18 after the 27th. But on the 27th, the main
 19 thing I took away from that was that they
 20 weren't going to be disclosing at that time,
 21 mainly because they felt that they were seeing
 22 really the results of new technology.
 23 COFFEY, Q.C.:
 24 Q. And if we look, please, at Exhibit P-0936?
 25 This is an e-mail of July 28th which is the

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1 next day, 9:50 a.m.
 2 MR. BOONE:
 3 A. Oh yes, okay, I remember this.
 4 COFFEY, Q.C.:
 5 Q. And this is Ms. Predham's e-mail to, original
 6 e-mail to Mr. Gulliver and Dr. Cook and Dr.
 7 Williams and this is talking about "trying to
 8 get the results for the time we ran both the
 9 DAKO and Ventana".
 10 MR. BOONE:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. So she sends it on to yourself and others
 14 saying, "This is for your information".
 15 MR. BOONE:
 16 A. I do remember this. I just breached a rule, I
 17 always tell witnesses not to be so definitive
 18 because actually I did have some interaction
 19 on the 28th of July, by the look of it. But I
 20 do recall this e-mail and getting a copy of
 21 it, yes.
 22 COFFEY, Q.C.:
 23 Q. And you understood you were being sent this
 24 why? What was your--just to be kept apprised?
 25 MR. BOONE:

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

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

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

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

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1 Q. So, Mr. Boone then, you know, what's your next
 2 recollection then of your involvement?
 3 MR. BOONE:
 4 A. My next recollection is the 26th of September
 5 of '05.
 6 COFFEY, Q.C.:
 7 Q. Okay, and I'll take that up with you in a
 8 second.
 9 MR. BOONE:
 10 A. And before we go there, could I ask you when
 11 you take your morning break? Because I don't
 12 know.
 13 COFFEY, Q.C.:
 14 Q. Usually around 11:10-11:15, but we can break
 15 earlier if you -
 16 THE COMMISSIONER:
 17 Q. If you'd like to have a break now?
 18 MR. BOONE:
 19 A. I'd like to, if we could. It doesn't have to
 20 be now, but I mean, you can go -
 21 COFFEY, Q.C.:
 22 Q. Okay, there's just one -
 23 THE COMMISSIONER:
 24 Q. We'll break at 11.
 25 COFFEY, Q.C.:

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

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

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

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1 the next day. So then I would have known that
 2 the outside lab they were sending to was Mount
 3 Sinai. 300 samples were due back the next
 4 day, that was the first batch. She told me
 5 that they had a quality review done or were
 6 doing it. I can't remember which it was, but
 7 that was part of what they were doing, but
 8 Heather and I know that--Heather knows that I
 9 have a practice that I don't look at quality
 10 reviews. I don't want to know what they are.
 11 I don't want to know what they say, so she
 12 wouldn't have told me anything about what was
 13 going on in respect of that, although at one
 14 point in time, I did ask her for the terms of
 15 reference, just to get an idea for retaining
 16 our own experts.
 17 But she told me that--I think that was
 18 most of the information that she conveyed to
 19 me at that time, and the most important thing
 20 was the 300 samples were due back, retested
 21 samples due back from Mount Sinai the next
 22 day. So I did nothing further and just took
 23 that information.
 24 COFFEY, Q.C.:
 25 Q. And then?

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1 MR. BOONE:
 2 A. And then. The next thing that happened was on
 3 the 27th of September, I don't know how it
 4 came to be, but I went to a meeting at Dr.
 5 Williams' office at 4:00 on the 27th of
 6 September. I don't know how that meeting came
 7 to be set up. I don't know who called me for
 8 it, but I went to the meeting, and at that
 9 meeting, they gave me information on the
 10 retests, if you like. Most of it was by Dr.
 11 Williams. Heather Predham was there, but my
 12 recollection is Heather wasn't there the whole
 13 time and I don't know if that meant she came
 14 late or left early. I don't remember. It
 15 wasn't a very long meeting in any event, and
 16 it was one of many meetings that Dr. Williams
 17 was having that day, as I understood it.
 18 The information imparted to me at that
 19 time was that rather than 300 samples having
 20 come back from Mount Sinai, 73 had been
 21 returned or I don't know if I'm using the
 22 right terminology. They had gotten back 73
 23 retests from Mount Sinai. Of the 73 retests
 24 that they had had returned to them, I remember
 25 these numbers, 41 people had been confirmed as

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1 being negative. 20 of the people had
 2 conversions which were considered to be
 3 significant at that point in time, and I might
 4 be able to describe that by describing the
 5 next number. The next number was 12. Dr.
 6 Williams told me there was 12 people whose
 7 test results had changed or there had been
 8 conversions, I guess, but of those 12, he had
 9 some information from Kara Laing, Dr. Laing,
 10 that they would have been already on
 11 Tamoxifen, so those 12 people. So effectively
 12 there were 20 people of the 73 test results
 13 that had come back who appear, on the basis of
 14 Mount Sinai testing, to have been qualified
 15 for Tamoxifen, but were not on it.
 16 COFFEY, Q.C.:
 17 Q. And so was there anything else at the meeting?
 18 MR. BOONE:
 19 A. Yeah. Dr. Williams discussed--because
 20 throughout at least the meetings that I went
 21 to, and I understood that--because I
 22 understood that once I left that meeting on
 23 the 27th of July (sic.), that activity didn't
 24 cease in respect of ER/PR. When I left that
 25 meeting on the 27th of July (sic.), there was

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1 a lot of really concerned people. There were
 2 health care professionals who were trying to
 3 work through this really significant issue
 4 that appeared to be then one that could affect
 5 their patients in a great way, or it might be
 6 nothing, and they were trying to work their
 7 way through this when I left them.
 8 One of the issues, of course, that they
 9 had in front of them was the question as to
 10 whether to tell patients, whether to tell the
 11 public, whether to tell--to give a broad-based
 12 disclosure, all these things. So that came up
 13 in the discussion with Dr. Williams and what
 14 he told me was that on the 27th, he told that
 15 his plan or at least a plan, I don't know if
 16 it had been approved by anybody, I don't know
 17 who would have to approve it, was to have a
 18 public announcement of the fact of the
 19 retesting and whatever they would put in there
 20 about what the results were at that time, and
 21 that further, that the plan for telling the
 22 people who had retested would be by amended
 23 pathology reports or addenda to pathology
 24 reports that would be then sent to the
 25 treating or attending physician for the

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1 patients who had converted. So that was
 2 essentially the two parts of the plan, if you
 3 like, as at that time, that was the 27th of
 4 September.
 5 COFFEY, Q.C.:
 6 Q. So you understood a public announcement about
 7 the fact that retesting was going on?
 8 MR. BOONE:
 9 A. Mr. Coffey, I got to say, a public
 10 announcement. I don't know what it was going
 11 to entail.
 12 COFFEY, Q.C.:
 13 Q. Okay.
 14 MR. BOONE:
 15 A. But certainly, you know, one would expect it
 16 would say that there had been retesting, that
 17 there might be a problem, and you know, all
 18 the things that you would expect someone to
 19 put in that kind of a public announcement
 20 would have been what would have been in mind,
 21 but that was Dr. Williams' plan himself. If
 22 he was entitled to make a plan, I don't know,
 23 but that was what he wanted to do, those two
 24 things.
 25 COFFEY, Q.C.:

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1 Q. And addendum reports would be prepared for
 2 which patients?
 3 MR. BOONE:
 4 A. The patients, well, I guess of the group that
 5 he had discussed with me, it would have been--
 6 and I don't know if it would have been the 20
 7 or the 32, you know, whether it would be all
 8 patients who had converted or patients who had
 9 converted where there was no obvious--where
 10 there was an obvious need for reconsideration
 11 of treatment. I don't know which one of those
 12 were going to get these addenda reports or
 13 amended reports.
 14 COFFEY, Q.C.:
 15 Q. And did you provide any input at that time?
 16 MR. BOONE:
 17 A. Yeah, I told him that that seemed to be a good
 18 thing to do, and that's about as far as it
 19 went, but I mean, there was nothing on which
 20 to comment at that time because there was
 21 nothing presented, in terms of a formal plan,
 22 but certainly I supported him in that. Dr.
 23 Williams, I recall what Dr. Williams was
 24 saying at that time was that a lot of the, if
 25 you like, dead ends and wrong roads down which

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1 they might have gotten over the summer had not
 2 proved in any way fruitful and what they were
 3 faced with was something that, I think he
 4 characterized it as a serious problem, and
 5 that people must be told, and that made
 6 perfect sense to me.
 7 COFFEY, Q.C.:
 8 Q. And by serious problem, in the context, you
 9 understood that meant what?
 10 MR. BOONE:
 11 A. An issue that needed to be explained, if you
 12 like. You know, in fact, there were going to
 13 be conversions is what he was saying to me.
 14 This is--he wasn't expecting that this 20 of
 15 73 was going to be other than representative
 16 of what was to come, and that therefore,
 17 represented a serious problem. It didn't mean
 18 that it was all their fault or it was all
 19 their mistakes. That's not what he was
 20 talking about. What he was saying to me was
 21 that we now have a situation where we have 20
 22 of 73 or 32 of 73, if you want to look at it
 23 that way, and I think what Bob, or Dr.
 24 Williams, was suggesting was that his
 25 anticipation was that that kind of ratio

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1 might, in fact, hold, and that would then have
 2 changed the view, for instance, that it was
 3 only Ventana or the update or upgrade to
 4 Ventana that explains it or those kinds of
 5 things, because I had understood, at least by
 6 that point, that Mount Sinai was testing on
 7 the DAKO platform. So all of those things
 8 were indicative of the fact that it was
 9 something that needed to get out, and he was
 10 of the view that it should.
 11 COFFEY, Q.C.:
 12 Q. I take it then, and you just referred to your
 13 understanding that, even at some point, that
 14 Mount Sinai was using the DAKO platform.
 15 MR. BOONE:
 16 A. Yeah.
 17 COFFEY, Q.C.:
 18 Q. Do you recall when you first learned that?
 19 MR. BOONE:
 20 A. No. No, I mean, it couldn't have been early
 21 because early there was no Mount Sinai
 22 testing, and I don't know when it--it might
 23 have been mentioned as an ancillary point
 24 somewhere along the way, because people talk
 25 what other hospitals did, but I don't recall

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1 anybody specifically telling me that, until
 2 the results came back.
 3 COFFEY, Q.C.:
 4 Q. And I take it then, bearing in mind Mount
 5 Sinai was doing the retesting and reporting
 6 the results and Dr. Williams was telling you
 7 that Eastern Health was acting upon those
 8 results, in terms of dealing with the
 9 patients?
 10 MR. BOONE:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. That this serious problem, you recall him
 14 describing it as, would not be attributable to
 15 the change in platforms per se?
 16 MR. BOONE:
 17 A. I don't recall if he said that or I just
 18 presumed that that was--you know, that would
 19 have followed naturally for me from the
 20 discussions I'd overheard in the summer, so I
 21 can't really say that Dr. Williams said that.
 22 COFFEY, Q.C.:
 23 Q. What then happened? Anything else--first of
 24 all, anything else -
 25 MR. BOONE:

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1 A. I wasn't there very long, because you know,
 2 Dr. Williams, as you can imagine, had more
 3 people to deal with than me, at that point in
 4 time.
 5 COFFEY, Q.C.:
 6 Q. Anything else in that meeting of September
 7 27th?
 8 MR. BOONE:
 9 A. Do I?
 10 COFFEY, Q.C.:
 11 Q. Anything else in the meeting of September 27th
 12 that you can recall?
 13 MR. BOONE:
 14 A. Nothing that was significant.
 15 COFFEY, Q.C.:
 16 Q. Okay.
 17 MR. BOONE:
 18 A. I mean, that was the most significant things
 19 was the results came back with an unexpectedly
 20 high rate, if you like, of conversion. That
 21 meant that the other things that they
 22 considered as being potentially causing the
 23 earlier conversions were not accurate, and
 24 that somebody--people have got to be told
 25 about this, and that was Dr. Williams' view at

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1 that time, and my understanding was when he
 2 said public announcement, it would either be a
 3 media release or a briefing or something like
 4 that, but I don't know a lot about that stuff.
 5 But that's what he was anticipating would
 6 occur from the 27th.
 7 COFFEY, Q.C.:
 8 Q. Now had you, up to that point, ever been
 9 shown--in your dealings with Eastern Health,
 10 had you become aware that they had, back in
 11 the summer apparently, prepared draft press
 12 releases?
 13 MR. BOONE:
 14 A. As I think I mentioned to you when I talked
 15 about the meeting of the 19th, I knew they
 16 were working on things of that nature, you
 17 know, and it doesn't take much of a leap to
 18 think that if they're thinking about how to
 19 communicate, they'd be looking at press
 20 releases, letters, you know, all kinds of
 21 things. There was some work being done in
 22 that area, and I was aware of that. Whether
 23 that work included draft press releases, I
 24 wasn't aware of that, but I think, you know,
 25 it would have been a fair assumption to have

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1 made.
 2 COFFEY, Q.C.:
 3 Q. That was back in the summer?
 4 MR. BOONE:
 5 A. In July, yeah.
 6 COFFEY, Q.C.:
 7 Q. In July, and how about letters to the
 8 patients, individual patients?
 9 MR. BOONE:
 10 A. I don't recall that being discussed. I can't
 11 say it wasn't, but I don't recall. And when
 12 you say the patients, what patients?
 13 COFFEY, Q.C.:
 14 Q. Well, the patients who were to be retested.
 15 MR. BOONE:
 16 A. No, I don't recall that. I can't say it
 17 wasn't happening though because no one shared
 18 it with me, you know, and there was work being
 19 done in that area.
 20 COFFEY, Q.C.:
 21 Q. And on the 27th of September, did Dr.
 22 Williams, do you recall, indicate to you that
 23 he had some knowledge about, or had reason by
 24 then to believe that he knew something about
 25 the reasons for the problem?

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1 MR. BOONE:
 2 A. No, we never had any -
 3 COFFEY, Q.C.:
 4 Q. Okay, and just in the context here, we do know
 5 that Dr. Banerjee had come and gone by that
 6 point. Ms. Wegrynowski had come and gone by
 7 that point.
 8 MR. BOONE:
 9 A. We had no discussion of that sort.
 10 COFFEY, Q.C.:
 11 Q. But he didn't intimate to you, "look, Dan, I
 12 know -
 13 MR. BOONE:
 14 A. No, what I took to mean when he said serious
 15 problem, was not a serious problem because
 16 we've made all these mistakes in the past. It
 17 was a serious problem because we have had now
 18 a ratio of conversions which would, to
 19 anybody, be unacceptable, and he expected that
 20 to hold through in what was going to come.
 21 That's what the serious problem was.
 22 COFFEY, Q.C.:
 23 Q. What happened then? What's next?
 24 MR. BOONE:
 25 A. The next thing that happens for me, I don't

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

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

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

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1 if you permit me to. I presume that what they
 2 were doing was contemplating or speculating
 3 that physicians were going to get questions
 4 from patients, and as a consequence someone
 5 must have decided to send a letter to
 6 physicians, and I was asked to review that. I
 7 don't recall if that date was the 5th or the
 8 6th.
 9 COFFEY, Q.C.:
 10 Q. And did you do so?
 11 MR. BOONE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. And did you respond to it?
 15 MR. BOONE:
 16 A. I did. I'm pretty certain you have my e-mail
 17 in evidence.
 18 COFFEY, Q.C.:
 19 Q. Yes.
 20 MR. BOONE:
 21 A. So do you want to pull it up?
 22 COFFEY, Q.C.:
 23 Q. Yes, and I'll -
 24 MR. BOONE:
 25 A. I'll tell you what I was saying.

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1 COFFEY, Q.C.:
 2 Q. If we could, please, Exhibit P-2589? And
 3 first of all, this is--it's a series of e-
 4 mails, but the first of them, in the line
 5 here, is one of October 5th, if we could, 2005
 6 from Dianne Smith to a number of individuals
 7 within Eastern Health. The subject is ER/PR
 8 notification, and "forward on Pat's behalf,
 9 please review attached once more, and provide
 10 your comments and/or changes."
 11 MR. BOONE:
 12 A. Right.
 13 COFFEY, Q.C.:
 14 Q. And then the same day, "once more, please
 15 review this copy. Disregard the previous
 16 message," and then there's an e-mail from Ms.
 17 Predham to various individuals on the next
 18 day, October 6th, saying "looks fine, except
 19 that I think the word 'Tamoxifen' is missing
 20 twice. I added it to the attached. It
 21 mightn't be Tamoxifen but a word is missing.
 22 Also we refer to the lab three different ways,
 23 St. John's Pathology lab, immunohistochemistry
 24 service and Eastern Health lab. Does that
 25 matter? I'm picky this morning. Dan wanted

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1 to see it before it went out, so I sent it to
 2 him as well." Do you recall communicating to
 3 Ms. Predham that you wanted to see this letter
 4 to physicians?
 5 MR. BOONE:
 6 A. I don't recall it, but obviously I did.
 7 COFFEY, Q.C.:
 8 Q. And why would you have wanted to see that?
 9 MR. BOONE:
 10 A. I think, Mr. Coffey, I'm not going to be
 11 facetious here, but anytime a client wants to
 12 put words together in a sentence and send them
 13 to somebody else, lawyers like to stick their
 14 nose in it. I mean, quite frankly, that's the
 15 best that I can put it. You know, if people--
 16 I would want to look at it to make sure that,
 17 from our perspective, I would have considered
 18 it to be accurate based on what I knew, and
 19 that's about the best I can say.
 20 COFFEY, Q.C.:
 21 Q. And here's the draft itself. It's dated
 22 October 4th, 2005. It's stamped "draft". I
 23 take it this is the letter that accompanied
 24 that e-mail to you?
 25 MR. BOONE:

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1 A. Yeah.
 2 COFFEY, Q.C.:
 3 Q. And if we could look, please, then at P-0088,
 4 and this is a series of e-mails of October 6th
 5 generally.
 6 MR. BOONE:
 7 A. Yeah, and mine is part way down the page.
 8 COFFEY, Q.C.:
 9 Q. Yours is there towards the bottom of the page
 10 here. At 9:52 a.m. you've written an e-mail
 11 to Ms. Predham, and it reads, "As per my voice
 12 mail of concerns with referring to a quality
 13 review in correspondence, and with
 14 characterizing the retesting of samples as
 15 part of the quality review, as I understand
 16 it, the retesting was done from a patient care
 17 perspective. I also would like to reconsider
 18 the necessity of referring to that one patient
 19 whose test results started it".
 20 MR. BOONE:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And if we could go back then because it might
 24 help in asking you about your remarks there.
 25 P-2589, please, this is the letter itself.

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1 Could you tell the Commissioner then what
2 concerns you had?
3 MR. BOONE:
4 A. Okay. I'll take them backwards from the way I
5 recounted in my e-mail, if you like. In the
6 third paragraph, it says, "Recently a patient
7 initially tested in 2002 with the DAKO System
8 was reported as ER/PR negative and converted".
9 I expressed a concern as referring to that
10 person who later became known, or maybe
11 earlier, as the index case. My concern there
12 really, frankly, wasn't legal. That person
13 was a person who was a member of a family, of
14 a doctor, fairly well known, and I was just
15 concerned that if we didn't need to put it in
16 there, why would we, because people--the
17 letter was going to doctors, people in the
18 medical community. So it wasn't a legal
19 concern at all, it was more a concern for Dr.
20 Dean and his family, I suppose, if you like.
21 Whether I'm entitled to have that concern, I
22 don't know, but I was. The next thing was the
23 question of referring to quality review at
24 all, I think was the next part of it I said.
25 COFFEY, Q.C.:

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1 Q. Yes.
2 MR. BOONE:
3 A. I think that the Commissioner has struggled
4 with this throughout the course of the hearing
5 and lots of people had to deal with it, but
6 the notion of what to do with quality reviews
7 how protected they are and all those kinds of
8 things, is obviously a matter that we're all
9 going to have to deal with going forward, but
10 from my point of view up until that point in
11 time, I was always of the view that if a
12 quality review was done, it wouldn't be spoken
13 of as such to people except for the people who
14 were going to get the reports, the results of
15 it. I don't think much turns on it, but it
16 just was a practice and a recommendation of
17 mine in the past. The third thing that I
18 mentioned was I didn't agree, if you like, and
19 "agree" is too strong a word, I didn't
20 understand that what they were doing when they
21 sent their test results to Mount Sinai was
22 quality review. It had a quality review
23 element, if you like, because they were hoping
24 that the end result of it was going to tell
25 them whether or not they had a problem in

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1 their previous tests, but it was mainly done
2 in respect of the care of the patients.
3 That's why they did it, and again back to the
4 meetings that I attended, I remember that was
5 all they cared about, let's find out if our
6 patients need changes in tests. So to me,
7 that wasn't--that didn't bear the hallmarks of
8 what one would call a quality review, and I
9 just said what I said.
10 COFFEY, Q.C.:
11 Q. And what then happened? Actually, I'll go
12 back perhaps to assist you, P-0088. Here this
13 is a e-mail at the top here--actually, here on
14 October 6th in the middle of the page at 9:52
15 is your e-mail to Ms. Predham.
16 MR. BOONE:
17 A. Yeah.
18 COFFEY, Q.C.:
19 Q. The one we just looked at, and then there's
20 another e-mail here, the same day, 10:14 a.m.
21 from Ms. Predham to Ms. Pilgrim and Dianne
22 Smith. She writes, "Here is Dan's feedback.
23 I figure we might as well say quality review
24 since Dr. Williams has been saying it all
25 along. How about this, "Recently it was

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1 discovered that samples tested in 2002 with
2 the DAKO System and reported as ER/PR
3 negative, were retested with the Ventana
4 System, and now reported as ER/PR positive. A
5 summary search indicates Tamoxifen may benefit
6 a patient up to ten years after diagnosis. It
7 was felt important to retesting all samples
8 determined to be negative for ER/PR", and then
9 she says, "I checked with Dan. He's okay with
10 this". Do you recall that?
11 MR. BOONE:
12 A. I don't recall it, but it's obvious what she
13 says.
14 COFFEY, Q.C.:
15 Q. And what, Mr. Boone, then happened?
16 MR. BOONE:
17 A. What then happened from my perspective, and I
18 keep emphasizing that -
19 COFFEY, Q.C.:
20 Q. I appreciate that.
21 MR. BOONE:
22 A. I don't know everything--I shouldn't smile.
23 The next thing from my perspective is I was
24 called to a meeting with Dr. Williams on
25 October 6th of 2005, and that meeting took

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1 place in his office, but it wasn't to be just
 2 with Dr. Williams. Heather Predham was there
 3 for part of it, but I don't think all of it,
 4 but the purpose of the meeting was so that Dr.
 5 Williams and I could speak to Peter Browne on
 6 the phone, which we did.
 7 COFFEY, Q.C.:
 8 Q. And that relates to the ER/PR matter?
 9 MR. BOONE:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. Okay, are you able to discuss that -
 13 MR. BOONE:
 14 A. I don't know. Mr. Browne was part--it was a
 15 conversation between two lawyers with a client
 16 present. I'm in your hands, the
 17 Commissioner's hands, and Mr. Browne, as to
 18 whether I can or can't.
 19 THE COMMISSIONER:
 20 Q. Mr. Browne, do you want to (inaudible).
 21 BROWNE, Q.C.:
 22 Q. (Inaudible) involved an individual patient.
 23 COFFEY, Q.C.:
 24 Q. Oh, okay.
 25 BROWNE, Q.C.:

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1 Q. That's the issue that Ms. Predham talked
 2 about.
 3 THE COMMISSIONER:
 4 Q. Yes, I do recall your being on your feet about
 5 that before.
 6 COFFEY, Q.C.:
 7 Q. Okay.
 8 THE COMMISSIONER:
 9 Q. So I take it, we're not pursuing that?
 10 COFFEY, Q.C.:
 11 Q. No, we're not.
 12 THE COMMISSIONER:
 13 Q. All right.
 14 COFFEY, Q.C.:
 15 Q. So was there anything else other than that
 16 patient -
 17 MR. BOONE:
 18 A. No, that was the only -
 19 COFFEY, Q.C.:
 20 Q. That was it. When then happened?
 21 MR. BOONE:
 22 A. I think the next thing that happened with my
 23 next interaction was my e-mail of October
 24 18th.
 25 COFFEY, Q.C.:

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1 Q. And if we could look, please, at Exhibit -
 2 THE COMMISSIONER:
 3 Q. I'm sorry, Mr. Glaspell, I really should have
 4 turned to you with that one as well, but I
 5 presume you're content.
 6 MR. GLASPELL:
 7 Q. Yes, I am.
 8 COFFEY, Q.C.:
 9 Q. Thank you, Commissioner. Exhibit P-0308.
 10 THE COMMISSIONER:
 11 Q. That's the disadvantage of being the new
 12 person in the room. We've been here a long
 13 time.
 14 COFFEY, Q.C.:
 15 Q. Mr. Boone, this is an e-mail from Heather
 16 Predham to Dr. Laing and other individuals on
 17 October 18th, 2005. The subject is a patient
 18 letter.
 19 MR. BOONE:
 20 A. Right.
 21 COFFEY, Q.C.:
 22 Q. That particular letter was a draft that was
 23 attached. She said, "I have attached a draft
 24 letter with the suggested changes. Before we
 25 send it out, we'll need to consider the

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1 following", and there are three bullets. She
 2 says, "I guess we also have to remember we
 3 will get negative reaction from the letters",
 4 and she goes on to talk about that, and,
 5 "Finally, I think we should be aware that we
 6 will not be able to notify everyone. Several
 7 on the list have moved, and we have no other
 8 contact information. I'm going to send this
 9 on to Dan Boone as well. I'm not sure how
 10 HIROC will feel about notifying people at this
 11 point in time and whether the media attention
 12 will make any difference. Let me know what
 13 changes you want made".
 14 MR. BOONE:
 15 A. Right.
 16 COFFEY, Q.C.:
 17 Q. So can you tell us, please, before the e-mail
 18 you sent, what if any communication you had
 19 with Ms. Predham about it?
 20 MR. BOONE:
 21 A. Yeah. I recall that I was having a
 22 conversation with Ms. Predham. It actually
 23 related to ER/PR. It related to some
 24 specific--I don't think the details are
 25 important, but it related to some specific

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1 notion of some samples that had come back, or
 2 there had been duplicate samples sent to Mount
 3 Sinai, something like that, and I was having
 4 this conversation with her from my office.
 5 Then she said she was going to send me a
 6 letter that the corporation intended to send
 7 to all the patients who were going to be
 8 retested, and she did send that letter.
 9 COFFEY, Q.C.:
 10 Q. And you read it, the letter?
 11 MR. BOONE:
 12 A. Yes, yes.
 13 COFFEY, Q.C.:
 14 Q. And if we could look at a copy of it, Exhibit
 15 P-2590. This is another version of that same
 16 e-mail we just looked at, Ms. Predham, of
 17 October 18th, but when one goes to the last
 18 page of this exhibit, there's a draft, October
 19 17th, 2005.
 20 MR. BOONE:
 21 A. Yeah.
 22 COFFEY, Q.C.:
 23 Q. "Dear Patient letter". This is the letter?
 24 MR. BOONE:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. And what--what then happened? So she sends
 3 you the e-mail.
 4 MR. BOONE:
 5 A. Right.
 6 COFFEY, Q.C.:
 7 Q. With the letter attached?
 8 MR. BOONE:
 9 A. Right, and I e-mailed her back.
 10 COFFEY, Q.C.:
 11 Q. Okay. Do you know if you had any
 12 communication with her before you sent the e-
 13 mail about what might be in your e-mail?
 14 MR. BOONE:
 15 A. She told me that what she was going to send me
 16 was a letter that was going to go to all
 17 patients who were going to be retested.
 18 COFFEY, Q.C.:
 19 Q. Yes.
 20 MR. BOONE:
 21 A. And I told her that I wasn't sure about
 22 whether that was necessary, or something like
 23 that. I said send the letter over anyway
 24 because you might need something from me, so
 25 she did.

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1 COFFEY, Q.C.:
 2 Q. And if we could look, please, at Exhibit P-
 3 2967. This is your--2967, thank you. This is
 4 an e-mail from yourself to Ms. Predham, as
 5 well to D. Hawkins, and M. Boyce, of HIROC?
 6 MR. BOONE:
 7 A. Right.
 8 COFFEY, Q.C.:
 9 Q. And it's October 18th, 2005, at 2:04 p.m. The
 10 subject is "patient letter", and this is the
 11 text of your e-mail, and I'll ask you about
 12 that in a moment, but there is another e-mail
 13 in this exhibit just before this, in the
 14 middle here from Ms. Predham, October 18th,
 15 2005, at 1:13 p.m. to yourself.
 16 MR. BOONE:
 17 A. That same day?
 18 COFFEY, Q.C.:
 19 Q. Yes, this would be--here's October 18th, 2005,
 20 at 1:12 p.m. in which she's sending the draft
 21 letter to Drs. Laing and Williams and so on.
 22 A minute later, or within--she sends you an e-
 23 mail saying, "I played innocent of your
 24 response so you can surprise me", and that
 25 went to you, which I gather with this e-mail

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1 that she sent to a number of individuals and a
 2 the draft letter attached, and then we see
 3 your response the same day at 2:04 p.m.
 4 MR. BOONE:
 5 A. Right.
 6 COFFEY, Q.C.:
 7 Q. So about an hour later or so?
 8 MR. BOONE:
 9 A. Right.
 10 COFFEY, Q.C.:
 11 Q. And that's why I asked you about this
 12 reference to whether you had any interaction
 13 with Ms. Predham between--just before you sent
 14 your e-mail?
 15 MR. BOONE:
 16 A. Well, I told you what happened. If I recall
 17 correctly, when Heather and I were having the
 18 conversation, she was sending me the e-mail,
 19 you know. Heather is like a lot of people, I
 20 think, and probably a lot of us do it too
 21 much, we'll talk to somebody on the phone and
 22 we'll be sending e-mails at the same time
 23 often to the same person. So I would imagine
 24 she was referring to that earlier
 25 conversation. Of course, I don't know because

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1 it's not what I wrote, she wrote it.
 2 COFFEY, Q.C.:
 3 Q. And here then you've written, "My initial
 4 reaction is I do not agree with sending this
 5 letter at this time", and you go on to talk
 6 about why. Could you--I'm going to ask you
 7 about particular statements you've made here.
 8 You note, "There are a significant number of
 9 people whose results will not be changed".
 10 MR. BOONE:
 11 A. Right.
 12 COFFEY, Q.C.:
 13 Q. And by that point in time, I take it, you
 14 would have understood that the ratio would
 15 probably be 35/65, 60/40, 40/60, that kind of
 16 -
 17 MR. BOONE:
 18 A. 20/73.
 19 COFFEY, Q.C.:
 20 Q. Yes, whatever, or, in fact, in terms of
 21 changed results -
 22 MR. BOONE:
 23 A. I mean, that's--that's the kind of -
 24 COFFEY, Q.C.:
 25 Q. Changed results would be 32/73.

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

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

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

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

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1 consequences of that. So that's the first
 2 paragraph, that's what I was talking about.
 3 Of course, what you have to remember too is
 4 that what also was in my mind at this time was
 5 that there had been intense media coverage of
 6 this circumstance over the two to--I think two
 7 week period mostly since The Independent story
 8 first broke. My understanding, right or
 9 wrong, would have been that virtually
 10 everybody who was involved in this would
 11 already know about it. So to some degree, the
 12 letter was, if you like, redundant, it was
 13 telling people something they already knew,
 14 and so I was concerned about that.
 15 COFFEY, Q.C.:
 16 Q. Why would you be concerned about telling
 17 people something they already knew?
 18 MR. BOONE:
 19 A. Well, for the reasons I outlined in my first
 20 paragraph.
 21 COFFEY, Q.C.:
 22 Q. Oh, the first--because of that?
 23 MR. BOONE:
 24 A. Right, yeah, I mean, because--you know,
 25 telling someone something they already knew

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1 there's nothing inherently wrong with that,
 2 but if doing so leads to a greater exposure to
 3 a legal action, then that's a concern to a
 4 lawyer.
 5 COFFEY, Q.C.:
 6 Q. And what if anything distinguished in your
 7 mind telling people--or Eastern Health telling
 8 people back on October--well, The Independent
 9 story on October 2nd, or in the media coverage
 10 that followed, October 3rd, and so on, what if
 11 anything distinguished Dr. Williams, for
 12 example, speaking about the retesting that was
 13 going on of negative ER results?
 14 MR. BOONE:
 15 A. Right.
 16 COFFEY, Q.C.:
 17 Q. Going out over the media airwaves -
 18 MR. BOONE:
 19 A. Right.
 20 COFFEY, Q.C.:
 21 Q. And all these patients hearing it.
 22 MR. BOONE:
 23 A. Perhaps nothing.
 24 COFFEY, Q.C.:
 25 Q. And saying -

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1 MR. BOONE:
 2 A. Perhaps nothing. The fact of the matter is
 3 once this kind of thing occurs, the
 4 possibility of being sued in a class action
 5 for the health care provider is there. There's
 6 really not a lot you can do about it, and the
 7 health care provider's main concern, of
 8 course, is with the health and welfare of its
 9 patients. So it has to act as best as it can
 10 act to fulfil those interests or to meet those
 11 interests and concerns. So really nothing,
 12 but if this letter had been presented to me,
 13 for instance, perhaps--maybe I shouldn't
 14 speculate, but if it was presented before the
 15 public was aware, my feelings about it might
 16 have been entirely different.
 17 COFFEY, Q.C.:
 18 Q. And what did you understand the purpose of the
 19 letter was?
 20 MR. BOONE:
 21 A. To tell people that they're being retested.
 22 COFFEY, Q.C.:
 23 Q. I take it, to bring it home to individual
 24 patients who might otherwise not be aware that
 25 they -

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1 MR. BOONE:
 2 A. That wouldn't have been my thinking. I would
 3 have thought you would have been telling
 4 people who were already aware.
 5 COFFEY, Q.C.:
 6 Q. So what would the purpose of the letter be
 7 then? I just -
 8 MR. BOONE:
 9 A. I don't know, but that's part of my reaction,
 10 quite frankly.
 11 COFFEY, Q.C.:
 12 Q. And what was your basis for thinking that all
 13 patients would already be aware?
 14 MR. BOONE:
 15 A. I couldn't say all patients. I would just
 16 expect that the vast majority of them would
 17 have been.
 18 COFFEY, Q.C.:
 19 Q. And why--what difference would it make whether
 20 it was a vast majority or all? I mean, why--
 21 the people, I mean, who would be the
 22 difference between the vast majority and all,
 23 what about them?
 24 MR. BOONE:
 25 A. I never thought about it.

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

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

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

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

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1 of tests which include ER/PR, would be broad
 2 enough to cover retesting, and I still think
 3 that that is the case, and people are retested
 4 all the time, you know, without being told
 5 that they have been retested. So I still
 6 think that the original consent would be
 7 brought enough. The rest of the paragraph is
 8 dedicated, if you like, to notional constructs
 9 of informed consent. You're trying to think
 10 about what would be the people--the patient
 11 population you're speaking of, what would they
 12 be thinking, what would be in their mind, what
 13 would be available to them, what would they
 14 likely do if they actually got this letter,
 15 was it needed to give it to them in order to
 16 get that consent. So that's what that's
 17 directed towards, although perhaps not
 18 eloquently worded, but that's what it's
 19 directed towards.
 20 COFFEY, Q.C.:
 21 Q. I take it, in essence, you're telling Ms.
 22 Predham that because of the media coverage,
 23 anyone who knew themselves to have originally
 24 been ER/PR negative, and who did not want to
 25 be retested, could voice their concerns in

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1 that regard to Eastern Health?
 2 MR. BOONE:
 3 A. Right, because, of course, then they would
 4 have the necessary information available to
 5 them to make that determination, and if they
 6 did not, we could presume that they wouldn't.
 7 COFFEY, Q.C.:
 8 Q. Had you been asked to provide a comment about
 9 consent?
 10 MR. BOONE:
 11 A. Not specifically, but, of course, I mean, I
 12 just told you what my thinking was. I mean,
 13 I'm presented with a letter. The first
 14 question that comes to my mind is does this
 15 letter need to be sent. There's a risk
 16 associated, which I've outlined, with sending
 17 this letter. From my perspective from the
 18 point of view of the effectiveness of the
 19 communication, it did not need to be sent. I
 20 might have been wrong, but that's what I
 21 believed to be true. The second thing I would
 22 then turn my mind to as a lawyer would be,
 23 well, is there any other legal reason to send
 24 this letter other than the question of
 25 effective communication, and the first thing

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1 that came to my mind was the issue of consent.
 2 COFFEY, Q.C.:
 3 Q. You then concluded by saying, "Therefore, I do
 4 not see how the letter advances the health
 5 care of the affected patients and it increases
 6 our exposure to claims for damages".
 7 MR. BOONE:
 8 A. Right.
 9 COFFEY, Q.C.:
 10 Q. "I would recommend against sending it". So
 11 would you agree then that this is--I
 12 appreciate it's advice, you're not the CEO of
 13 Eastern Health, but that this e-mail was
 14 advice to Eastern Health from you to the
 15 effect of because of the potential to increase
 16 the exposure to claims for damages, the letter
 17 should not be sent?
 18 MR. BOONE:
 19 A. Right, but you have to consider that what's
 20 involved here at any time is a balance. The
 21 last sentence, which says--the "therefore" is
 22 misplaced because I don't think anything that
 23 I say in the last paragraph flows from the
 24 first two, but when I say I don't see how the
 25 letter advances the health care, I'm not a

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

17 COFFEY, Q.C.:

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

22 MR. BOONE:

23 A. Uh-hm.

24 COFFEY, Q.C.:

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

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1 gotten this e-mail as well -

2 MR. BOONE:

3 A. Yes, she did.

4 COFFEY, Q.C.:

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

11 MR. BOONE:

12 A. Right.

13 COFFEY, Q.C.:

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

18 MR. BOONE:

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

23 COFFEY, Q.C.:

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

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

3 MR. BOONE:

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

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

4 COFFEY, Q.C.:

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

10 MR. BOONE:

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

14 COFFEY, Q.C.:

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

22 MR. BOONE:

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

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

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

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1 COFFEY, Q.C.:
 2 Q. To the very same patients.
 3 MR. BOONE:
 4 A. And again--look, again I'm not going to be too
 5 picky because I'm not sure--I'm pretty certain
 6 what you mean is did the subject matter of
 7 letters to patients who were going to be
 8 retested come up again.
 9 COFFEY, Q.C.:
 10 Q. Yes.
 11 MR. BOONE:
 12 A. And the answer to that is, no, no one raised
 13 it with me again. I wouldn't necessarily have
 14 expected that they would. It just -
 15 COFFEY, Q.C.:
 16 Q. What then happened?
 17 MR. BOONE:
 18 A. Lots.
 19 COFFEY, Q.C.:
 20 Q. Okay.
 21 MR. BOONE:
 22 A. I'm sorry, but at this point in time I don't
 23 know what--I don't know what else happened,
 24 from what perspective, I don't know.
 25 COFFEY, Q.C.:

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

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1 I'll be in touch". So this is the
 2 notification from Roebbothan, McKay, and
 3 Marshall, that's what you're talking about
 4 there?
 5 MR. BOONE:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. The letter, okay. If we could, please,
 9 Exhibit P-0693. This is an e-mail from Ms.
 10 Predham to a number of individuals. It's
 11 December 13th, 2005. She says, "Hello
 12 everyone, we've received a Statement of Claim
 13 regarding ER/PR", and it goes on to talk about
 14 that. The Commissioner has seen this already.
 15 This is, I take it, the first formal--the
 16 action itself?
 17 MR. BOONE:
 18 A. Yes, it was.
 19 COFFEY, Q.C.:
 20 Q. Okay, and you were -
 21 MR. BOONE:
 22 A. And the only one for a time.
 23 COFFEY, Q.C.:
 24 Q. And you would have been--you, on behalf of
 25 your firm, were retained to deal with the

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1 matter?
 2 MR. BOONE:
 3 A. Yes, we would have been retained by--we were
 4 already retained in a sense. We were involved
 5 in this file, but the retainer would have then
 6 have expanded to include the defense of
 7 Eastern Health in respect of this claim.
 8 COFFEY, Q.C.:
 9 Q. If we could look, please, at Exhibit P-2065.
 10 Mr. Boone, this is a series of e-mails
 11 beginning in March of 2006. I'll show you an
 12 e-mail on page four of this. It's March 16th,
 13 2006, at 9:14 a.m. from Ms. Predham to
 14 yourself. It's involving an ATIPP request.
 15 It says, "For your information, I'll put
 16 whoever is going to coordinate this in touch
 17 with you so you guys can figure out how to
 18 determine what is excluded or not", and just
 19 to put it in context for you, Mr. Boone,
 20 there's a series of e-mails that begins with
 21 this March 15th one here, at 3:42 p.m. from
 22 Ms. Predham saying, "I've just received the
 23 ATIPP request from Mark Quinn at CBC for", and
 24 she spells out what it is and talks about the
 25 nature--from her perspective, her involvement

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1 in it, and the time frames and so on. Why was
 2 this e-mail sent to you?
 3 MR. BOONE:
 4 A. Well, I guess I'd have to say, Mr. Coffey, at
 5 this point is that everything we've talked
 6 about up to this point, as I understand it,
 7 has been the subject of either a clear waiver
 8 of privilege or not. As you know, as a
 9 lawyer, as a solicitor, I'm bound to not
 10 disclose confidential information given to me
 11 by a client or discuss privileged matters, and
 12 I think at this point we're getting beyond
 13 what at least I understand has been the
 14 subject of any clear waiver of privilege, so
 15 I'm going to have to take direction from
 16 somebody as to whether I can speak about any
 17 issues such as this.
 18 COFFEY, Q.C.:
 19 Q. Okay.
 20 MR. BOONE:
 21 A. I mean, I can tell you that--no, I guess I
 22 can't tell you anything until I have some
 23 direction as to what I can do.
 24 COFFEY, Q.C.:
 25 Q. And well, if I could, on that point, and

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

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

9 MR. BOONE:
 10 A. I guess, Mr. Coffey, the same statement I made
 11 earlier would have to apply.

12 COFFEY, Q.C.:
 13 Q. Okay.

14 MR. BOONE:
 15 A. I understand what you're suggesting, and I
 16 fully appreciate what you're suggesting is
 17 that there may have been some kind of waiver
 18 of privilege in respect of this.

19 COFFEY, Q.C.:
 20 Q. In respect of just that narrow -

21 MR. BOONE:
 22 A. I'm not in a position, sitting here as a
 23 witness, to make that determination and I'm
 24 duty bound, as a lawyer, to keep the
 25 confidences of my client and so what I'm

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

9 COFFEY, Q.C.:
 10 Q. Okay.

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

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

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1 THE COMMISSIONER:
 2 Q. Well, I'm just--in terms of the flow, if we
 3 can just put this aside.

4 COFFEY, Q.C.:
 5 Q. Sure.

6 THE COMMISSIONER:
 7 Q. If we discover there were a number of things,
 8 then we'll make sure that Mr. Boone has that
 9 opportunity, but -

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

17 THE COMMISSIONER:
 18 Q. Okay.

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

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

9 THE COMMISSIONER:
 10 Q. So we have three exhibits?

11 COFFEY, Q.C.:
 12 Q. Yes.

13 THE COMMISSIONER:
 14 Q. Relating to the ATIPP response. Is that
 15 correct?

16 COFFEY, Q.C.:
 17 Q. Yes, that's my understanding, Commissioner.

18 THE COMMISSIONER:
 19 Q. Okay.

20 COFFEY, Q.C.:
 21 Q. And perhaps for now, Commissioner, if we
 22 could, if we could just put that aside for the
 23 moment?

24 THE COMMISSIONER:
 25 Q. Yes.

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

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

1 other individuals.
 2 MR. BOONE:
 3 A. Yeah, and I can tell you, just so you won't
 4 get bogged down, that from my perspective, my
 5 role there was not such as would render that
 6 privileged.
 7 COFFEY, Q.C.:
 8 Q. And I had understood that from your counsel.
 9 So in relation to this, can you tell us,
 10 please, what you recall about this? Like for
 11 example, how you ended up there at all and -
 12 MR. BOONE:
 13 A. I was--I ended up there at all because I was
 14 invited by Mr. Singleton through Ms. Predham.
 15 Ms. Predham, I think, actually got in touch
 16 with me, but Mr. Singleton asked for me to
 17 come.
 18 COFFEY, Q.C.:
 19 Q. And go ahead then, what happened? What do you
 20 recall about -
 21 MR. BOONE:
 22 A. I went.
 23 COFFEY, Q.C.:
 24 Q. And what happened? What do you recall?
 25 MR. BOONE:

1 and she was also an ethicist in that she was
 2 affiliated with the university, not with
 3 Eastern Health, and that--and Heather Predham
 4 was there. So I remember all those people
 5 being there.
 6 The discussion was going to be about the
 7 question, as I understood it at the outset,
 8 further testing of the samples of people who
 9 had become deceased up until that point. In
 10 other words, would their samples be retested
 11 in the same manner as the other samples had
 12 already been, I thought, completely retested,
 13 but in January of '06.
 14 I don't know how that system or that
 15 question percolated up to become a question
 16 which was the subject of an ethics review. I
 17 don't know who initiated that kind of a
 18 discussion. My knowledge of ethics reviews is
 19 it usually comes from somewhere, a clinician
 20 or somewhere else, would ask for an ethics
 21 consult, in other words, where they sit down
 22 with their colleagues and people who have
 23 other knowledge of the matter to talk about
 24 what they should do, and that's what an ethics
 25 consult is, as I understand it.

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

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1 right away as to--the issue became different
 2 than what I originally thought, because the
 3 original thought process that I had going in
 4 was it was about the question as to whether or
 5 not they were going to continue to retest. I
 6 don't know if I was right or wrong about that,
 7 but that was my impression. But it became
 8 also the question as to whether or not they
 9 would disclose to people who had already been
 10 retested, because I don't think I appreciated
 11 that people had been retested already.
 12 COFFEY, Q.C.:
 13 Q. This is some deceased -
 14 MR. BOONE:
 15 A. Some deceased samples had been tested.
 16 COFFEY, Q.C.:
 17 Q. Okay.
 18 MR. BOONE:
 19 A. There were some numbers of that that were
 20 spoken of during the ethics review. I
 21 honestly don't recall what those numbers were,
 22 but a substantial number had already been
 23 retested. Then Dr. McCarthy spoke about her
 24 view of disclosure and Dr. McCarthy spoke,
 25 again fairly passionately, about her view on

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1 this, and it was one that, to me, made a lot
 2 of sense intuitively, emotionally, and
 3 intellectually, if you like, but what she told
 4 us was that she and the other oncologists deal
 5 with their patients and their patients'
 6 families near end of life. It's a big part of
 7 what they do, and once the patient, the cancer
 8 patient has passed, the oncologists don't
 9 consider that their job is done, and that they
 10 feel they still owe a lot of obligations to
 11 the families of the deceased people, and that,
 12 you know, the families go through mourning
 13 processes and, you know, these are fairly well
 14 known, I suppose, as to what they might be.
 15 I remember she spoke to us about the fact
 16 that she and her colleagues, the oncologists,
 17 they don't just let the patient, the deceased
 18 patient go out the door. They continue to
 19 follow up with the family. They go to the
 20 wakes. They go to the funerals. They are
 21 there for questions afterwards. They're there
 22 to talk to people for comfort. They're there
 23 for anything anybody wants and their time
 24 allows them to give. They're there for them.
 25 And that from her perspective, at a certain

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1 point in time, from her years of observation
 2 of this process, families of deceased cancer
 3 patients, and I honestly don't know whether
 4 you could say it of other families too, but
 5 certainly families of deceased cancer patients
 6 achieve a point in their life where they have
 7 found closure. They have managed to deal with
 8 their relatives' usually untimely death, and
 9 they've moved on. And that Dr. McCarthy felt
 10 quite strongly that to go back now, in this
 11 circumstance, and to open up that closure that
 12 had been achieved by recounting to people the
 13 results of retesting or asking them about
 14 other retesting would be a bit too much for
 15 the families to bear and that she felt, and
 16 her recommendation strongly was, as a person
 17 who was, you know, deals with these people, I
 18 suppose, the patients at first instance, was
 19 that we ought not to--Eastern Health ought not
 20 to continue to retest and not to disclose to
 21 families where retests had occurred, unless
 22 they wanted us to.
 23 She also spoke, I remember this at the
 24 time, she said this wasn't just her view, but
 25 this was also the view, I remember she said of

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

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

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

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

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

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

16 COFFEY, Q.C.:
 17 Q. Yes, go ahead.

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

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

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

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1 Hospitals Act"--because I'd been dealing with
 2 this for years and years and years, "the
 3 Hospitals Act left a gap when a patient died
 4 as to who could access their records. There's
 5 no provision in the Hospitals Act" at the
 6 time, and I think actually the new Act had
 7 come in place at that time, and it still
 8 hadn't been filled, but the Hospitals Act at
 9 the time gave no direction to a hospital as to
 10 what it could do for release of patient
 11 records once someone died.
 12 Lawyers being lawyers would, I think,
 13 interpret that if a person can access their
 14 records, then their personal representative
 15 can also do so, and what that would mean to
 16 lawyers would be that then a person who wants
 17 access to the deceased family's records would
 18 have to go out and get an estate administered
 19 or a will probated and become a legal
 20 appointee, and for years up to that point in
 21 time, and I'm willing to bet it would be 15
 22 years up to that point in time, I have been
 23 advising hospitals in that setting, rightly or
 24 wrongly, that in the event that a patient
 25 comes to them--or sorry, a relative of a

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1 deceased person comes to them with some
 2 complaint, vague or clear, about the treatment
 3 that their relative received, that in those
 4 settings, the hospital ought not to stand on
 5 the interpretation of the Hospitals Act which
 6 I've just given you, and make those records--
 7 they should make those records available to
 8 people, because these are people who are
 9 complaining about the care. The hospital is
 10 the custodian of the records. It always
 11 seemed wrong to me that the hospital would say
 12 you have to go out and get a will probated or
 13 an estate administered before we're going to
 14 give you the records. That just seems totally
 15 wrong. There's a lot of money involved in
 16 that. Doesn't make any sense.
 17 So in that setting, when someone was
 18 considering either a complaint to a
 19 professional body, a complaint to the hospital
 20 or even suing the hospital, the view that I
 21 had expressed to hospital authorities across
 22 the province was that they should make those
 23 records available, and so that's--that was my
 24 two cents worth, if you like, and that, to me,
 25 was near the end of the meeting, and that's my

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1 recollection of that consult.
 2 COFFEY, Q.C.:
 3 Q. If we could just look at the bottom of the
 4 page here on this exhibit 0782, if we could?
 5 Sorry, gone a bit too far.
 6 MR. BOONE:
 7 A. This is the report of the consult?
 8 COFFEY, Q.C.:
 9 Q. Yes.
 10 MR. BOONE:
 11 A. I don't think I ever received this.
 12 COFFEY, Q.C.:
 13 Q. No, and there's no suggestion.
 14 MR. BOONE:
 15 A. Okay. I don't believe I ever did.
 16 COFFEY, Q.C.:
 17 Q. If I could just take you to--there's an
 18 assertion in here, in what Mr. Singleton
 19 wrote. He refers to "the obligation to
 20 disclose the information to families is based,
 21 from ethnics perspective, on the negative
 22 right of families to the information about the
 23 deceased."
 24 MR. BOONE:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. And he goes on to speak about that. "The
 3 obligation to inform is different in this
 4 situation than if situations where a mistake
 5 has been made, where the information would
 6 make a difference or a potential difference in
 7 the care plan or interventions of a patient."
 8 I wanted to ask you about, and you've
 9 indicated that there was discussion about it
 10 couldn't be said categorically one way or the
 11 other whether or not in any particular
 12 patient's case it might have prolonged their
 13 life, but I wanted to ask you about the
 14 assertion that if--that should be presumably
 15 in situations where a mistake has been made.
 16 Do you recall any discussion about mistakes or
 17 the notion of mistakes and whether there had
 18 been any mistakes made by anyone in relation
 19 to the testing process?
 20 MR. BOONE:
 21 A. No. No, I don't recall it. I mean, there was
 22 discussion as to whether there was one, I
 23 suppose, but I don't recall anybody saying
 24 this is a mistake.
 25 COFFEY, Q.C.:

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

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1 Q. In the sense of is it a direct route or, I
 2 mean, -
 3 MR. BOONE:
 4 A. Yeah, that's my understanding.
 5 THE COMMISSIONER:
 6 Q. I'm not quite sure what it is -
 7 MR. BOONE:
 8 A. Sorry, Commissioner.
 9 THE COMMISSIONER:
 10 Q. I guess what I'm saying is that I'm not quite
 11 sure perhaps what Dr. Singleton was looking
 12 for, let alone sort of -
 13 MR. BOONE:
 14 A. What he got.
 15 THE COMMISSIONER:
 16 Q. - what he got from it.
 17 MR. BOONE:
 18 A. Perhaps if I could, one of the things I'd ask
 19 that could be done, you have to back up a
 20 little bit. I think the question was not
 21 whether or not anything done within Eastern
 22 Health, in relation to ER/PR, could be
 23 connected to a death. My understanding was
 24 whether or not anything--if there was any
 25 mistakes in the lab, could they be connected

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1 to the death. In other words, it was more
 2 remote than that, if you appreciate what I'm
 3 trying to say.
 4 THE COMMISSIONER:
 5 Q. Okay.
 6 MR. BOONE:
 7 A. In other words, there wasn't a discussion
 8 along the way of what--you know, as I think
 9 all of you now would know would occur, which
 10 would be whether or not the clinician takes
 11 the test and what they do with it. There was
 12 none of that discussion. The chain was not,
 13 if you like, followed right through from
 14 beginning to end.
 15 THE COMMISSIONER:
 16 Q. Okay.
 17 MR. BOONE:
 18 A. The question that was asked and posited by Mr.
 19 Singleton was whether or not, let's say there
 20 was a mistake in a lab test and which I think--
 21 -no, actually, let's say there's a change in a
 22 test result.
 23 THE COMMISSIONER:
 24 Q. Yes.
 25 MR. BOONE:

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1 A. Can somebody say that that change, if the
 2 change had been known, if they got it right
 3 the first time, could that have prevented the
 4 death, and that was the -
 5 THE COMMISSIONER:
 6 Q. That sounds to me like a direct relationship,
 7 nothing complicated, kind of question.
 8 MR. BOONE:
 9 A. Yeah, that's exactly what it was. That was
 10 the kind of discussion that then followed, was
 11 that, and the discussion that followed was not
 12 very long and was not very complicated. I
 13 remember that.
 14 THE COMMISSIONER:
 15 Q. As opposed to an impact kind of question?
 16 MR. BOONE:
 17 A. Yeah, there was no--I mean, no discussion
 18 about--I mean, I think all of you would know
 19 what essentially the steps along the way would
 20 be to allow someone to make that decision.
 21 Those steps were not discussed individually,
 22 not were all the steps outlined or anything of
 23 the sort. It was a change in a lab result,
 24 can we tell if the lab result had been
 25 different first, would the person not have

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1 died? That was the question that was posited.
 2 THE COMMISSIONER:
 3 Q. All right.
 4 COFFEY, Q.C.:
 5 Q. Here, in this report, third paragraph, Mr.
 6 Singleton had written, "important facts to the
 7 history," and understand, which presumably is
 8 "understanding of this case include the
 9 following. There were no mistakes or
 10 technical errors at the root of this problem.
 11 It is impossible to know in any specific case
 12 if the outcome for any individual patient
 13 would have been different. Intervention for
 14 post-menopausal women have positive impact by
 15 lengthening life in 47 percent of patients
 16 treated." The second assertion, "is it
 17 possible to know in any specific case if the
 18 outcome for any individual patient would have
 19 been different?" You've already referred to
 20 that.
 21 MR. BOONE:
 22 A. That's definitely the conversation that I
 23 heard.
 24 COFFEY, Q.C.:
 25 Q. Do you recall anyone or any assertion during

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1 that meeting to the effect that there were no
 2 mistakes or technical errors at the root of
 3 this problem?
 4 MR. BOONE:
 5 A. I don't recall anything being said like that.
 6 I don't know what the root of the problem
 7 would be or what he would have been--Mr.
 8 Singleton would have been thinking was the
 9 problem. I really don't. I can't interpret
 10 the sentence, but I don't--if what he's saying
 11 is that somebody asserted that Eastern Health
 12 did nothing wrong here, I don't think I ever
 13 heard that.
 14 COFFEY, Q.C.:
 15 Q. And that's in the context, because if you look
 16 back, he says "the problems with the results
 17 was rooted in the test procedures used in the
 18 time period from 1997 through 2005" and he
 19 goes on to talk about it there, so presumably
 20 that's the problem he's talking about, and you
 21 certainly don't recall any reference to--or
 22 anybody asserting, "look, there were no
 23 mistakes -
 24 MR. BOONE:
 25 A. If that's what that assertion is intended to

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1 convey, nobody said anything of the sort.
 2 COFFEY, Q.C.:
 3 Q. If we could look, please, at Exhibit P-781?
 4 And I take it, Mr. Boone, in relation to the
 5 ethics consult, you did not receive a copy of
 6 that report. Did it ever come up afterward,
 7 except in the context of Commission of
 8 Inquiry, but do you ever recall it being
 9 raised?
 10 MR. BOONE:
 11 A. I don't recall. When you say "it" do you mean
 12 the consult or the report?
 13 COFFEY, Q.C.:
 14 Q. The consult, the ethics consult itself, that
 15 ethics consult, the issue dealt with there.
 16 MR. BOONE:
 17 A. I know at some point in time, whatever the
 18 recommendation of the ethics consult, which I
 19 presume was followed -
 20 COFFEY, Q.C.:
 21 Q. Well -
 22 MR. BOONE:
 23 A. I don't know if it was or not, but it was
 24 reversed, if you like. At some point in time,
 25 I know that Eastern Health was told to retest

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1 all the samples, including those of deceased.
 2 COFFEY, Q.C.:
 3 Q. Oh, yes, and that would be May of '07.
 4 MR. BOONE:
 5 A. I'm not sure when that was. I do know it
 6 happened. But beyond that, I mean, I don't
 7 have any--I didn't follow the ethics consult
 8 through whatever route it was supposed to go.
 9 Let's put it that way.
 10 COFFEY, Q.C.:
 11 Q. No one consulted--what I'm asking, I suppose,
 12 is no one consulted you further about it, in
 13 the way that you'd been consulted -
 14 MR. BOONE:
 15 A. And nor would I really have been expected to,
 16 you know.
 17 COFFEY, Q.C.:
 18 Q. Exhibit, this is P-0781, and it's an e-mail
 19 from Mr. Singleton to Dr. Williams of June
 20 20th, 2006, 10:20 a.m. and he writes "Hi, Bob.
 21 Yesterday we had the ethics consult on ER/PR.
 22 Very good discussion and outcome. I will
 23 forward this summary later. In the meantime,
 24 an issue came up that I want to bring"--I'm
 25 sorry, "want to give you a heads up on. Dr.

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1 Denic had a document or report from a external
 2 review of the lab process, etcetera, here. He
 3 read from it and mentioned he would use the
 4 report as part of information he was sharing
 5 with others. It seems the reported opinion
 6 had been done for Dan Boone and he did not
 7 want the information shared, as at this time
 8 it is privileged. Dr. Denic understood from
 9 you that he was not to copy it, but Dan seemed
 10 to be a bit concerned that it was being
 11 quoted, the expert being referred to. Dan's
 12 concern seems to be about the privileged
 13 status of the report, which he may need in a
 14 proceeding later on. Anyway, just thought you
 15 might want to know there was a bit of fuss
 16 about this." Signed Rick.
 17 Now, Mr. Boone, I'm not going to ask you
 18 anything about the report itself or anything.
 19 I just wanted to ask you to confirm, does that
 20 account accord with your recollection of what
 21 happened at the meeting, in relation to that
 22 topic?
 23 MR. BOONE:
 24 A. Frankly I'm at a bit of a loss as to how I can
 25 answer the question, I mean, what we're

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1 talking about here is privileged material and
 2 let's put it this way: I had a privileged
 3 report, someone that I just met for the very
 4 first time whose name I couldn't even spell
 5 had it, that caused me a concern.
 6 COFFEY, Q.C.:
 7 Q. No, no, no, I'm not asking you all in terms--
 8 all I wanted to know is if what's here, what's
 9 written here in terms of the account that
 10 there was something read out and that the
 11 account that you spoke up and that apparently
 12 ended -
 13 MR. BOONE:
 14 A. Well I just told you what my account of it
 15 was, I really don't recall anything else.
 16 COFFEY, Q.C.:
 17 Q. Okay, in your account to the Commissioner
 18 before I refer to this, this was not referred
 19 to, you do recall it, I take it, occurring?
 20 MR. BOONE:
 21 A. Sure, but I wasn't going to refer to it, I
 22 mean, look, I don't see why I should refer to
 23 a report that was privileged and I don't see
 24 how it even came to the attention of this
 25 inquiry.

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1 COFFEY, Q.C.:
 2 Q. And well, we're in the position where it has
 3 come to our attention, okay, and witnesses
 4 have spoken about it, so I'm simply asking you
 5 can you confirm that that is an accurate
 6 account of what happened in relation to that
 7 matter at the time. I don't want to know
 8 what's in the report at all.
 9 THE COMMISSIONER:
 10 Q. You have been very careful about that, Mr.
 11 Boone, not to go into what was said or what
 12 might be in the report or even who -
 13 COFFEY, Q.C.:
 14 Q. Not even what Dr. Denic said.
 15 MR. BOONE:
 16 A. I had sent my report to Dr. Williams under
 17 cover of correspondence which you have seen -
 18 COFFEY, Q.C.:
 19 Q. Oh yes and -
 20 MR. BOONE:
 21 A. Let me answer.
 22 COFFEY, Q.C.:
 23 Q. Sure.
 24 MR. BOONE:
 25 A. That said that this report is solicitor and

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1 client privileged and is not to be shared with
 2 anybody, it's part of our solicitor's work
 3 product. When I came to the meeting, Dr.
 4 Denic had it. I was not aware of having--I
 5 certainly didn't give any instructions that he
 6 could have it. There was nothing really wrong
 7 with that, he's the clinical chief of
 8 pathology, I may have shared it with him in
 9 the right circumstance, but not at that time
 10 and he had it. I don't recall him reading
 11 from it. I recall him having it and I
 12 recognized what it was and I recall taking it
 13 up with him at the time and expressing
 14 surprise, I suppose and a little consternation
 15 that a report that I would have considered to
 16 have been privileged was in the hands of
 17 somebody who I didn't know. So, I mean,
 18 that's the best that I can recall about it.
 19 COFFEY, Q.C.:
 20 Q. And if we could, please, Exhibit P-1167? And
 21 Mr. Boone, this is just an e-mail from Leona
 22 Barrington, August 8th, 2006 to a number of
 23 individuals, you'll see you're last in the
 24 list of the main recipients.
 25 MR. BOONE:

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1 A. Right.

2 COFFEY, Q.C.:

3 Q. It's a transcript of the CBC, The Current

4 program. She writes, "Good afternoon,

5 attached is the transcript from The Current,

6 CBC's National radio program regarding the

7 Myrtle Lewis case" and I understand it's a

8 matter of public record that your firm acts

9 for Eastern Health in relation to that matter?

10 MR. BOONE:

11 A. Yes, we do, yes.

12 COFFEY, Q.C.:

13 Q. And this is the matter, Ms. Lewis' case would

14 be the action that initiated the class action

15 proceedings, would that be -

16 MR. BOONE:

17 A. I can't recall, the representative of the

18 Plaintiff is Verna Doucette.

19 COFFEY, Q.C.:

20 Q. Okay, may not be. Verna Doucette actually is-

21 -I stand corrected.

22 MR. BOONE:

23 A. Ms. Lewis is or purports to be a class member,

24 I think.

25 COFFEY, Q.C.:

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1 Q. Yes, that's it, I apologize, it is Verna

2 Doucette but Ms. Lewis was related somehow or

3 alleged to be related somehow to the class

4 action.

5 MR. BOONE:

6 A. Yes.

7 COFFEY, Q.C.:

8 Q. In this context. And so, and again for the

9 Commissioner to kind of flesh out your

10 account, by that point in time, the class

11 action was on the go, as it were.

12 MR. BOONE:

13 A. I think I learned of the class action coming

14 in the--I'm going to say late May of 2006

15 through various sources that it was coming,

16 but it was actually--I was sent a courtesy

17 copy by Mr. Crosbie of a Statement of Claim

18 issued under the Class Actions Act on July

19 14th at 2006.

20 COFFEY, Q.C.:

21 Q. Uh-hm, and I asked you about it only because

22 the next exhibit I'm going to refer you to -

23 MR. BOONE:

24 A. Right.

25 COFFEY, Q.C.:

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1 Q. - to put it in some context, P-0125, page 34

2 please? Well actually if we could, just to

3 give Mr. Boone the sense of this, page 31

4 please?

5 MR. BOONE:

6 A. Can you tell me what this is?

7 COFFEY, Q.C.:

8 Q. Yes, and I'm going to show you, this is -

9 MR. BOONE:

10 A. Oh, this is one of the collection of

11 documents, is that right?

12 COFFEY, Q.C.:

13 Q. Yes, this is a collection, a large collection

14 of briefing notes internal to the government.

15 This particular one as you'll see is a

16 briefing note, Department of Health and

17 Community Services, this is one that ended up

18 in Executive Council, you can see the

19 distribution list up here. Titled "Update on

20 Pathology Reports Legal Action for Women

21 Diagnosed with Breast Cancer." Do you see

22 that?

23 MR. BOONE:

24 A. Yes.

25 COFFEY, Q.C.:

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1 Q. And the issue is "current status of pathology

2 testing and legal claims related to women

3 diagnosed with breast cancer.

4 MR. BOONE:

5 A. Okay.

6 COFFEY, Q.C.:

7 Q. And the Commissioner has seen the text of this

8 on a number of occasions. Page 3 of the

9 document, page 33 of the exhibit, you'll

10 notice here is "current status, legal

11 activity. Currently we have two legal claims

12 that have been filed, Michelle Hanlon's and

13 Verna Doucette" and then there's a reference

14 to recent media reports identified Myrtle

15 Lewis.

16 MR. BOONE:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. Then under summary, refers to legal action

20 initiated by Ms. Myrtle Lewis. I don't know

21 if that's technically correct, but anyway,

22 that's there. And it goes on to say here

23 under "Action Required" okay, "This notice is

24 provided for your information purposes only.

25 Should the Premier require further detail,

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1 officials from Eastern Health, as well as
 2 their legal counsel will be available for an
 3 in-person briefing."
 4 MR. BOONE:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. Are you able to tell the Commissioner -
 8 THE COMMISSIONER:
 9 Q. Excuse me, Mr. Coffey, Mr. Glaspell is going
 10 to speak. Yes.
 11 MR. GLASPELL:
 12 Q. There was an exchange of correspondence
 13 between counsel, letters dated October 17th
 14 and October 18th. We identified eight
 15 different areas where Mr. Boone could be asked
 16 questions and then we've been dealing with the
 17 privilege issue in delicate fashion. This--
 18 and I haven't heard the question yet, but this
 19 is not an area. It's one of the eight areas
 20 that were identified.
 21 COFFEY, Q.C.:
 22 Q. Yeah, I appreciate, Mr. Glaspell and if I
 23 could just ask the question, it may or it may
 24 not be--the question is simply, Mr. Boone,
 25 were you aware that you were being off--I

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1 presume you're the legal counsel, you were
 2 being offered up, as it were?
 3 THE COMMISSIONER:
 4 Q. Do you have a problem with that question. The
 5 question is whether or not he was--you
 6 understand what this document is, sir, it's
 7 prepared with the exception of one person, the
 8 others are officials of the Government of
 9 Newfoundland and Labrador. Ms. Predham is an
 10 employee of Eastern Health.
 11 MR. GLASPELL:
 12 Q. Right. What is the question?
 13 THE COMMISSIONER:
 14 Q. The question is whether or not Mr. Boone was
 15 aware that somebody who drafted these
 16 documents or reviewed them were indicating to
 17 the Government of Newfoundland and Labrador,
 18 in effect the Premier, that he was available
 19 for a briefing. So it's a question of whether
 20 or not he knew he was being offered to make a
 21 briefing--whether anybody had consulted him to
 22 say you can go brief the Premier?
 23 MR. SIMMONS:
 24 Q. If I might offer a suggestion, if Mr. Boone,
 25 himself, has any doubt at all about whether

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1 this is an appropriate area, this might be one
 2 of those things which can be heard with the
 3 others and (inaudible).
 4 MR. GLASPELL:
 5 Q. (Inaudible).
 6 THE COMMISSIONER:
 7 Q. All right then, well if Mr. Boone himself was
 8 the writer there.
 9 MR. BOONE:
 10 A. I don't have any problem, I'll answer it.
 11 THE COMMISSIONER:
 12 Q. He doesn't seem to have that problem, Mr.
 13 Simmons, so if you're willing to defer to Mr.
 14 Boone's view on this -
 15 MR. SIMMONS:
 16 Q. I'm being (inaudible).
 17 THE COMMISSIONER:
 18 Q. Thank you.
 19 MR. BOONE:
 20 A. I never saw this briefing note until the
 21 Inquiry and I don't remember if I actually
 22 read it since, I think I knew this was there.
 23 I recall at one point in time and I don't know
 24 who prepared this briefing note or whether
 25 it's a government briefing note. I have to

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1 say that until I got involved in this Inquiry,
 2 I don't think I ever knew in my life what a
 3 briefing note was or -
 4 THE COMMISSIONER:
 5 Q. Let alone how complicated they are, Mr. Boone.
 6 MR. BOONE:
 7 A. I have no idea. But I do recall at some point
 8 in time a lawyer from the Department of Health
 9 approached me. I don't know if it was--it
 10 might have been around that time and she asked
 11 me for some information and I remember giving
 12 her some basic information, including some of
 13 the documents that we had filed in respect of
 14 the certification briefing, that would have
 15 been later. I had an earlier contact from
 16 someone with Health, a lawyer though, looking
 17 for information on, you know, where we were
 18 and the status of the action, that kind of
 19 thing and I was very concerned about that
 20 because, of course, the Government of
 21 Newfoundland and Labrador would not be my
 22 client under any notional view of the world,
 23 and so I would be concerned with disclosing to
 24 the government whatever litigation strategies
 25 might be or whatever else might be because I

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

24 Q. Thank you very much, Mr. Boone. Exhibit P-
 25 2658 and this is an e-mail from Leona

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1 Barrington of October 20th, 2006, it's to a
 2 number of individuals, you're there in the
 3 middle of the cc'd people. The subject is
 4 "Taking Action in The Independent." "The
 5 attachments are taking action in The
 6 Independent on October 20th, 2006." She
 7 writes, "Attached is an article on ER/PR that
 8 appears in this week's Independent, I am going
 9 to begin to put together a communication
 10 strategy around the release of the rate of
 11 error results, as well as the announcement of
 12 us beginning to retest. After speaking with
 13 Heather, we would like to aim for an end of
 14 November announcement. Terry/Nash will we be
 15 ready by then, please advise." So I take it
 16 that the actual--you being on the distribution
 17 list for the media story, we've seen other
 18 ones and you've told the Commissioner that at
 19 times you were just copied on, the
 20 distribution list apparently they were
 21 including you on some of the ER/PR, so your
 22 name would be there anyway in terms of that.
 23 MR. BOONE:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Okay. The underlying topic in the e-mail
 2 itself, the text of the e-mail relates to this
 3 matter of, what turned into, I understand, the
 4 December 11th, 2006 media briefing.
 5 MR. BOONE:
 6 A. Yes.
 7 COFFEY, Q.C.:

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

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1 COFFEY, Q.C.:

2 Q. Okay. And I refer you to that by way of an
 3 introduction to the next exhibit. Exhibit P-
 4 2108. These are minutes of an Executive
 5 Management meeting held November 21st, 2006 at
 6 8:30 a.m., and there's a list of those
 7 present. The guests for ER/PR presentation
 8 are listed there, your name is the last on the
 9 list. And then there's a--after the reference
 10 to who is welcomed it says, "A copy of the
 11 detailed slide presentation that was given to
 12 the medical staff was circulated." And then
 13 presentation ER/PR, "Dr. Denic's presentation
 14 focused on the reliability of the test and the
 15 variables that influence the results.
 16 Discussion focused on documentation and
 17 standardized procedures semi-automated systems
 18 verses the new Ventana system" and then he
 19 goes on to describe Dr. Laing's presentation,
 20 what that focused on and then on the next
 21 page, there's a note, "The following points
 22 were raised during the presentation"--check
 23 mark--"The organization cannot speak publicly
 24 on the findings and recommendations of the
 25 review because there is currently a class

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1 action lawsuit ongoing. This information is
 2 protected under The Evidence Act. Discussion
 3 ensued regarding the need to share the
 4 experience with the other pathologists within
 5 the province. Dr. Howell and Dan Boone to
 6 discuss further prior to making any"--I
 7 presume it is decision, it reads "discussion"
 8 but it probably should be decision--"to
 9 discuss the reviewer's report with the
 10 provincial pathologists", do you see that?
 11 MR. BOONE:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. Do you recall--what, if anything, do you
 15 recall about that, Mr. Boone?
 16 MR. BOONE:
 17 A. About what? You told me a lot.
 18 COFFEY, Q.C.:
 19 Q. Okay, well in particular -
 20 MR. BOONE:
 21 A. I recall going to the Executive Management
 22 meeting. I recall that I went there really
 23 for my information purposes. It was a great
 24 opportunity to hear the experts talk about a
 25 case that I was defending, that's why I went.

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1 I never saw the minutes. As a matter of fact,
 2 I'm seeing these minutes I really do believe
 3 for the first time. I don't think I even went
 4 back and read them since this started, so this
 5 is new to me. What do I recall about it? If
 6 the organization said they couldn't speak
 7 publicly on the findings and recommendations
 8 of the review because there's currently a
 9 class action lawsuit ongoing, I wouldn't have
 10 agreed with that. This information is
 11 protected under the Evidence Act, I agree with
 12 some of that. Discussion ensued regarding
 13 the need to share the experience with other
 14 pathologists, I remember that. I don't
 15 remember any discussion that Dr. Howell and I
 16 were going to get together to discuss further
 17 at all, no discussion of that. And I don't
 18 remember ever having that discussion with him.
 19 COFFEY, Q.C.:
 20 Q. Then or afterward.
 21 MR. BOONE:
 22 A. I had lots of discussions with Dr. Howell, I
 23 don't recall that discussion.
 24 COFFEY, Q.C.:
 25 Q. You've indicated that the assertion that the

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1 organization cannot speak publicly on the
 2 findings and recommendations of a review
 3 because there is currently a class action
 4 lawsuit ongoing, I think you indicated just
 5 now you would not -
 6 MR. BOONE:
 7 A. Maybe I overstated myself, Mr. Coffey, because
 8 the worse part of it is right now we're
 9 getting into areas that -
 10 COFFEY, Q.C.:
 11 Q. Okay.
 12 MR. BOONE:
 13 A. - I have no idea if they are privileged still
 14 or I think they were privileged to begin with
 15 and again, you know, my responsibility as
 16 counsel is to maintain the confidentiality of
 17 my client and the information conveyed to me
 18 by my client and to keep privilege the advice
 19 I give. Until someone shows me that I can
 20 speak to these issues, I really don't think I
 21 can.
 22 COFFEY, Q.C.:
 23 Q. And I won't pursue it any further, Mr. Boone,
 24 I appreciate that.
 25 MR. BOONE:

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1 A. That's fine.
 2 COFFEY, Q.C.:
 3 Q. The point, in fact the real point I was asking
 4 about was if you had any recollection of
 5 what's in fact in the bold print there, which
 6 is the -
 7 MR. BOONE:
 8 A. I don't.
 9 COFFEY, Q.C.:
 10 Q. And you've indicated you don't recall.
 11 MR. BOONE:
 12 A. I don't recall having read it, I don't recall
 13 it being spoken of at the Executive Management
 14 meeting, although it may have been and I
 15 certainly don't recall speaking to Oscar
 16 Howell about that particular issue as
 17 described there.
 18 COFFEY, Q.C.:
 19 Q. Okay. Exhibit P-0184 please? Mr. Boone, this
 20 is an exhibit, an e-mail of December 9, 2006
 21 from Susan Bonnell to a number of individuals
 22 including yourself and Ms. Bussey from your
 23 firm. The attachments are--and they're all
 24 listed there. She writes, "hello again.
 25 Following conversations with Nash, Heather,

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1 Dan and Oscar, I've revised the original
 2 drafts in anticipation for a meeting at 1:00
 3 p.m. today. We can make further revisions at
 4 that point. I will bring copies with me.
 5 Please note that I have added speaking points
 6 to the slides, especially for Oscar, less so
 7 for Kara and Nash. I guess the most
 8 significant change we'll note from the
 9 original materials is the lack of reference to
 10 a "rate of error". We can anticipate this
 11 will be a major pressing point with the
 12 media"--and she goes on to talk about it and
 13 then she speaks about "Re: the dead, we must
 14 also be prepared"--and she speaks about that.
 15 Mr. Boone, what, if anything, are you in a
 16 position to tell the Commissioner about what
 17 you recall about what could or couldn't be
 18 said to the media in that December 11th
 19 briefing?
 20 MR. BOONE:
 21 A. Unfortunately I'm going to have to say nothing
 22 on my own, because, as I said before, I gave
 23 advice and maybe going too far to say I gave
 24 advice, advice was given but any advice given
 25 was privilege. Any information conveyed to me

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1 was confidential; unless someone waives it or
 2 establishes a waiver, I can't speak to any of
 3 this.
 4 COFFEY, Q.C.:
 5 Q. No.
 6 MR. BOONE:
 7 A. So unfortunately I can't--now in the meantime,
 8 if you want to pursue with counsel whether or
 9 not I can speak to that, I certainly have no
 10 problem.
 11 COFFEY, Q.C.:
 12 Q. And we'll do that when we break to discuss
 13 that other matter.
 14 MR. BOONE:
 15 A. You're telling me I'm not going home at lunch,
 16 are you?
 17 COFFEY, Q.C.:
 18 Q. You can go home for lunch, I'm just going to
 19 ask that you come back please, okay.
 20 THE COMMISSIONER:
 21 Q. Mr. Coffey, it is close to the lunch hour, so
 22 I suggest you make the place to break soon.
 23 COFFEY, Q.C.:
 24 Q. Yes, why don't we then--in fact, this is a
 25 good spot, so we'll break for lunch and we'll

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1 attend to those matter over the lunch hour,
 2 Commissioner, thank you.
 3 THE COMMISSIONER:
 4 Q. All right then, 2:10.
 5 (ADJOURNED FOR LUNCH)
 6 THE COMMISSIONER:
 7 Q. Please be seated. Mr. Coffey.
 8 COFFEY, Q.C.:
 9 Q. Thank you, Commissioner. If we could, please,
 10 perhaps before I go to the exhibit, Mr. Boone,
 11 before lunch you did indicate to the
 12 Commissioner that, I believe it was the
 13 September 27th, 2005, Ms. Predham--was it Ms.
 14 Predham or Dr. Williams, one or the other, had
 15 made you aware about the external reviews.
 16 You did comment that at some point you became
 17 aware that there were external reviews done.
 18 MR. BOONE:
 19 A. Yes, I think in both occasions, 26th--sorry, I
 20 should back up, the 19th of August when I
 21 spoke to Ms. Predham, I was aware that they
 22 were going to be done, I didn't know by whom
 23 or anything else.
 24 COFFEY, Q.C.:
 25 Q. Uh-hm.

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1 MR. BOONE:
 2 A. On the 26th of September, I had become aware
 3 that they had been done and on the 27th of
 4 September I think Dr. Williams mentioned them
 5 again, that's about it.
 6 COFFEY, Q.C.:
 7 Q. And you've indicated that your normal
 8 arrangement or understanding with Ms. Predham
 9 is that you don't want them, you don't receive
 10 them.
 11 MR. BOONE:
 12 A. No, we don't receive them, no. As acting for
 13 the hospital in defence of a claim, we make it
 14 a point not to review external quality reviews
 15 or peer reviews.
 16 COFFEY, Q.C.:
 17 Q. And in relation to the reviews conducted by
 18 Ms. Wegrynowski and Dr. Banerjee, did you ever
 19 receive them?
 20 MR. BOONE:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And are you able to say when in the context?
 24 MR. BOONE:
 25 A. Yes, after Judge Dymond's decision.

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1 COFFEY, Q.C.:

2 Q. And how about being told about the contents of

3 them, in a summary way of what the reviewers

4 had found?

5 MR. BOONE:

6 A. Very little. I saw some recommendations that

7 I understood might have come out of the

8 review, but I never understood that they were

9 directly from the reviewers as much as they

10 were people's extrapolation of

11 recommendations.

12 COFFEY, Q.C.:

13 Q. And were these these spreadsheets?

14 MR. BOONE:

15 A. No, there was some information, you mentioned

16 an Executive Management meeting I went to on

17 November 21st.

18 COFFEY, Q.C.:

19 Q. Yes, 2006, yes.

20 MR. BOONE:

21 A. I believe at that point in time there was some

22 discussion of that.

23 COFFEY, Q.C.:

24 Q. Okay, and that's the one where there was the

25 ER/PR presentation?

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1 MR. BOONE:

2 A. The slide presentation by Dr. Denic and Dr.

3 Laing and I can't remember who else.

4 COFFEY, Q.C.:

5 Q. Okay, so at that point there was some

6 discussion about--and some kind of a listing

7 of recommendations that you saw at that point.

8 MR. BOONE:

9 A. That's right.

10 COFFEY, Q.C.:

11 Q. Okay, if we could please look at Exhibit P-

12 0926? And this is, in terms of your

13 involvement in the matter, this is an e-mail

14 of July 19th, 2005 at 8:22 a.m. from Ms.

15 Predham to a number of individuals and I just

16 want to take you through some of this and ask

17 you some questions.

18 MR. BOONE:

19 A. Okay.

20 COFFEY, Q.C.:

21 Q. "I had a long conversation with

22 representatives from HIROC yesterday evening"-

23 -that would be Ms. Predham--"as a bit of

24 background they are currently defending a

25 class action lawsuit against Health Labrador

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1 re: processing of equipment. Apparently the

2 aspect of this lawsuit in which they are most

3 vulnerable was the method that people were

4 informed. Ches Crosbie has alleged in the

5 lawsuit that people suffered significant and

6 mental anguish from the way they were told and

7 that the risk of disease from their exposure

8 did not warrant the stress and anxiety they

9 suffered by being told. The organization felt

10 the need to disclose publicly, ran it by their

11 legal counsel and then wrote letters to every

12 person affected and sent out a news release

13 (sound familiar??). Their vulnerability

14 comes from a lack of weighing out the risk

15 from the exposure verses the anxiety of being

16 told about it. In this case, the risk from

17 the exposure was very small. This leads to

18 our situation, it's not that they don't want

19 us to disclose, they just don't want us to

20 disclose until we are sure of our facts. I've

21 had a quick voice mail from Dan after my chat

22 with HIROC. They contacted him after they

23 hung up from me reiterating this and that they

24 will be in touch again in the morning. So I

25 guess we will have to re-evaluate where we are

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1 before we plan to send those letters, et

2 cetera. Should we chat about this face to

3 face? Signed Heather." Mr. Boone, the voice

4 mail from yourself--or that you left that time

5 to Heather Predham and what she describes as

6 re-iterating this, which presumably is -

7 MR. BOONE:

8 A. I wouldn't have known what I was reiterating,

9 so -

10 COFFEY, Q.C.:

11 Q. And I appreciate you wouldn't know it, do you

12 recall what it was you said in the voice

13 message that you left?

14 MR. BOONE:

15 A. No, I'd really have to say I'd be speculating

16 significantly if I did that. I mean, I've

17 read this e-mail before, I've tried to use

18 this e-mail to refresh my memory. I don't

19 believe that I have any recollection of what I

20 actually said in the voice mail except for I

21 might have said--I'd be speculating, I think.

22 COFFEY, Q.C.:

23 Q. Okay, and in relation to this, the reference

24 to here "where we are before we plan to send

25 those letters, et cetera." Now, on the 19th

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1 of July, the 20th or 21st of July of 2005, did
 2 you become aware that Easter Health in--
 3 proposed to and in fact intended or planned to
 4 send letters to individual patients?
 5 MR. BOONE:
 6 A. I'm pretty certain I answered that question
 7 this morning because I told you that at the
 8 time that I went to the meeting on the 19th, I
 9 was aware that they were planning some form of
 10 communication with patients and perhaps an
 11 even broader communication. Did I become
 12 aware that there were letters? I really can't
 13 recall when I became aware that there were. I
 14 didn't see any letters, I didn't see any
 15 communications that were in draft of anything
 16 of the sort.
 17 COFFEY, Q.C.:
 18 Q. And can you tell the commissioner by what
 19 point in time you were aware that there was a
 20 plan to send letters? Just kind of thinking
 21 it through in terms of well, by a certain
 22 point in time I must have known that they
 23 planned to send letters.
 24 MR. BOONE:
 25 A. You have to remember that after the 19th of

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1 July, I went to two meetings. I don't recall
 2 the letters, you know, the subject of letters
 3 to patients or anything else really being
 4 discussed at those meetings. I recall generic
 5 discussions, if you like, of broad based
 6 disclosure which, you know, could have meant
 7 letters, could have meant anything, but I
 8 don't recall the actual specific question as
 9 to whether or not there were letters drafted
 10 being discussed. I don't remember it anyway.
 11 COFFEY, Q.C.:
 12 Q. Now, if we can look, please, at Exhibit P-
 13 2940, page 12 and these are notes of Ms.
 14 Predham which were provided relatively
 15 recently to the Commission and this is dated
 16 July 20th, there's a reference to Dr. Williams
 17 you'll see.
 18 MR. BOONE:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. And there's also a reference to--she says
 22 "Sunday afternoon" and I gather, if I recall
 23 correctly, she told the Commissioner that may
 24 have had something to do with a plan meeting
 25 for Sunday. "Dan, media release".

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1 MR. BOONE:
 2 A. I see that.
 3 COFFEY, Q.C.:
 4 Q. Yes. "QI would be notifying patients if there
 5 is a problem with what we did"--there's a
 6 blank--well actually it's "If there's a
 7 problem with what we did, by making an
 8 exposure, will we create a"--blank--"can't
 9 expect HIROC to pay for it."
 10 MR. BOONE:
 11 A. Are you sure that word is "exposure". I don't
 12 read it that way.
 13 COFFEY, Q.C.:
 14 Q. Well, can you think of -
 15 MR. BOONE:
 16 A. I can't think of anything else it would be,
 17 but it doesn't really look like that to me. I
 18 presume that you've had evidence on that
 19 point.
 20 COFFEY, Q.C.:
 21 Q. Yes, and "someone else is going", and it's
 22 hard to know what that -
 23 MR. BOONE:
 24 A. It looks like "going out" to me.
 25 COFFEY, Q.C.:

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1 Q. Going out. So do you recall discussing with
 2 Ms. Predham any of these topics at that point
 3 in time, July 19th and 20th.
 4 MR. BOONE:
 5 A. The Sunday afternoon, I presume--I'll just
 6 take it from the top.
 7 COFFEY, Q.C.:
 8 Q. Yes.
 9 MR. BOONE:
 10 A. The Sunday afternoon, I presume, refers to the
 11 meeting that eventually took place on Sunday
 12 morning. It says, "Dan, media release". I
 13 would presume that that was some expectation I
 14 was going to review one. I obviously wasn't
 15 going to draft one. I didn't. I don't recall
 16 being asked to do it. I'm pretty certain I
 17 was not. "QI notifying patients", I really
 18 don't know what that means. "If there is a
 19 problem with what we did", I don't know what
 20 that means. I don't know what any of the rest
 21 of it means, quite frankly. I've never seen
 22 it before except when it came in evidence in
 23 the inquiry last week.
 24 COFFEY, Q.C.:
 25 Q. Well, did you ever--do you recall ever

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1 discussing the topic which is referred to
 2 there, "by making an exposure", I'm going to
 3 suggest that it's exposure, "will we create
 4 a", can't expect HIROC to pay for it, in this
 5 case probably in the context, "A cause of
 6 action, can't expect HIROC", who is your
 7 client, to pay for it. Do you recall that
 8 coming up on July 19th or 20th with Ms.
 9 Predham?
 10 MR. BOONE:
 11 A. Okay, I guess I'll put it this way, I think
 12 you've made some conclusions as to what that
 13 means, and I presume they're supported by the
 14 evidence, I don't know if they are or not,
 15 because I certainly don't read into it what
 16 you apparently are reading into it, so when
 17 you say the topic, maybe you can be more
 18 precise and ask me -
 19 COFFEY, Q.C.:
 20 Q. Do you recall the topic of HIROC, if Eastern
 21 Health did something such as send out letters
 22 -
 23 MR. BOONE:
 24 A. Right.
 25 COFFEY, Q.C.:

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1 Q. When you look back at that July 19th e-mail,
 2 it certainly spells of the idea of sending
 3 letters.
 4 MR. BOONE:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. Labrador, and so on.
 8 MR. BOONE:
 9 A. Yes, yeah. It doesn't say HIROC knew about
 10 it, but certainly Eastern Health talks about
 11 it.
 12 COFFEY, Q.C.:
 13 Q. Did the topic come up on July 19th or 20th
 14 that you recall between yourself and Ms.
 15 Predham, or anyone else for that matter
 16 involving Eastern Health, connected with the
 17 idea that HIROC would refuse to pay for
 18 something that Eastern Health did which HIROC
 19 had cautioned against?
 20 MR. BOONE:
 21 A. No, I'm absolutely certain it didn't come up.
 22 COFFEY, Q.C.:
 23 Q. Did the topic come up about--did you give or
 24 were you asked about, and to your knowledge,
 25 was HIROC asked about whether or not Eastern

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1 Health should communicate with individual
 2 patients directly by phone call or by letter?
 3 MR. BOONE:
 4 A. When?
 5 COFFEY, Q.C.:
 6 Q. July 19th or 20th?
 7 MR. BOONE:
 8 A. No.
 9 COFFEY, Q.C.:
 10 Q. The reference in the e-mail--if we could look
 11 at P-0926. Here, that last larger paragraph
 12 says, "This leads to our situation. It's not
 13 that they don't want us to disclose, they just
 14 don't want us to disclose until we are sure of
 15 our facts".
 16 MR. BOONE:
 17 A. Uh-hm.
 18 COFFEY, Q.C.:
 19 Q. Do you recall that coming up?
 20 MR. BOONE:
 21 A. Yeah, I think that was--what I said to you
 22 before that I don't have a great recollection
 23 of either Mike Boyce and Ellen Morton's voice
 24 mail to me, or mine to Heather. I do recall
 25 that being part of what they talked about,

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1 being sure of the facts.
 2 THE COMMISSIONER:
 3 Q. "They" being?
 4 MR. BOONE:
 5 A. Sorry, Mike and Ellen, Mike Boyce and Ellen
 6 Morton.
 7 COFFEY, Q.C.:
 8 Q. Sure of what facts? Did you have any
 9 understanding of what facts?
 10 MR. BOONE:
 11 A. I certainly wouldn't have when I got the phone
 12 call because I knew very little at this time.
 13 As I got to the meeting on the 19th, and that
 14 meeting concluded, I would have presumed that
 15 the facts about which they needed to be sure
 16 were whether or not they had a problem which
 17 could affect a broad group of patients. I
 18 mean, that would seem to me to be a fact that
 19 would be necessary to know before you disclose
 20 to those people.
 21 COFFEY, Q.C.:
 22 Q. How about if you disclosed publicly?
 23 MR. BOONE:
 24 A. Sorry?
 25 COFFEY, Q.C.:

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1 Q. How about publicly?

2 MR. BOONE:

3 A. I would -

4 COFFEY, Q.C.:

5 Q. Disclose to the people is one thing, to

6 disclose publicly -

7 MR. BOONE:

8 A. I would think even more so, yeah.

9 COFFEY, Q.C.:

10 Q. Now here in this e-mail, Ms. Predham seems to

11 analogize between the Health Labrador

12 situation and she frames that this leads us to

13 our situation, Eastern Health's at the time.

14 What would be the concern about Eastern Health

15 disclosing without being sure of the facts?

16 MR. BOONE:

17 A. As I outlined to you before, the concern that

18 I would have had, which I presume and I'm

19 fairly certain was also the concern that HIROC

20 had, was the possibility of a negligent

21 notification because there is in the case law

22 something know as a negligent notification.

23 In other words, you tell some people, a group

24 of people that a problem may have occurred,

25 may affect them, cause them distress and

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1 anxiety as a consequence of it before you've

2 done your due diligence to determine whether

3 or not there is or is not a problem. That

4 would be the concern that I would have had.

5 COFFEY, Q.C.:

6 Q. And HIROC having so informed Eastern Health,

7 if Eastern Health went ahead, anyway, without

8 being sure of their facts, what situation

9 would then ensue?

10 MR. BOONE:

11 A. In what respect?

12 COFFEY, Q.C.:

13 Q. Well, if they went ahead and were--did perform

14 a negligent disclosure.

15 MR. BOONE:

16 A. Right.

17 COFFEY, Q.C.:

18 Q. Or was something that was alleged to be a

19 negligent exposure--disclosure, would they

20 then be subject to being sued?

21 MR. BOONE:

22 A. I would presume.

23 COFFEY, Q.C.:

24 Q. And in that context here, would there be some

25 concern possibly about HIROC paying for it?

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1 MR. BOONE:

2 A. Concern on who's part?

3 COFFEY, Q.C.:

4 Q. Well -

5 MR. BOONE:

6 A. Mine or HIROC's?

7 COFFEY, Q.C.:

8 Q. HIROC's, Eastern Health, either one?

9 MR. BOONE:

10 A. I'll put it to you this way, coverage was

11 never an issue here. As far as I can see in

12 this whole series of events, I can never see a

13 point in time when it could have been

14 considered that if Eastern Health acted when

15 it felt it ought to, that it wouldn't be

16 covered under its policy. I certainly know of

17 no condition of the policy which would have

18 led to anybody to have that belief, and I can

19 tell you that from experience, just because

20 they don't take, for instance, my direction,

21 it certainly wouldn't resonate or result in a

22 denial of coverage. I know of no principle of

23 insurance law or condition of the HIROC policy

24 which would lead to that.

25 COFFEY, Q.C.:

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1 Q. How about if they went ahead on the 19th,

2 unsure of their facts and made a disclosure,

3 anyway?

4 MR. BOONE:

5 A. Well, that would be an event of coverage, not

6 an event of denial of coverage.

7 COFFEY, Q.C.:

8 Q. Despite HIROC having cautioned them against

9 doing so?

10 MR. BOONE:

11 A. I think maybe you're using--caution is too

12 strong a term.

13 COFFEY, Q.C.:

14 Q. Advised them against doing so?

15 MR. BOONE:

16 A. I mean, you're using the term "caution" in the

17 same manner in which you might suggest that

18 some enforcement official would caution

19 somebody. That's not the way, in my

20 experience, that HIROC works or HIROC's

21 counsel works with its subscribers. You have

22 to remember that HIROC is -

23 COFFEY, Q.C.:

24 Q. And -

25 MR. BOONE:

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

20 COFFEY, Q.C.:

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

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

9 MR. BOONE:

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

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

7 COFFEY, Q.C.:

8 Q. And then I take it then there's nothing in
 9 your dealings with Ms. Predham on the 19th or
 10 20th of July 2005 that you can recall,
 11 anything you might have said or done, that
 12 could have led her to the conclusion that you
 13 can't expect HIROC to pay for it?

14 MR. BOONE:

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

19 COFFEY, Q.C.:

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

22 MR. BOONE:

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

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1 COFFEY, Q.C.:

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

10 MR. BOONE:

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

15 COFFEY, Q.C.:

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

19 MR. BOONE:

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

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1 think of that I would have said to her that
 2 would have led her to think that that was the
 3 case.
 4 COFFEY, Q.C.:
 5 Q. Okay. Thank you very much, Mr. Boone. Those
 6 are my questions.
 7 MR. BOONE:
 8 A. Thank you.
 9 THE COMMISSIONER:
 10 Q. Mr. Pritchard?
 11 MR. PRITCHARD:
 12 Q. Thank you, Commissioner. I don't have any
 13 questions for this witness. Thank you for
 14 your evidence, Mr. Boone.
 15 THE COMMISSIONER:
 16 Q. Mr. Simmons?
 17 MR. SIMMONS:
 18 Q. I have no questions, thank you, Commissioner,
 19 Mr. Boone.
 20 THE COMMISSIONER:
 21 Q. Mr. Browne?
 22 BROWNE, Q.C.:
 23 Q. No questions, Commissioner. Thank you for
 24 your evidence, Mr. Boone.
 25 THE COMMISSIONER:

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1 Q. Mr. Eaton?
 2 EATON, Q.C.:
 3 Q. No questions, Commissioner.
 4 THE COMMISSIONER:
 5 Q. As tempting as it is, Mr. Eaton? Ms. Newbury?
 6 MS. NEWBURY:
 7 Q. No questions.
 8 THE COMMISSIONER:
 9 Q. Mr. Glaspell?
 10 MR. GLASPELL:
 11 Q. No questions.
 12 THE COMMISSIONER:
 13 Q. I think you have the record, Mr. Boone, and I
 14 don't think there could be anything arising
 15 out of no questions, Mr. Coffey.
 16 COFFEY, Q.C.:
 17 Q. (Unintelligible). No, thank you.
 18 THE COMMISSIONER:
 19 Q. Okay then. Thank you very much, Mr. Boone,
 20 for your assistance.
 21 MR. BOONE:
 22 A. Thank you.
 23 THE COMMISSIONER:
 24 Q. Is the next witness ready? We think?
 25 COFFEY, Q.C.:

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1 Q. Ms. Chaytor is up next.
 2 THE COMMISSIONER:
 3 Q. All right then. Mr. Glaspell, I suspect you
 4 won't want to be staying with us, so I just
 5 wish you a bon voyage and thank you.
 6 MR. GLASPELL:
 7 Q. Thank you very much.
 8 THE COMMISSIONER:
 9 Q. Now sir, if you'd just come up to this seat.
 10 Thank you. Ms. Chaytor?
 11 CHAYTOR, Q.C.:
 12 Q. The next witness is Joseph White.
 13 THE COMMISSIONER:
 14 Q. All right then, thank you.
 15 MR. JOSEPH WHITE, SWORN, EXAMINATION BY SANDRA CHAYTOR,
 16 Q.C.
 17 REGISTRAR:
 18 Q. Would you please state and spell your complete
 19 name for the Commission?
 20 MR. WHITE:
 21 A. Joseph White, J-O-S-E-P-H W-H-I-T-E.
 22 REGISTRAR:
 23 Q. Thank you.
 24 THE COMMISSIONER:
 25 Q. Thank you, Mr. White.

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1 CHAYTOR, Q.C.:
 2 Q. Good afternoon, Mr. White.
 3 MR. WHITE:
 4 A. Good afternoon.
 5 CHAYTOR, Q.C.:
 6 Q. Commissioner, there's two new exhibits this
 7 afternoon, P-3580 and P-3581.
 8 THE COMMISSIONER:
 9 Q. Entered.
 10 EXHIBITS ENTERED AND MARKED P-3580 AND P-3581
 11 CHAYTOR, Q.C.:
 12 Q. Mr. White, perhaps you can begin by telling
 13 the Commissioner, what is your occupation?
 14 MR. WHITE:
 15 A. Generally referred--I'm self-employed,
 16 generally referred to as field service
 17 technician, field service rep, or field
 18 service engineer. Take your pick, they all
 19 mean the same thing.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and what is it that you service?
 22 MR. WHITE:
 23 A. For the last 20 years, I've been servicing lab
 24 equipment in the hospitals.
 25 CHAYTOR, Q.C.:

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1 Q. And so that's been 20 years you've been doing
 2 that?
 3 MR. WHITE:
 4 A. Yeah.
 5 CHAYTOR, Q.C.:
 6 Q. And lab equipment here in the hospitals in St.
 7 John's?
 8 MR. WHITE:
 9 A. I've serviced lab equipment in every hospital
 10 in the province.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, and what type of equipment would you
 13 service in the labs?
 14 MR. WHITE:
 15 A. Basically anything with a plug. I've serviced
 16 chemistry analyzers, hematology analyzers,
 17 blood gas analyzers, tissue processors,
 18 microtomes, microscopes, anything else you
 19 can--everything basically in the labs.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and so in terms of then servicing
 22 microscopes here in the City of St. John's,
 23 have you ever had any concern in doing that as
 24 to the level of maintenance carried out on the
 25 equipment?

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

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1 specimen at the same time. In any case, this
 2 was a single-head scope. I believe it was an
 3 ICON 11 fosco (phonetic), about 25 years old.
 4 The age of it is not important because
 5 microscopes last a long time. I checked the
 6 optics on the microscope and they were about
 7 40 percent contaminated, and they wanted it
 8 fixed. There's not much that I can't fix when
 9 it comes to a microscope, but this was like
 10 absolutely disgusting, for lack of a better
 11 word.
 12 CHAYTOR, Q.C.:
 13 Q. And where was this microscope located?
 14 MR. WHITE:
 15 A. It was in--just outside the OR.
 16 CHAYTOR, Q.C.:
 17 Q. So it was in a room just outside the OR?
 18 MR. WHITE:
 19 A. Yes, that's correct.
 20 CHAYTOR, Q.C.:
 21 Q. And did you check the microscope to see
 22 whether or not it had any stickers or labels
 23 on it to indicate when it had last been
 24 maintained or serviced?
 25 MR. WHITE:

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

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1 MR. WHITE:
 2 A. He told me he had no money, and he had no
 3 replacement scope for it.
 4 CHAYTOR, Q.C.:
 5 Q. And were you able to be of any further
 6 assistance?
 7 MR. WHITE:
 8 A. I said to Barry, "well, if you want," I said,
 9 "I'll go speak to Terry. Maybe there's
 10 something that Terry can do." It was very
 11 important. He said "you can if you wish." I
 12 went to Terry's office. He just happened to
 13 be in. You very seldom see Terry in his
 14 office.
 15 CHAYTOR, Q.C.:
 16 Q. So you know them well enough to be calling
 17 them Barry and Terry? They're well known to
 18 you over the years, I take it?
 19 MR. WHITE:
 20 A. Well, 20 years, I've never called him Mr.
 21 Gulliver or Mr. Dyer.
 22 CHAYTOR, Q.C.:
 23 Q. And I take it you were frequent in the lab, so
 24 you were well known to them?
 25 MR. WHITE:

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

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

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

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1 would think they had money left to buy
 2 equipment or do maintenance or whatever the
 3 case was. And they would tell you that they
 4 didn't have 2003's budget. I mean, that's--
 5 and this didn't happen on one occasion. This
 6 happened over a period of several years and
 7 several different managers told me the same
 8 thing.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. And Mr. White, would you have
 11 interactions with other laboratory staff
 12 besides Mr. Gulliver and Mr. Dyer? Would you
 13 interact with the other staff? For example,
 14 the staff working the microtomes, would you
 15 have occasion to speak to them?
 16 MR. WHITE:
 17 A. Every time I would walk into a lab, I spoke to
 18 every single person that I met. And a lot of
 19 times, the lab techs, if they were doing
 20 something or they had a problem with a
 21 microscope or a microtome, they would stop me
 22 in the hall and ask me if they could make--if
 23 I could make a small adjustment or what do you
 24 think of this or what do you think of that?
 25 Under normal circumstances, I would do that.

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1 If it required a lot of work, I would go to
 2 Barry or Terry and tell them I needed a
 3 purchase order to spend an extended period of
 4 time to fix something.
 5 CHAYTOR, Q.C.:
 6 Q. And did you ever have occasion where you
 7 determined that the microtomes, for example,
 8 needed to be serviced and you brought that to
 9 the attention of Mr. Dyer, but was told, for
 10 example, like you've just indicated, that
 11 there's no funding, that they don't have any
 12 funding left in their current budget? Did
 13 that ever happen with respect to the
 14 microtomes?
 15 MR. WHITE:
 16 A. I'm not really sure, it's possible, not that I
 17 remember.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. And in terms of--have you carried out
 20 maintenance on the microtomes over the years?
 21 MR. WHITE:
 22 A. I did maintenance on the microtomes twice a
 23 year since 1989, right up until last year, I
 24 guess, when this Inquiry started, the policies
 25 changed and I believe technical services at

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1 the University now, they're providing the
 2 maintenance on the microscopes and microtomes.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And what do you understand to be the
 5 importance of a microtome in the lab and the
 6 importance for it to be operating properly and
 7 well maintained?
 8 MR. WHITE:
 9 A. Just to give you a general idea, the pathology
 10 lab at the Health Sciences is, without
 11 question, the busiest lab in this province.
 12 I've been in every lab and there's no
 13 comparison. There's not enough room; there's
 14 not enough technologists; there's not enough
 15 equipment; and there's not enough money, in my
 16 humble opinion. Those microtomes are worked
 17 to death. Manufacturers will tell you that
 18 these instruments will last seven to ten
 19 years. Under normal circumstances, in a
 20 medium to low throughput lab, sure, they
 21 will. At the Health Sciences, no, in my--they
 22 should be replaced every five years, whether
 23 they're working or not. They're just wore out
 24 basically and the tissue processors, the same
 25 thing. They shouldn't be over in those labs

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

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1 guy--and this is just not for pathology, this
 2 includes all the labs, chemistry, hematology,
 3 bactine (phonetic) and so on where you need
 4 general maintenance, daily routine
 5 maintenance. There should be somebody on
 6 staff who does that on a regular basis so the
 7 lab techs are not tasked to do it.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. And Mr. White, in the circumstances
 10 where you did have occasion to speak to Mr.
 11 Dyer and/or Mr. Gulliver about feeling that
 12 maintenance needed to be carried out and they
 13 weren't in a position to do so because of
 14 funding issues, what happened in those
 15 circumstances?
 16 MR. WHITE:
 17 A. Two occasions and this would have been around
 18 2003 to 2005, I provided service work to the
 19 lab, some minor service work, maybe an hour's
 20 labour. I was told beforehand that they had
 21 no money to pay for any maintenance and I
 22 don't know if this was Barry Dyer, it may have
 23 been Barry, there was no money to get any
 24 maintenance done and lab techs probably
 25 stopped me in the hall and asked me for

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1 maintenance and I mentioned it to them. They
 2 had no money to get it done. So, in any case,
 3 I would provide the service and wait until the
 4 first of April to get a purchase order.
 5 CHAYTOR, Q.C.:
 6 Q. And bill your services in their new fiscal
 7 year?
 8 MR. WHITE:
 9 A. Yeah.
 10 CHAYTOR, Q.C.:
 11 Q. And that happened on at least two occasions,
 12 you say, that you know of.
 13 MR. WHITE:
 14 A. At least one, maybe two occasions, yeah.
 15 CHAYTOR, Q.C.:
 16 Q. Now, Mr. White, there's a DAKO autostainer
 17 which is of interest to the subject matter of
 18 this Inquiry. Did you ever service the DAKO
 19 autostainer?
 20 MR. WHITE:
 21 A. No, I did no service on that, no.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And at some point, did the autostainer
 24 come into your possession?
 25 MR. WHITE:

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1 A. Yes, it did.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. And perhaps you can tell the
 4 Commissioner then when and under what
 5 circumstances you took possession of the DAKO
 6 autostainer.
 7 MR. WHITE:
 8 A. I believe it was in late 2004, early 2005 and
 9 that's just a general timeframe. I don't know
 10 exactly, somewhere between six and nine months
 11 timeframe. It may have been and I'm not
 12 absolutely positive. It may have been when
 13 the flood happened over at the Health
 14 Sciences, down at the pathology lab. It may
 15 have been, I remember that incident because I
 16 went in one morning and all the ceilings were
 17 down and the maintenance crews were there and
 18 so on. It was around that general timeframe.
 19 I had asked for that instrument on a couple of
 20 occasions and mainly because if I didn't ask
 21 for it, it was going to the landfill and it's
 22 not just the autostainer that would have went
 23 to the landfill. Basically everything that
 24 comes out of that institution goes to the
 25 landfill whether it's working or not.

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1 CHAYTOR, Q.C.:
 2 Q. And so you have asked for it on a couple of
 3 occasions and what were you told?
 4 MR. WHITE:
 5 A. We don't know what we're doing with it yet.
 6 CHAYTOR, Q.C.:
 7 Q. Okay.
 8 MR. WHITE:
 9 A. And I think the last time I had asked Mr.
 10 Gulliver about it, I believe he said he was
 11 checking with the College of the North
 12 Atlantic to see if they could use it with
 13 their lab techs program. And some time after
 14 that I had asked him again because I knew they
 15 had their new instrument in and I knew it was
 16 going to the landfill. And I went in one
 17 morning and I had asked them again and he just
 18 said yeah, go take it, yeah, nobody wants it.
 19 CHAYTOR, Q.C.:
 20 Q. And did you also take possession of the
 21 computer that is used with the autostainer?
 22 MR. WHITE:
 23 A. I didn't think so. I don't mean to be funny
 24 about that, but I've been asked all these
 25 questions over the last month or so. I don't

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1 ever think I had a computer with that
 2 instrument, no.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. Did you pay for the DAKO machine?
 5 MR. WHITE:
 6 A. Pay for it?
 7 CHAYTOR, Q.C.:
 8 Q. Yes, was any money exchanged hands?
 9 MR. WHITE:
 10 A. Absolutely not, no.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And was there any paperwork completed
 13 with respect to you taking it?
 14 MR. WHITE:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. And perhaps we can look at P-3109.
 18 Now, it's going to come up on your screen, Mr.
 19 White.
 20 MR. WHITE:
 21 A. Okay.
 22 CHAYTOR, Q.C.:
 23 Q. And I just want to show you, we have some
 24 photographs attached. We have a letter here
 25 from you, but I'm going to take you to that in

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1 a minute. But this also has some photographs
 2 which we understand to be the condition of the
 3 lab after the flood that you mentioned.
 4 MR. WHITE:
 5 A. That's--yeah.
 6 CHAYTOR, Q.C.:
 7 Q. So, you remember being in the lab around the
 8 time and seeing it -
 9 MR. WHITE:
 10 A. Yeah, I believe there was a couple of weeks
 11 that it took to clean that place up.
 12 CHAYTOR, Q.C.:
 13 Q. Okay.
 14 MR. WHITE:
 15 A. It was a mess.
 16 CHAYTOR, Q.C.:
 17 Q. All right. And you've had a chance--I've
 18 shown you these photographs before.
 19 MR. WHITE:
 20 A. Yeah.
 21 CHAYTOR, Q.C.:
 22 Q. And was the DAKO autostainer in any of those
 23 photos?
 24 MR. WHITE:
 25 A. No, I don't see the autostainer, no.

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1 CHAYTOR, Q.C.:
 2 Q. And when you saw the autostainer and was
 3 interested in taking it, was it in this part
 4 of the lab or where was it? Was it in a
 5 different part? I mean, you can flick
 6 through--do you want me to flick through it
 7 for you? Here's the third picture and I think
 8 that's it.
 9 MR. WHITE:
 10 A. It's very hard to tell by the pictures. It
 11 was in--as far as I can remember, it was in
 12 the main lab where the lab techs do their
 13 cuttings in the morning with the microtomes.
 14 There's normally maybe eight or ten lab techs
 15 there. And at the back of that lab, say, on
 16 the east side of that lab, there's a door and
 17 it joins onto another lab where they had, I
 18 believe, the new Ventana machine. I believe
 19 it sat on a desk, actually, it may have even
 20 been that desk that's right there. It
 21 probably straddled both of them. I'm not
 22 positive. That's just what I think.
 23 CHAYTOR, Q.C.:
 24 Q. It's hard to tell from the photos in terms of
 25 -

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1 MR. WHITE:
 2 A. Yes, it is.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And when you removed the machine, I
 5 take it though, the lab wasn't in this
 6 condition. It was cleaned up from this
 7 condition?
 8 MR. WHITE:
 9 A. I'm not really sure. It might have been in
 10 this condition or it might have been cleaned
 11 up. I'm not positive.
 12 CHAYTOR, Q.C.:
 13 Q. So, there was no concern with you going into
 14 the lab with it in that condition or was there
 15 any -
 16 MR. WHITE:
 17 A. I wouldn't have been concerned about it, no.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. And who was present when you removed
 20 the DAKO autostainer from the lab? You spoke
 21 to Mr. Gulliver and he said, yes--on this
 22 occasion when you asked him--he said it was
 23 okay for you to take it. And then did you
 24 take it that day or was it some period of time
 25 went by before you -

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

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

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

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

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1 it. So, anyway we were on our way home and I
 2 was speaking to you on my cell phone and you
 3 were asking me about the autostainer and you
 4 were asking me if there was a computer. So,
 5 just to confirm that there was no computer, my
 6 son had done the testing, so I turned to him
 7 and I said, do we have a computer with that
 8 instrument. He thought about it for two
 9 seconds and he said, oh yeah, we had to have a
 10 computer in order to run the self test
 11 diagnostics. He caught me by surprise because
 12 I was just after telling you second before
 13 there was no computer.
 14 CHAYTOR, Q.C.:
 15 Q. Yes.
 16 MR. WHITE:
 17 A. So, yeah, there was a computer with that
 18 instrument, yeah.
 19 CHAYTOR, Q.C.:
 20 Q. And I'll take you through that in a little
 21 more detail in a moment. I'm just wondering
 22 though, before you actually took possession of
 23 the autostainer, did you inquire of anyone as
 24 to its condition? You said you knew that
 25 there was a value in it.

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1 MR. WHITE:
 2 A. I'm sorry, Ms. Chaytor, I got off topic that
 3 time.
 4 CHAYTOR, Q.C.:
 5 Q. No, no, that's okay, that's fine. And whether
 6 or not you contacted anyone to see if it had
 7 any repairs over the years.
 8 MR. WHITE:
 9 A. Right.
 10 CHAYTOR, Q.C.:
 11 Q. So, to assure yourself it did have value is
 12 basically what I'm asking.
 13 MR. WHITE:
 14 A. Right. I spoke to the guy who had performed
 15 the maintenance on it over a period of time
 16 from Tech Services. His name is Bruce. And I
 17 thought for sure I had asked him if any major
 18 parts had been replaced on that instrument.
 19 If that was the case, even if the instrument
 20 wasn't working, I could have made money on the
 21 parts. There's a worldwide industry for parts
 22 for lab equipment, just as there is in cars.
 23 And I thought he had told me that the robotic
 24 arm or the robotic head had been replaced at
 25 some point.

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1 CHAYTOR, Q.C.:
 2 Q. And I take it the robotic arm is a significant
 3 component to this machine?
 4 MR. WHITE:
 5 A. It's about 30 percent of the value of the
 6 machine, I would say.
 7 CHAYTOR, Q.C.:
 8 Q. So, that would have made the machine more
 9 valuable to you to know it has a new robotic
 10 arm.
 11 MR. WHITE:
 12 A. If that machine was absolute garbage and there
 13 was a new robotic arm on it, I would have
 14 taken it anyway. I could have sold it for
 15 half the retail price.
 16 CHAYTOR, Q.C.:
 17 Q. And are you able to say if the robotic arm had
 18 failed at any point on the instrument? Do you
 19 have any knowledge as to whether or not the
 20 robotic arm had failed?
 21 MR. WHITE:
 22 A. I thought according to Bruce, at the time, I
 23 had questioned him on it just to see and I
 24 thought that's what he had told me. And as a
 25 matter of fact, last week, I called him and I

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1 asked him if he remembered the autostainer.
 2 He said he did. And I asked him when, not if,
 3 when he replaced the robotic arm and he says
 4 he never had replaced the robotic arm. So,
 5 I'm not sure where I got that -
 6 CHAYTOR, Q.C.:
 7 Q. So, if that were the case, he wasn't the
 8 person who did it or it wasn't done -
 9 MR. WHITE:
 10 A. Well, he told me somebody else was doing the
 11 service on it and I remember seeing work
 12 orders that myself and yourself looked at and
 13 his name is on the work orders and he told me
 14 that he hadn't done any service on that
 15 machine. Now, in the meantime, he may have
 16 misunderstood me, probably thought I was
 17 talking about the Ventana machine which is the
 18 new machine that's there. Because he's now in
 19 another building. I thought about it after
 20 and maybe that's what he thought at the time.
 21 CHAYTOR, Q.C.:
 22 Q. And if the robotic arm had failed, do you know
 23 what might be the implications for any tests
 24 that were being run at the time of -
 25 MR. WHITE:

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1 A. If the robotic arm had failed, there would be
 2 no test. That machine would not operate.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And how would someone operating the
 5 machine know whether or not the robotic arm
 6 had failed?
 7 MR. WHITE:
 8 A. Whether or not it had failed?
 9 CHAYTOR, Q.C.:
 10 Q. Yes.
 11 MR. WHITE:
 12 A. It would just stop.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And if it was causing any kind of
 15 difficulties like interruption in the runs,
 16 was there anything on the machine, any alarm
 17 system, anything, do you know that would
 18 trigger them to know there's an issue with the
 19 robotic arm?
 20 MR. WHITE:
 21 A. Generally speaking, not necessarily for that
 22 instrument, but generally speaking, any kind
 23 of a robotic instrument has stops and limits
 24 that if it goes outside of its stops and
 25 limits or it doesn't fall where it's supposed

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

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1 Q. And you're just looking at find out whether or
 2 not the location of the DAKO is shown here.
 3 MR. WHITE:
 4 A. Okay, excuse me, if you look at the bottom
 5 picture here and you see this sink.
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 THE COMMISSIONER:
 9 Q. Yes.
 10 MR. WHITE:
 11 A. That's up on the back of the lab on the east
 12 side of that lab, towards the front is where
 13 all the lab techs would perform their cuttings
 14 in the morning.
 15 THE COMMISSIONER:
 16 Q. Um-hm.
 17 MR. WHITE:
 18 A. To the left of that sink or just a bit further
 19 back, there would have been a desk and that's
 20 where the autostainer would have sat.
 21 CHAYTOR, Q.C.:
 22 Q. So, back this way from -
 23 MR. WHITE:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. Let's just see now, we'll look at the next
 2 page and see, is it in those photos.
 3 MR. WHITE:
 4 A. No, that's the front of the lab, no.
 5 CHAYTOR, Q.C.:
 6 Q. That's the front, no. And is this the sink?
 7 MR. WHITE:
 8 A. I don't--there's a couple of sinks there. If
 9 you go--right there behind that yellow bag, is
 10 that a yellow bag right there?
 11 CHAYTOR, Q.C.:
 12 Q. That looks like a yellow bag.
 13 MR. WHITE:
 14 A. Right behind that there, there's a shovel and
 15 there's another sink. It would have been just
 16 beyond that, I believe.
 17 CHAYTOR, Q.C.:
 18 Q. And let's just see, here's the other photos.
 19 Nothing in those? No?
 20 MR. WHITE:
 21 A. Actually, could you go back one, please
 22 MR. WHITE:
 23 A. Sure. No, that looks like the gross room.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. And I think one more. Anything in any

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1 of those photos?
 2 MR. WHITE:
 3 A. No, I don't think so.
 4 CHAYTOR, Q.C.:
 5 Q. And if we could have, please Registrar, P-
 6 3112? Mr. White--and it'll come up on the
 7 screen--these are the maintenance records for
 8 the autostainer that we've been provided from
 9 Eastern Health.
 10 MR. WHITE:
 11 A. Okay.
 12 CHAYTOR, Q.C.:
 13 Q. Or certainly some maintenance records. It
 14 says, "there are maintenance records" -
 15 MR. WHITE:
 16 A. Right.
 17 CHAYTOR, Q.C.:
 18 Q. Attached are maintenance records. Whether or
 19 not it's all of them, I don't know if that's
 20 been determined, but, for example, here's the
 21 first one and it says, "Checked hose, cleaned
 22 drain filter".
 23 MR. WHITE:
 24 A. Right.
 25 CHAYTOR, Q.C.:

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1 Q. Would that have anything to do -
 2 MR. WHITE:
 3 A. No, that's just--that's just basic
 4 maintenance. That would be part of a PM or a
 5 weekly check.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and then this one is 1999, March 18th,
 8 1999, is the request date, and this says,
 9 "Fungus lines. Replace lines". What would
 10 that be referring to?
 11 MR. WHITE:
 12 A. That would be from lack of maintenance.
 13 CHAYTOR, Q.C.:
 14 Q. Okay.
 15 MR. WHITE:
 16 A. That's why those lines are changed on a
 17 regular basis is to prevent fungus from
 18 building up in them. So that might have been--
 19 maybe somebody overlooked it, or somebody--
 20 they may have been busy, but if they're left
 21 for any period of time, there's all kinds of
 22 weird and wonderful things that go through
 23 those lines, and if you don't replace them,
 24 you will get fungus.
 25 MR. SIMMONS:

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1 Q. Excuse me, on that one, and I know I'll get a
 2 chance after, but I wonder looking at that
 3 particular record if you can identify maybe
 4 that is the autostainer? Would this be work
 5 on that one?
 6 MR. WHITE:
 7 A. It's a slide stainer.
 8 CHAYTOR, Q.C.:
 9 Q. It's the serial number -
 10 MR. SIMMONS:
 11 Q. See if we can match--okay, thank you.
 12 CHAYTOR, Q.C.:
 13 Q. Yes, we understood from your e-mail these all
 14 were related to the DAKO autostainer.
 15 MR. SIMMONS:
 16 Q. I just saw the reference to the (inaudible).
 17 CHAYTOR, Q.C.:
 18 Q. Okay.
 19 THE COMMISSIONER:
 20 Q. Mr. Simmons, are you questioning that the
 21 serial number is the DAKO in concern?
 22 MR. SIMMONS:
 23 Q. No, I hadn't--I just saw a different reference
 24 (inaudible). For a moment there, I wasn't
 25 sure.

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1 THE COMMISSIONER:
 2 Q. Okay, all right. Thank you.
 3 CHAYTOR, Q.C.:
 4 Q. Because there is--there is a discrepancy in
 5 the serial number, but we've had that
 6 discussion before and I understood this is the
 7 autostainer, though.
 8 THE COMMISSIONER:
 9 Q. Thank you.
 10 CHAYTOR, Q.C.:
 11 Q. There's one digit that was different, and my
 12 understanding is that that's perhaps an error
 13 in these maintenance records, yes. We're on
 14 page six now, sorry, Mr. White, of the
 15 exhibit.
 16 MR. WHITE:
 17 A. Sure.
 18 CHAYTOR, Q.C.:
 19 Q. And this is "tubing".
 20 MR. WHITE:
 21 A. Tygon tubing, that's correct.
 22 CHAYTOR, Q.C.:
 23 Q. Okay, and that's more--is that more just
 24 regular maintenance?
 25 MR. WHITE:

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1 A. General maintenance, yeah.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, I'm sorry, and the date on that one was
 4 into 2000 now, February 7th, 2000, and then
 5 the next one as well, February 17th, 2000, and
 6 this is tubing as well?
 7 MR. WHITE:
 8 A. Uh-hm.
 9 CHAYTOR, Q.C.:
 10 Q. And the next one, October 10th, 2000, and this
 11 is--we see, "B. Cocker". Is that Mr. Cocker?
 12 MR. WHITE:
 13 A. That would be Bruce, yeah.
 14 CHAYTOR, Q.C.:
 15 Q. Bruce Cocker, that you were speaking with.
 16 CHAYTOR, Q.C.:
 17 Q. And it says, "PM completed". So that's your
 18 preventative maintenance, I take it?
 19 MR. WHITE:
 20 A. Preventative maintenance, that's correct.
 21 CHAYTOR, Q.C.:
 22 Q. And then October 4th, 2001, I believe, and
 23 it's Mr. Cocker's name again?
 24 MR. WHITE:
 25 A. Uh-hm.

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1 CHAYTOR, Q.C.:
 2 Q. "Probe not injecting, Due PM", what's that
 3 about?
 4 MR. WHITE:
 5 A. That a problem with the robotic head.
 6 CHAYTOR, Q.C.:
 7 Q. That is?
 8 MR. WHITE:
 9 A. That would be a problem with the robotic head,
 10 yes, as far as I can remember now.
 11 CHAYTOR, Q.C.:
 12 Q. Okay.
 13 MR. WHITE:
 14 A. But many years ago in Grand Falls, I serviced
 15 a similar instrument, and it was--it probably
 16 dispensed something else, I don't remember
 17 exactly, but if the probe is not injecting,
 18 there's not necessarily a problem with the
 19 robotic head, the probe sits in a robotic
 20 head, and there are pumps that would come on
 21 and off at certain segments and would force
 22 fluid up to the robotic head down to your
 23 syringe where it would actually deposit onto
 24 your slides.
 25 CHAYTOR, Q.C.:

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

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

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

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1 however, and completed September 24th. So the
 2 dates, there seems to be an issue with the
 3 dates.
 4 MR. WHITE:
 5 A. Yeah.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. So, Mr. White, you took possession of
 8 the autostainer.
 9 MR. WHITE:
 10 A. Uh-hm.
 11 CHAYTOR, Q.C.:
 12 Q. And you now realize that it included both the
 13 autostainer and the accompanying computer.
 14 What did you do with it?
 15 MR. WHITE:
 16 A. What do you mean, when I disposed of it?
 17 CHAYTOR, Q.C.:
 18 Q. Yeah, once you got it, and you said you
 19 cleaned it up a bit, your son ran some sub-
 20 test diagnostics, I believe you called it?
 21 MR. WHITE:
 22 A. Self-test diagnostics.
 23 CHAYTOR, Q.C.:
 24 Q. Yes, and how long did you have it in your
 25 possession and then what happened to it?

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1 MR. WHITE:
 2 A. I'm guessing it probably would have been no
 3 more than several weeks because I would have
 4 wanted to just get it in, get it out, generate
 5 some revenue from it, that's the only thing I
 6 was looking at.
 7 CHAYTOR, Q.C.:
 8 Q. And you would have gotten it either late 2004
 9 or early 2005?
 10 MR. WHITE:
 11 A. That's just a guess on my part. I think it's
 12 around that general time frame.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, so then you had it for several weeks?
 15 MR. WHITE:
 16 A. Uh-hm.
 17 CHAYTOR, Q.C.:
 18 Q. So then what happened, where did it go from
 19 you?
 20 MR. WHITE:
 21 A. I sold it to a company down in North Carolina.
 22 They are a pathology broker, Southeast
 23 Pathology Instruments, and the guy's name is
 24 Michael Dietrich. He was the owner.
 25 CHAYTOR, Q.C.:

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1 Q. Michael Dietrich, and, Mr. White, how much did
 2 you sell it for?
 3 MR. WHITE:
 4 A. I think about \$4,000.00 including shipping.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, US?
 7 MR. WHITE:
 8 A. US, absolutely.
 9 CHAYTOR, Q.C.:
 10 Q. Now, Mr. White, in the spring and summer of
 11 2005, were you contacted by anyone from
 12 Eastern Health to inquire about the
 13 whereabouts of the DAKO machine and/or its
 14 computer?
 15 MR. WHITE:
 16 A. I don't think so, no.
 17 CHAYTOR, Q.C.:
 18 Q. And when were you first contacted by anyone
 19 from Eastern Health about the DAKO machine?
 20 MR. WHITE:
 21 A. I think Terry Gulliver phoned me--he never
 22 phoned me. I was walking by his office about
 23 five weeks ago, and he was on the phone, his
 24 door was open, and he waved to me more or less
 25 to say that he wanted to speak to me, and I

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1 waited for a second. He got off the phone and
 2 he asked me did I remember the autostainer,
 3 and I said, yeah, I do. He said was there a
 4 computer with it, and I told him, no, there
 5 was no computer. He said are you sure, and I
 6 said, yeah, I'm pretty sure.
 7 CHAYTOR, Q.C.:
 8 Q. Mr. White, would it surprise you if there was
 9 any issue as to the DAKO machine or whether or
 10 not it had been operating properly back in
 11 2005 or whether or not it contained any
 12 records, would it surprise you that you
 13 weren't contacted back then?
 14 MR. WHITE:
 15 A. This is way before the inquiry. I don't know
 16 why somebody would even contact me.
 17 CHAYTOR, Q.C.:
 18 Q. Back in 2005, if--like, June, say, July, 2005,
 19 if there was any question within Eastern
 20 Health as to that DAKO machine, whether or not
 21 it was operating properly, or whether it had
 22 any records on the computer, if any question
 23 arose back then in that time period, shortly
 24 after you'd taken the machine -
 25 MR. WHITE:

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1 A. Yeah.
 2 CHAYTOR, Q.C.:
 3 Q. Are you surprised that nobody would have
 4 contacted you then and said, well, Joe, do you
 5 have the computer or what condition was the
 6 machine in when you got it? The questions I'm
 7 asking you today, are you surprised if those
 8 questions had come up back in 2005, that you
 9 wouldn't have been asked back then about it?
 10 MR. WHITE:
 11 A. I don't think anybody asked me those
 12 questions, but if it had been important, why
 13 wouldn't they ask me.
 14 CHAYTOR, Q.C.:
 15 Q. And I take it, you were around as frequently
 16 as ever?
 17 MR. WHITE:
 18 A. No, actually there was a period of time there
 19 where I was in a traffic accident about four
 20 years ago, and it really did a number on me
 21 physically and I was in there infrequently.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. So when would that have been?
 24 MR. WHITE:
 25 A. That would have been four years ago this

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1 January.
 2 CHAYTOR, Q.C.:
 3 Q. So back in the summer of 2005, would you have
 4 been around to be asked about -
 5 MR. WHITE:
 6 A. Possibly not.
 7 CHAYTOR, Q.C.:
 8 Q. And were you otherwise--had you moved, were
 9 you around? Like, if anyone from Eastern
 10 Health wanted to track you down, you know,
 11 Terry and Barry very well, would you have been
 12 around for them to be able to call?
 13 MR. WHITE:
 14 A. I had a cell phone.
 15 CHAYTOR, Q.C.:
 16 Q. And I take it they have your number?
 17 MR. WHITE:
 18 A. They know where to get me pretty well 24 hours
 19 a day if they need me.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and the first time you were asked any
 22 question about the DAKO machine was five weeks
 23 ago, around five weeks ago?
 24 MR. WHITE:
 25 A. Yeah, as far as I can remember, yeah.

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1 CHAYTOR, Q.C.:
 2 Q. And did you ask Mr. Gulliver why this is an
 3 issue now, why he was asking you about it?
 4 MR. WHITE:
 5 A. I knew the inquiry was on the go. I thought
 6 if there was a computer, that the issue would
 7 have been a privacy issue, and that's why
 8 everybody was--everybody, well, you guys, and
 9 Terry was asking about the computer. I mean,
 10 fair enough, if it was a privacy issue, then I
 11 would have been concerned whether or not the
 12 hard drive was formatted, so if there was any
 13 patient files on it, then it wasn't easily
 14 accessible.
 15 CHAYTOR, Q.C.:
 16 Q. Yes, and so you had told Mr. Gulliver that.
 17 He'd asked you whether or not you also had the
 18 computer and you told him that you didn't
 19 think you had the computer?
 20 MR. WHITE:
 21 A. Uh-hm.
 22 CHAYTOR, Q.C.:
 23 Q. And you've told us about how you realized
 24 otherwise.
 25 MR. WHITE:

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

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1 White has confirmed that he only took the DAKO
 2 instrument and not the old PC. There were no
 3 records kept with the DAKO machine's hard
 4 drive. There are also no records/discs from
 5 the old PC anywhere in the lab. We can only
 6 assume that when the PC was discarded after
 7 the flood, any disc/paper records went with
 8 it". So I take it, Mr. White, you told Mr.
 9 Gulliver that you only took the instrument,
 10 not the old computer, not the old PC?
 11 MR. WHITE:
 12 A. Yeah, see at the time, the only thing that
 13 would have been of any interest to me was the
 14 instrument itself, and not the accessories
 15 that went with it.
 16 CHAYTOR, Q.C.:
 17 Q. Okay.
 18 MR. WHITE:
 19 A. So I probably took--the computer was probably
 20 with it, it may have been physically plugged
 21 into it, but I--I still don't remember to this
 22 day having the computer with it.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and the--whether or not the--I take it
 25 you weren't the source of the information in

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

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

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1 in the lab?
 2 MR. WHITE:
 3 A. No, no, Barry Dyer would have asked me about
 4 it first.
 5 CHAYTOR, Q.C.:
 6 Q. Barry asked you about it first?
 7 MR. WHITE:
 8 A. Yeah.
 9 CHAYTOR, Q.C.:
 10 Q. And what did Mr. Dyer ask you when he
 11 contacted you? Was that a phone conversation
 12 or -
 13 MR. WHITE:
 14 A. No, no, I was walking by again one day.
 15 CHAYTOR, Q.C.:
 16 Q. Okay.
 17 MR. WHITE:
 18 A. And Barry had stopped me and he asked me--he
 19 told me got an e-mail, I guess from somebody
 20 at the inquiry, maybe it was yourself, and
 21 someone was looking for the whereabouts of the
 22 autostainer, or who took it, or something
 23 along those lines, and he asked me if I could
 24 write a note just saying that I had taken it
 25 at some point in time, whenever that might

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1 have been, and he may have asked me what I did
 2 with it at the time, but according to this
 3 note here, it was just--it's just the time
 4 frame in which I actually removed the
 5 instrument.
 6 CHAYTOR, Q.C.:
 7 Q. So Mr. Dyer asked you if you'd write a note?
 8 MR. WHITE:
 9 A. Uh-hm.
 10 CHAYTOR, Q.C.:
 11 Q. And what did you understand you had to write
 12 in your note?
 13 MR. WHITE:
 14 A. Just that I had taken it in a certain period
 15 of time.
 16 CHAYTOR, Q.C.:
 17 Q. And did he make any inquiries of you as to
 18 where did the machine go or what you did with
 19 it after having taken possession of it?
 20 MR. WHITE:
 21 A. No, I don't think so.
 22 CHAYTOR, Q.C.:
 23 Q. So it was just as to the fact you had taken it
 24 and the time period that you had taken it?
 25 MR. WHITE:

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

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1 to Southeast Pathology, did you have any
 2 records as to when that happened?
 3 MR. WHITE:
 4 A. No, I didn't, no.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, and do you know--you thought you kept it
 7 for several weeks. Do you have any idea as to
 8 when that sale took place to Southeast
 9 Pathology?
 10 MR. WHITE:
 11 A. If I took it in late 2004, it would--depending
 12 on whether it was December or November, if I
 13 took it in November, I probably sold it in
 14 December, if I--if it was early 2005, say
 15 January, February, March, probably say within
 16 a month of either one of those months, and
 17 again, I'm only guessing. I don't know the
 18 exact time frame.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, and when you were first contacted by Mr.
 21 Dyer about this, did he seem to have any
 22 knowledge about you having the machine or did
 23 it seem to be news to him that you had the
 24 machine?
 25 MR. WHITE:

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1 A. I think he--I'm not sure.
 2 CHAYTOR, Q.C.:
 3 Q. And the date of the letter being September
 4 17th, 2008, is that the same day that Mr. Dyer
 5 contacted you or -
 6 MR. WHITE:
 7 A. No, it probably would have been the day
 8 before.
 9 CHAYTOR, Q.C.:
 10 Q. So he probably contacted you on the 16th,
 11 you're saying?
 12 MR. WHITE:
 13 A. I think, well, that day I was in the lab was
 14 probably on the 16th, he had asked me for
 15 something or whatever, that I sent it to him,
 16 but I mean, I would have to go home to my
 17 computer and do it up and then the next day
 18 bring it back to him.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, and you're sure though that's the date
 21 you wrote the letter, September 17th?
 22 MR. WHITE:
 23 A. Well, that should be accurate.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, and then did you drop the letter off the

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

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

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1 said that when he took it, he cleaned it up, a
 2 few minor repairs, performed diagnostic check
 3 and preventive maintenance. At some point, he
 4 sold it to a surplus equipment place and he
 5 thinks it is in Bermuda/Bahamas.'" Do you
 6 recall giving that information to Mr.
 7 Gulliver?
 8 MR. WHITE:
 9 A. I don't recall it. That's not to say that I
 10 didn't give it to him. I don't remember
 11 giving anybody that information.
 12 CHAYTOR, Q.C.:
 13 Q. And this would have just been, well, a month
 14 ago, September 22nd. So you don't remember
 15 telling that to Mr. Gulliver?
 16 MR. WHITE:
 17 A. I may have. I don't recall a conversation,
 18 but he may have asked me some questions about
 19 it.
 20 CHAYTOR, Q.C.:
 21 Q. Is there any reason why you would tell him
 22 Bermuda or Bahamas?
 23 MR. WHITE:
 24 A. Absolutely not, no.
 25 CHAYTOR, Q.C.:

1 Q. Okay, and -
 2 MR. WHITE:
 3 A. No, because I wouldn't have--I wouldn't have
 4 known. I had to go back and check when you
 5 called me, I think the next day I had to phone
 6 to find out where it actually went to.
 7 CHAYTOR, Q.C.:
 8 Q. Where it went after you--you sold it to the
 9 States. I take it you remembered that?
 10 MR. WHITE:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. And Southeast Pathology, you knew that?
 14 MR. WHITE:
 15 A. Um-hm.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, all right, and then you had to go and
 18 check and do what, after I phoned and asked
 19 you about it?
 20 MR. WHITE:
 21 A. After I spoke to you on the phone that day on
 22 my way home, I phoned Southeast Pathology the
 23 next day. I spoke to Michael Dietrich, he was
 24 the owner. I asked him if he remembered me,
 25 because I hadn't spoken to him since I sold

1 Virginia and I asked him if there was anything
 2 on the purchase order that would indicate
 3 there was a computer. He said no. So I still
 4 wasn't convinced there was a computer, even
 5 though my son told me it was there. I asked
 6 him if he had a contact name, e-mail,
 7 telephone number for the University of Western
 8 Virginia where it was sold to. He gave me
 9 that information.
 10 The same day, I believe this was on a
 11 Friday, I called the University of Western
 12 Virginia with the number that I had and I got
 13 someone's voice mail. I left a message. I
 14 waited for 48 hours, which brought us up to a
 15 Tuesday or a Wednesday, can't remember
 16 exactly, and I had no response. So I had an
 17 e-mail address. I sent off an e-mail to this
 18 same guy, and within an hour, he responded to
 19 my e-mail and he said, yeah, they did have the
 20 autostainer and yes, they had the original
 21 computer that was sent with it.
 22 CHAYTOR, Q.C.:
 23 Q. And there's a couple of e-mails that I'll take
 24 you to about that.
 25 MR. WHITE:

1 that autostainer. He said he did. I asked
 2 him if there was a computer with that
 3 instrument. He said he didn't know. I told
 4 him what was going on with the Inquiry and so
 5 on and it was important that we try to locate
 6 it. I asked him if he remembered where he
 7 sold it, and he said he thinks he knew where
 8 he sold it at the time, and I asked him if he
 9 had any paperwork on it, and at the time, he
 10 was on his cell phone and he wasn't in his
 11 office. So I asked him if when he got back to
 12 his office, if he would check, and I sent him
 13 an e-mail to remind him and asked him some
 14 questions, basically whether or not it was
 15 formatted, because at the time I thought it
 16 was a privacy issue. I had asked him some
 17 other questions about any maintenance that he
 18 may have done to it and so on.
 19 After I sent him the e-mail, I had no---I
 20 waited for 48 hours. There was no response.
 21 So I called him back again, and at the time,
 22 he was in his office, and I asked him if he
 23 could take a look to see if he had any
 24 paperwork, and he did. He told me had a
 25 purchase order from the University of West

1 A. Sure.
 2 CHAYTOR, Q.C.:
 3 Q. And Mr. White, in terms of the issue of it
 4 being a privacy issue, I take it you're
 5 referring to the document I showed you when
 6 you were in, and I don't know if I have the
 7 number handy, but is it 2154, page eight?
 8 It's the one with the computer document. Do
 9 you remember, Registrar? If not, 2140 maybe.
 10 No, it's not this one.
 11 REGISTRAR:
 12 Q. The other number?
 13 CHAYTOR, Q.C.:
 14 Q. Maybe 2140? Does anyone else remember that?
 15 COFFEY, Q.C.:
 16 Q. 2147.
 17 CHAYTOR, Q.C.:
 18 Q. 2147, thank you. Do you think? Maybe.
 19 THE COMMISSIONER:
 20 Q. No memory of it either, no.
 21 REGISTRAR:
 22 Q. No.
 23 CHAYTOR, Q.C.:
 24 Q. No, okay. Anyhow, there was a form that--I
 25 know it's page eight of 23 -

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1 REGISTRAR:
 2 Q. 2152.
 3 CHAYTOR, Q.C.:
 4 Q. 2152, thank you. Now, and page eight, please,
 5 Registrar. This is the document that we were
 6 looking for, Mr. White. Is this what you're
 7 referring to, the type of information that we
 8 were looking to see if it's on the DAKO
 9 machine?
 10 MR. WHITE:
 11 A. This is the information that you guys were
 12 looking to retrieve?
 13 CHAYTOR, Q.C.:
 14 Q. Yes.
 15 MR. WHITE:
 16 A. This is the information that I thought you
 17 wanted to get rid of. That's why I thought it
 18 was the privacy issue.
 19 CHAYTOR, Q.C.:
 20 Q. To get rid of?
 21 MR. WHITE:
 22 A. When I say it was a privacy issue -
 23 CHAYTOR, Q.C.:
 24 Q. Okay.
 25 MR. WHITE:

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1 A. - just say I sent this computer and there was
 2 patient information on it.
 3 CHAYTOR, Q.C.:
 4 Q. Oh, okay.
 5 MR. WHITE:
 6 A. I thought it was a privacy issue that you
 7 didn't want anybody -
 8 CHAYTOR, Q.C.:
 9 Q. Oh, I see what you mean.
 10 MR. WHITE:
 11 A. - retrieving this information or looking at
 12 it, you know, that type of thing.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, I see what you mean.
 15 MR. WHITE:
 16 A. When I spoke to you, you told me that you were
 17 trying to retrieve the documentation -
 18 CHAYTOR, Q.C.:
 19 Q. Yes.
 20 MR. WHITE:
 21 A. - that's a different issue altogether. I
 22 mean, the privacy issue was important, but I
 23 mean, I had no idea you were looking to
 24 retrieve information.
 25 CHAYTOR, Q.C.:

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

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1 MR. WHITE:
 2 A. Right.
 3 CHAYTOR, Q.C.:
 4 Q. And he's the owner of the company you sold the
 5 machine to?
 6 MR. WHITE:
 7 A. That's correct.
 8 CHAYTOR, Q.C.:
 9 Q. "Nice chatting with you this morning. As I
 10 indicated, there is a local legal inquiry
 11 ongoing in our province and one of the items
 12 of interest is the DAKO autostainer that I
 13 sold to you several years ago. I was asked if
 14 I had the computer for that instrument and I
 15 honestly do not remember if indeed I had one
 16 and shipped it to you with the autostainer.
 17 Can you confirm whether or not the instrument
 18 came with a computer? If so, was the hard
 19 drive formatted at the time or did you format
 20 the drive yourself? Can you tell me the
 21 condition of the autostainer when you received
 22 it? Did it require parts and/or adjustments
 23 before you resold the instrument? And
 24 finally, can you tell me where you sold the
 25 instrument and if indeed the instrument is

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1 still in service. A contact name and number
 2 will be greatly appreciated. Thanks, Joe."
 3 And did you receive a response back from Mr.
 4 Dietrich?
 5 MR. WHITE:
 6 A. No, he never responded. This was the first e-
 7 mail that I had sent him, and before he
 8 replied to the e-mail, I had called him back
 9 for the second time, and the second time he
 10 told me that his computer was down and that's
 11 why he never responded.
 12 CHAYTOR, Q.C.:
 13 Q. And so you got the information over the phone
 14 instead?
 15 MR. WHITE:
 16 A. Yes, the information as to who had the
 17 instrument, yeah.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, and if we could then look, please, at P-
 20 3581? And then this is an e-mail exchange. I
 21 think it starts at the bottom, and you'll see
 22 Mr. White, these black marks are just where we
 23 have redacted or taken out information so that
 24 anything that might be contact information
 25 basically for people.

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

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

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1 Q. He was prepared to delete them for you if you
 2 wanted that.
 3 MR. WHITE:
 4 A. Yeah.
 5 CHAYTOR, Q.C.:
 6 Q. Yes, okay, and then we--and we were also at
 7 the same time, in contact with the University
 8 at this time period, and happy to tell you
 9 that we received the information today that we
 10 were looking for, but we're not in a--we
 11 haven't read it yet, in terms of seeing how
 12 much is actually there and whether or not it's
 13 the documents that -
 14 MR. WHITE:
 15 A. You actually have the computer now?
 16 CHAYTOR, Q.C.:
 17 Q. No, we have the data off the computer.
 18 MR. WHITE:
 19 A. Oh, okay.
 20 CHAYTOR, Q.C.:
 21 Q. Whatever was there, we have.
 22 MR. WHITE:
 23 A. All right.
 24 CHAYTOR, Q.C.:
 25 Q. We've received it. So thank you for your

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1 efforts in that regard.
 2 MR. WHITE:
 3 A. Well, no problem. The other thing is you
 4 received data from the computer, I think we
 5 discussed this before, just the data that you
 6 got from the computer, I would have thought
 7 that you would have asked for the whole
 8 computer.
 9 CHAYTOR, Q.C.:
 10 Q. Yes. Would that be of benefit, do you think?
 11 MR. WHITE:
 12 A. If there was information on that hard drive--
 13 and I have an intimate understanding of
 14 computers. If there was information on the
 15 hard drive on that computer that was deleted
 16 at some time in the past, if it was formatted
 17 at some time in the past, that information is
 18 retrievable by an IT expert or even someone
 19 like my son. He has to ability to do that if
 20 he wanted to get that information. Just
 21 because you ask for the information that's on
 22 the hard drive, if it was deleted or
 23 formatted, you'll never get the information
 24 that you're looking for.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. So if there's anything missing or
 2 anything else that we think we might need, it
 3 could still be on the computer and it would be
 4 worthwhile getting the computer?
 5 MR. WHITE:
 6 A. I think I even suggested to you at one time if
 7 you wanted that computer, I would have had it
 8 here.
 9 CHAYTOR, Q.C.:
 10 Q. To get the computer?
 11 MR. WHITE:
 12 A. And have a forensic analysis done to that
 13 computer.
 14 CHAYTOR, Q.C.:
 15 Q. Yes.
 16 MR. WHITE:
 17 A. Because if it was formatted--a lot of people
 18 think that if you format a hard drive on a
 19 computer, all that information is gone and
 20 nothing can be further from the truth.
 21 There's still a small compacted file that you
 22 can retrieve where you can get information if
 23 that information is missing.
 24 CHAYTOR, Q.C.:
 25 Q. That's good to know. Thank you. Those are my

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1 questions. Thank you, Commissioner.
 2 THE COMMISSIONER:
 3 Q. All right then. Mr. Pritchard, do you have
 4 any questions for Mr. White?
 5 MR. PRITCHARD:
 6 Q. I don't, Commissioner. Thank you for your
 7 evidence, Mr. White.
 8 THE COMMISSIONER:
 9 Q. Mr. Simmons?
 10 MR. SIMMONS:
 11 Q. Thank you, Commissioner. No, I don't have any
 12 questions for Mr. White.
 13 THE COMMISSIONER:
 14 Q. Mr. Browne?
 15 BROWNE, Q.C.:
 16 Q. No questions, but I was wondering if Mr. White
 17 has a business card.
 18 THE COMMISSIONER:
 19 Q. You think Mr. White has interesting
 20 information.
 21 BROWNE, Q.C.:
 22 Q. I think he could be quite handy.
 23 THE COMMISSIONER:
 24 Q. Mr. Pritchett?
 25 MR. PRITCHETT:

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1 Q. No questions, Commissioner.
 2 THE COMMISSIONER:
 3 Q. Ms. Newbury?
 4 MS. NEWBURY:
 5 Q. No questions.
 6 THE COMMISSIONER:
 7 Q. Mr. Crosbie?
 8 CROSBIE, Q.C.:
 9 Q. No questions, thank you.
 10 THE COMMISSIONER:
 11 Q. Oh, twice in one day, no questions. Mr.
 12 White, I want to add to Ms. Chaytor's thanks
 13 on behalf of the Commission for your efforts
 14 on our behalf in locating what we hope will be
 15 valuable information, and I'm sure we'll let
 16 you know what we find.
 17 MR. WHITE:
 18 A. You're welcome.
 19 THE COMMISSIONER:
 20 Q. Thank you very much. I suggest we take the
 21 afternoon break before we continue with the
 22 next witness.
 23 CHAYTOR, Q.C.:
 24 Q. Thank you.
 25 (BREAK)

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1 THE COMMISSIONER:
 2 Q. Please be seated.
 3 COFFEY, Q.C.:
 4 Q. Commissioner, the next witness is Dr. David
 5 Saltman.
 6 DR. DAVID SALTMAN, SWORN, EXAMINATION BY BERNARD COFFEY,
 7 Q.C.
 8 REGISTRAR:
 9 Q. Would you please state and spell your complete
 10 name for the Commission?
 11 DR. SALTMAN:
 12 A. My name is David Saltman, S-A-L-T-M-A-N.
 13 REGISTRAR:
 14 Q. Thank you.
 15 COFFEY, Q.C.:
 16 Q. First of all, Commissioner, I'm going to ask
 17 that Exhibit P-3584 be entered, please.
 18 THE COMMISSIONER:
 19 Q. Entered.
 20 EXHIBIT ENTERED AND MARKED P-3584
 21 COFFEY, Q.C.:
 22 Q. And if we could bring it up on the screen,
 23 please, Registrar? Dr. Saltman, I take it
 24 that--of course you'd understand that the
 25 black parts are redacted because they're

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1 personal information. This is a copy of your
 2 CV?
 3 DR. SALTMAN:
 4 A. It is.
 5 COFFEY, Q.C.:
 6 Q. Doctor, could you give the Commissioner,
 7 please, an overview of your educational and
 8 professional background?
 9 DR. SALTMAN:
 10 A. I'll start--well, I'll start from the
 11 beginning. I grew up in Conception Bay North
 12 where I went to high school, went to
 13 university at Memorial in St. John's, and I
 14 went to medical school and I graduated in
 15 1982. From there, I went to Montreal where I
 16 studied internal medicine. Followed that by
 17 more internal medicine in Vancouver and
 18 hematology, and then I received a Medical
 19 Research Council of Canada fellowship and went
 20 to Edinburgh in Scotland where I did a PhD in
 21 cancer cell biology, which I completed in
 22 1989, and then I went to Stanford Medical
 23 Centre in Stanford, California, where I was a
 24 post-doctoral fellow in molecular
 25 cytogenetics, also interested in cancer, and

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1 that I guess was completion of my education.
 2 From then, I worked in either industry or more
 3 recently as a clinician in medical oncology.
 4 COFFEY, Q.C.:
 5 Q. And can you tell the Commissioner, please,
 6 where you've worked as a physician per se, as
 7 a clinician?
 8 DR. SALTMAN:
 9 A. Well, I've worked many places, mostly in
 10 Canada as an oncologist, which is probably the
 11 most relevant to this Commission. I trained
 12 in hematology, but more recently I've worked
 13 as an oncologist and most of my experience is
 14 with the B.C. Cancer Agency, and I've also
 15 worked for Cancer Care Ontario and worked at
 16 the Juravinski Cancer Centre, which is in
 17 Hamilton in Ontario.
 18 COFFEY, Q.C.:
 19 Q. And you worked there as an oncologist?
 20 DR. SALTMAN:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And most recently, before coming to St.
 24 John's, you worked--where were you located?
 25 DR. SALTMAN:

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1 A. I worked for the B.C. Cancer Agency, which has
 2 four, I think soon to be five, radiation
 3 oncology centres and one of these was in the
 4 interior of the province, in a place called
 5 Kelowna and that was one of the B.C. Cancer
 6 Agency's radiation oncology sites. We had a
 7 catchment area of about a million people and
 8 covering the geographic area, probably about
 9 two and a half sizes times the size of
 10 Newfoundland, the island of Newfoundland, so
 11 actually quite a lot of similarities in terms
 12 of the province and how the cancer care
 13 program is run in Newfoundland.
 14 COFFEY, Q.C.:
 15 Q. And that would be in relation to the Kelowna
 16 centre?
 17 DR. SALTMAN:
 18 A. That's right, there was one centre and then we
 19 had satellite clinics. We had actually board
 20 certified oncologists, which is different, in
 21 some of these centres and then we had
 22 community centres and we also did visiting
 23 clinics, and we also had a tele-oncology
 24 program which is also similar to what they
 25 have in Newfoundland.

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1 COFFEY, Q.C.:

2 Q. And Doctor, how long were you in Kelowna?

3 DR. SALTMAN:

4 A. I was in Kelowna since 2004, and before then,

5 I was in Hamilton, but I had worked in British

6 Columbia on and off since 19--the 1990s. At

7 one point, I had been a private practice

8 oncologist, but then the clinic I worked in

9 was incorporated into the B.C. Cancer Centre.

10 COFFEY, Q.C.:

11 Q. And from 2004, I take it through 2008, the

12 beginning of 2008, you were in Kelowna and

13 that centre is part of the B.C. Cancer Agency?

14 DR. SALTMAN:

15 A. That's right.

16 COFFEY, Q.C.:

17 Q. And you've indicated as well that you worked

18 in Hamilton for a while?

19 DR. SALTMAN:

20 A. Yes.

21 COFFEY, Q.C.:

22 Q. And what was the centre there?

23 DR. SALTMAN:

24 A. It was called the Hamilton Regional Cancer

25 Centre, and then somebody gave them, I think,

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1 16 or 20 million dollars and got naming

2 rights. That person was called Juravinski,

3 and so now it's called the Juravinski Cancer

4 Centre. Probably at that time, it was the

5 busiest cancer centre in Canada, in terms of

6 total number of people treated in terms of

7 chemotherapy and radiation.

8 COFFEY, Q.C.:

9 Q. And Doctor, how long were you in Hamilton?

10 DR. SALTMAN:

11 A. I was there for about three years, yeah.

12 COFFEY, Q.C.:

13 Q. And that would have been what time period?

14 DR. SALTMAN:

15 A. That would have been around 2001-2002 to 2004.

16 COFFEY, Q.C.:

17 Q. Okay, so you went from Hamilton to Kelowna?

18 DR. SALTMAN:

19 A. That's right.

20 COFFEY, Q.C.:

21 Q. Okay. Doctor, could you tell the

22 Commissioner, please, then--because well,

23 first of all, I'll ask you, where are you now

24 located?

25 DR. SALTMAN:

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1 A. I now work in St. John's. I have an

2 appointment, I'm the chair and professor of

3 oncology at the University. This is a brand

4 new discipline within the Faculty of Medicine.

5 I also have a clinical appointment with

6 Eastern Health at the Bliss Murphy Cancer

7 Centre.

8 COFFEY, Q.C.:

9 Q. And when did you take up that post, Doctor?

10 DR. SALTMAN:

11 A. I arrived in--well, I shouldn't--I started

12 working in March of 2008.

13 COFFEY, Q.C.:

14 Q. And so you have a clinical appointment as an

15 oncologist with Eastern Health?

16 DR. SALTMAN:

17 A. Um-hm.

18 COFFEY, Q.C.:

19 Q. And you're a professor of oncology with

20 Memorial University's Medical School?

21 DR. SALTMAN:

22 A. That's right.

23 COFFEY, Q.C.:

24 Q. And is there any understanding, formal or

25 informal, about the amount of time you're

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1 supposed to devote to--or what percentage of

2 your time is supposed to be devoted to either?

3 DR. SALTMAN:

4 A. I think this is a brand new venture and I

5 think there's--I haven't looked at my contract

6 recently, but the understanding is essentially

7 that I would be expected to see less patients

8 than an oncologist who doesn't have as much

9 responsibility in terms of administrative or

10 academic. I don't think there's any set

11 number of patients, but the expectations would

12 be I would do a considerable amount of non-

13 direct patient care as part of my appointment.

14 As it turns out, I do a considerable amount of

15 clinical care. It's not onerous, but probably

16 more so than somebody with a similar

17 appointment in another institution.

18 COFFEY, Q.C.:

19 Q. And Doctor, you've indicated that this is, you

20 understand, as professor of oncology, chair

21 and professor of oncology with the medical

22 school that this is a new position?

23 DR. SALTMAN:

24 A. Yes. The idea of having a discipline of

25 oncology within the Faculty of Medicine is

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1 relatively new in Canada, and there's very few
 2 of them, and in the United States and in
 3 Europe, there are some, but it's a relatively
 4 new idea to actually have a separate
 5 discipline. Historically, oncology has been
 6 included within the discipline of internal
 7 medicine. I think the feeling is or was, and
 8 is here, is that due to the complexity of
 9 oncology and the number of different people
 10 involved, medical oncologists, radiation
 11 oncologists, radiation physicists, nursing,
 12 pharmacy, researchers, that there might be
 13 some utility in creating a discipline of
 14 oncology and that, I think, was the feeling
 15 here at Memorial.
 16 COFFEY, Q.C.:
 17 Q. What do you understand then your role is?
 18 DR. SALTMAN:
 19 A. Well -
 20 COFFEY, Q.C.:
 21 Q. First of all, I'll ask you because you have
 22 different roles, I take it.
 23 DR. SALTMAN:
 24 A. Yeah.
 25 COFFEY, Q.C.:

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1 Q. One is your clinical appointment as an
 2 oncologist per se. I'll deal with that first.
 3 DR. SALTMAN:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. I take it that that involves you providing
 7 clinical services to oncology patients?
 8 DR. SALTMAN:
 9 A. Right. So I'm a medical oncologist and so I
 10 have two clinics a week. I have a clinic on
 11 Wednesday afternoon where I see new patients,
 12 and I have a clinic on Friday mornings where I
 13 will generally see follow up patients, and
 14 those are not fixed. I can see new patients
 15 on Friday, whatever, but that's generally what
 16 happens. I also do visiting clinics to Corner
 17 Brook as part of a rotation. There's three
 18 oncologists, medical oncologists, and
 19 radiation oncologists that rotate to Corner
 20 Brook, and I also actively participate in the
 21 tele-oncology program, and that's where
 22 actually a lot of my patient load actually is
 23 generated. I really don't like patients
 24 driving all the way from Corner Brook or Grand
 25 Falls to see me for an hour, only to turn

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1 around and drive right back. So I do a lot of
 2 new patient consultation, follow up visits,
 3 actually through the video link, which we
 4 refer to as tele-oncology, and I do those--I
 5 don't really have a fixed day, but I'll do
 6 those on the days I don't have--usually on the
 7 days I don't have clinics within the cancer
 8 program.
 9 COFFEY, Q.C.:
 10 Q. And then within medical oncology, as you
 11 indicated you practise as a medical
 12 oncologist, is there any particular area of
 13 medical oncology that you--I won't say
 14 specialize in, but spend more time at?
 15 DR. SALTMAN:
 16 A. My interest have been, in the past, have been
 17 gastrointestinal malignancies, hematological
 18 malignancies like leukemias and lymphomas and
 19 that's where I've done most of my research,
 20 and in neuro-oncology or brain tumours. In
 21 Newfoundland, I do almost exclusively
 22 gastrointestinal malignancies, but if someone
 23 comes in the door and they need to be seen
 24 with kidney cancer, whatever, I will see them,
 25 and when we go to Corner Brook, we have to

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1 follow people who have breast cancer, lung
 2 cancer, again whatever has to be seen. But
 3 primarily, I do gastrointestinal malignancies,
 4 such as bowel cancer or stomach cancer.
 5 COFFEY, Q.C.:
 6 Q. And Doctor, I'm going to ask you then about
 7 your role as a professor of oncology, as the
 8 professor of oncology and the discipline
 9 chair, which I take it is in effect the same
 10 thing, or are they?
 11 DR. SALTMAN:
 12 A. The professor is an academic appointment. You
 13 could be discipline chair and be an associate
 14 professor or whatever. So that's just based
 15 on your research experience, your publication
 16 experience, and the chair of oncology is the
 17 appointment itself. As I mentioned, this is a
 18 new venture for the University and so it's a
 19 bit open as to how this is going to evolve. I
 20 have spent a fair amount of my time actually
 21 trying to establish my practice as a medical
 22 oncologist and also trying to assess with some
 23 of the processes within the cancer care
 24 program, trying to make sure that this is a
 25 place I feel comfortable practising medicine

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1 and doing the best for my patients.
 2 At the same time, I've been working to
 3 try to help the various potential members of
 4 the discipline, in terms of getting more
 5 involved with research, making connections
 6 between the other disciplines. We're very
 7 interested in working with the cancer genetic
 8 group at the Terry Fox lab. So there's been a
 9 lot of meetings with various disciplines,
 10 trying to get this venture off the ground.
 11 COFFEY, Q.C.:
 12 Q. Okay, and in relation to some of those and
 13 what sorts of initiatives in those regards
 14 have you been involved in, I take it in the
 15 past seven to eight months since you started
 16 in March? Perhaps--well, I'll ask you first
 17 of all about tele-oncology, first of all, and
 18 the usage of tele-oncology and perhaps
 19 communications devices?
 20 DR. SALTMAN:
 21 A. Yes. Well, tele-oncology is very important
 22 for a province like Newfoundland and I have a
 23 fair amount of experience with this in British
 24 Columbia because, as I mentioned earlier, we
 25 have similar situations. We have a single

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1 radiation oncology centre in B.C. within the
 2 centre of the province, and we service areas
 3 which may be eight hour drive by car. You may
 4 have to go across several mountain passes.
 5 The idea is to provide care closer to home and
 6 this is very similar to Newfoundland.
 7 What's different in B.C. is that we have
 8 satellite clinics, which may have oncologists
 9 in them or we have what are called general
 10 practice oncologists, and these people are
 11 often full-time employees of the cancer
 12 program, and they look after patients who are
 13 currently on treatment, whereas our job may be
 14 to mostly look after new patients and do new
 15 patient consultations.
 16 In Newfoundland, a lot of patients,
 17 despite the tele-oncology program, are still
 18 being asked to travel to St. John's to have
 19 initial consultation, whereas the visiting
 20 clinics are almost exclusively to follow up
 21 patients. So in terms of participating in the
 22 tele-oncology program, I have probably been
 23 busier than I was in British Columbia, because
 24 I'm trying to see new patients here and to
 25 prevent them having to travel to St. John's.

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1 That is not really a research project in
 2 itself. We have some people within the cancer
 3 care program, such as Dr. Greenland, who's
 4 been very, very active in this.
 5 One of the areas that I'm interested in,
 6 I'm interested in community oncology and I'm
 7 interested in also communication, and I've
 8 been working a lot with Dr. Max House, who's
 9 really a pioneer in this field. He's got the
 10 Order of Canada for his work in tele-medicine,
 11 and he's been very interested in taking this a
 12 step further about using even the internet to
 13 be able to provide oncology services and other
 14 tele-health services around the province.
 15 I think he's been a bit frustrated by
 16 some of the regulations within the health care
 17 system, within Eastern Health. He attempted
 18 to initiate a project a couple of years ago
 19 using handheld devices, such as Blackberrys,
 20 to look at efficiency within the cancer care
 21 program, and I think he wanted to target the
 22 pharmacists, and unfortunately Eastern Health
 23 would not give the go ahead to this project.
 24 So when I came to Newfoundland and met with
 25 Dr. House, this is something he wanted to

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1 pursue, so I've been working with Eastern
 2 Health IT people and we've been able to
 3 resurrect this as a research project and I
 4 have a very good medical student who is
 5 working on this.
 6 It's really a study to look at
 7 efficiency, but it's also an attempt to
 8 convince the health authorities that these
 9 devices are not harmful, but in fact, very,
 10 very useful. 46 percent of all oncologists in
 11 Canada use handheld devices in their daily
 12 practices. You're talking about, you know,
 13 prestigious institutions within the country,
 14 Sunnybrook, Princess Margaret, the B.C. Cancer
 15 Agency, the Ottawa Cancer Centre. Oncologists
 16 all use these devices as a daily practice to
 17 do radiation planning, to do sign off charts,
 18 to communicate with patients, with other
 19 health care faculties. So we're really behind
 20 here and this project is really an attempt to
 21 get some information to determine the utility
 22 of this, but also to convince the health
 23 authorities that these--that communication is
 24 really, really important.
 25 COFFEY, Q.C.:

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1 Q. And why is that sort of communication
 2 important, Doctor, in your experience?
 3 DR. SALTMAN:
 4 A. Well, I'll give you someone else's experience
 5 because evidence based results are what you're
 6 looking for. There's been very few formal
 7 studies, but there was one from Mississauga
 8 Hospital where they looked at efficiency
 9 within their intensive care unit. They had a
 10 couple of near misses of patients almost had
 11 severe adverse events and they determined that
 12 the problem was lack of effective
 13 communication between doctors and ICU nurses,
 14 that the traditional paging system just wasn't
 15 doing the trick, and so they gave nurses and
 16 doctors Blackberries. They did a study over
 17 12 months and they were able to demonstrate a
 18 16 percent reduction in adverse events and
 19 they've gone from a pilot project to put this
 20 as part of their standard of care, and they
 21 certainly didn't see any of the concerns that
 22 some of the health authorities such as here in
 23 Newfoundland are concerned about, interference
 24 with other medical devices, those sort of
 25 things. So my interest is in that it can

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1 provide better efficiency, but also help with
 2 safety issues.
 3 COFFEY, Q.C.:
 4 Q. And, doctor, the idea of community medicine,
 5 community oncology, in particular, that you
 6 referred to, in your experience, have you
 7 found or encountered situations where
 8 information can be made available and is made
 9 available to oncologists, for example, via the
 10 internet from some centralized server?
 11 DR. SALTMAN:
 12 A. Absolutely, yes. I think one of the strengths
 13 of the BC Cancer Agency is its website. It's
 14 probably one of the best in the world and gets
 15 one of the largest numbers of hits worldwide
 16 for a cancer website. One of the deficiencies
 17 of the Cancer Care Program in Newfoundland is
 18 we're the only cancer care program in the
 19 country that doesn't actually have a website.
 20 There was, I think, under the old Newfoundland
 21 Cancer Treatment Foundation, a website, and my
 22 understanding is in 2005 when they
 23 amalgamated, this was not carried forward.
 24 I've had various discussions about the
 25 importance of this, and about resurrecting

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

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1 program here.
 2 COFFEY, Q.C.:
 3 Q. Have you made any inquiries in that regard?
 4 DR. SALTMAN:
 5 A. I have, yes.
 6 COFFEY, Q.C.:
 7 Q. What happened?
 8 DR. SALTMAN:
 9 A. Well, I spoke to our management team about
 10 this, and unless I'm mistaken, I don't think
 11 there's been much progress on this. I think
 12 from the perspective of Eastern Health IT,
 13 they don't design a website, they put it up,
 14 probably it would be linked to the Eastern
 15 Health website, so it means that somebody in
 16 this program, in the clinical care program,
 17 has to create this website. It's a lot of
 18 work, but you need to--somebody needs to do it
 19 and somebody needs to be delegated to do this.
 20 It really is quite important. I have started
 21 designing a website which will be the
 22 Discipline of Oncology website, but that's
 23 going to serve a different function, although
 24 there's some overlap. I can't emphasize how
 25 important this would be to what is not just

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1 Eastern Health program, this is a provincial
 2 program.
 3 COFFEY, Q.C.:
 4 Q. The Cancer Care Program?
 5 DR. SALTMAN:
 6 A. Yes, it has a provincial focus, and the
 7 website would be invaluable for physicians,
 8 nurses, pharmacists, patients across the
 9 province.
 10 COFFEY, Q.C.:
 11 Q. Doctor, in relation to--you just referred to
 12 the idea that, and you recognized that this
 13 could be a fair amount of work.
 14 DR. SALTMAN:
 15 A. Uh-hm.
 16 COFFEY, Q.C.:
 17 Q. And it would require knowledgeable people,
 18 people knowledgeable in the area to design it.
 19 This sort of work, I take it at times is done
 20 by committees. What has been your experience
 21 in relation to that compared to elsewhere in
 22 terms of participation on committees?
 23 DR. SALTMAN:
 24 A. I mean, every cancer centre is structured
 25 different and there's many ways to skin a cat,

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

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1 somebody had a solution, and it got done.
 2 What we didn't have is a middle management
 3 structure where things sort of either started
 4 there or had to percolate up there first
 5 before they, you know, actually got underway,
 6 and here it's a bit of a different structure.
 7 I think we have what's called a--and I'm
 8 talking about the clinical care program now,
 9 I'm not talking my discipline, oncology. I
 10 think we have what's called a leadership team,
 11 and I'm sure there's other committees within
 12 the cancer care program, but this is a
 13 committee where a lot of decisions which could
 14 be made at a lower level and actually
 15 implemented to go into that structure, and I
 16 think--I think it's not a structure that maybe
 17 is the most conducive for creativity or
 18 getting things done.
 19 COFFEY, Q.C.:
 20 Q. In terms of--what has been your experience in
 21 terms of your observations here locally in
 22 terms of the amount of participation or lack
 23 thereof of doctors on committees?
 24 DR. SALTMAN:
 25 A. Again I will -

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1 COFFEY, Q.C.:
 2 Q. And I'm saying, of course, in comparison to
 3 elsewhere.
 4 DR. SALTMAN:
 5 A. Yes, and I stand corrected, but my impression
 6 is that a number of physicians who sit on a
 7 committee or multiple committees is not what
 8 it should be. That's my personal opinion.
 9 It's certainly less than what I'm used to
 10 working in other places, such as British
 11 Columbia and in Ontario, and I think that's
 12 very important--most of us are not going to
 13 volunteer for working on committees, and I
 14 think that has to come from management to say
 15 that you're expect to be on "x" number of
 16 committees, and again it's a way of
 17 networking, you should be expected to be on
 18 committees not just within the cancer care
 19 program, but within your host hospital. So
 20 again it's a way of networking with other
 21 people in different disciplines.
 22 COFFEY, Q.C.:
 23 Q. And what if any are the implications for
 24 patient care if doctors are not required and
 25 do not participate in such committee work?

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1 Are there any possible implications for
 2 patient care?
 3 DR. SALTMAN:
 4 A. Well, I don't know if there's been any
 5 studies, but intuitively, you would think
 6 indirectly there would be. I mean, I think,
 7 you know--I think in our system here, not only
 8 are people not participating in enough
 9 committees, but there probably aren't enough
 10 committees, and again there's different
 11 management structures and maybe people feel
 12 that they don't need a lot of committees, but
 13 again I think the more people you have talking
 14 about the same problem or different problems,
 15 the more opportunity you get to find out
 16 what's going on, and it is a quality assurance
 17 thing as well.
 18 COFFEY, Q.C.:
 19 Q. And why is that, doctor?
 20 DR. SALTMAN:
 21 A. Well, I think the more cross-talk you have, I
 22 think the less likely you're going to--you're
 23 going to pick up--somebody is going to say
 24 something in a committee or a meeting and
 25 you're going to say, well, I think we should

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1 look at this in a bit more detail or a bit
 2 more depth, or someone will say, well, I've
 3 seen something similar in my area and that's
 4 something we need to look at, and sometimes a
 5 lot of these things are very serendipitous,
 6 but that's--what's different about the BC
 7 Cancer Agency is multiple levels of
 8 redundancy. The chances that something is
 9 going to fall through the cracks is much less
 10 because you have these multiple people
 11 involved in the system rather than a very top
 12 down sort of approach to running a cancer care
 13 program.
 14 COFFEY, Q.C.:
 15 Q. And you refer to serendipity. I take it that--
 16 just people are required to have a certain
 17 amount of contact with each other, clinicians
 18 of various sorts, and of the same sort, on a
 19 routine and regular basis, that the chances
 20 are better that new ideas or problems being
 21 identified are more likely to occur?
 22 DR. SALTMAN:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. Likely to be better education of each other?

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1 DR. SALTMAN:
 2 A. Yes, yeah.
 3 COFFEY, Q.C.:
 4 Q. And problems potentially identified?
 5 DR. SALTMAN:
 6 A. Sure. I mean, one of the things -
 7 COFFEY, Q.C.:
 8 Q. If I could, doctor -
 9 DR. SALTMAN:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. Otherwise, what's the effect? If you don't
 13 take part in committees, and you're just doing
 14 your clinical work, what can happen?
 15 DR. SALTMAN:
 16 A. Well, again I think that's very intuitive as
 17 well in that I think you're not aware of
 18 what's happening in the other disciplines.
 19 Within oncology now, we work often in multi-
 20 disciplinary teams. Now they may not be
 21 formal teams, but many of our treatments are
 22 multi-modality where we're giving
 23 chemotherapy, radiation, or immuno therapies,
 24 and this cross-talk between health care
 25 professionals, I think, is very, very

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1 important. Within the Cancer Care Program in
 2 Newfoundland, we have a Division of Medical
 3 Oncology, which all the oncologists in
 4 Newfoundland are in St. John's, so that's
 5 obviously centred here. We have a Division of
 6 Radiation Oncology, and they meet on a regular
 7 basis, but we don't actually have a structure
 8 where radiation oncologists and medical
 9 oncologists meet on a regular basis. So if
 10 problems arise in these multi-modality
 11 therapies, you can talk about them in the
 12 hallways or over coffee, or in the clinic, but
 13 in most institutions you will have on a
 14 regular basis, whether it's every two or three
 15 months, an opportunity for both disciplines to
 16 actually sit in the same room and formally
 17 talk about any concerns that they may have,
 18 and again this is how you--this is how you
 19 pick up these problems and sometimes avert
 20 some of these problems.
 21 THE COMMISSIONER:
 22 Q. Mr. Coffey, if you're going to address this
 23 with the witness, by all means, we'll wait,
 24 but I'm interested in the relationship with
 25 other centres in that in that issue we're

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1 dealing with here, you would have had
 2 pathologists from other regions feeding into
 3 Eastern Health, and then information going
 4 back and the oncologist might be still back in
 5 St. John's. So there seemed to be a lot of
 6 movement back and forth, and I'm concerned
 7 about how good the communications might be
 8 between--I know all oncologists are in St.
 9 John's, so it would have to be between the
 10 oncologists and, for example, pathologists who
 11 were in other centres, and frankly up to date
 12 I've not seen something which causes me to
 13 have a lot of confidence that that
 14 communication is very good. So could you tell
 15 me what your experience has been about the
 16 communication and what your view is--if you
 17 don't think it's up to scratch, what your view
 18 is of ways of improving that kind of
 19 communication?
 20 DR. SALTMAN:
 21 A. Again I'll preface it by saying I've been here
 22 eight months, I don't profess to know
 23 everything about this program, and everything
 24 about how health care works in the province,
 25 but it is also a concern of mine that the

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

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1 in Hamilton, who were part of the Cancer Care
 2 Program. They actually had an office within
 3 the centre. My impression when I came to
 4 Newfoundland is that communication between
 5 pathologists within the province and the
 6 oncologists had lots of room for improvement,
 7 and when I came here--even before I came here,
 8 I asked members of the Cancer Care Program to
 9 put me in touch with an oncology pathologist
 10 or an oncological pathologist or somebody who
 11 had an interest in oncology, and I was put in
 12 touch with Dr. Bev Carter, and while Bev was
 13 here before she resigned from Eastern Health,
 14 we established a very good relationship. I
 15 think she had found it frustrating that she
 16 didn't have the funding to start to go out to
 17 different centres, to talk to other
 18 pathologists, or to bring the pathologists to
 19 St. John's for educational sessions, updates
 20 on management.
 21 So we worked very closely together and I
 22 got her money and I brought every pathologist
 23 in Newfoundland, except for one, everyone and
 24 that's easy to do because there's only about
 25 23 of them and brought them to the Murray

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

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

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

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

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1 of your job.
 2 COFFEY, Q.C.:
 3 Q. And so, Doctor, I take it then in addressing
 4 the Commissioner's question, responding to it,
 5 that there are very few formal mechanisms
 6 right now in place where there is interaction
 7 between, like groups of pathologists and
 8 groups of oncologists or groups of surgeons on
 9 a routine basis. I mean, there's the tumour
 10 board of Wednesday, tumour board rounds of
 11 Wednesdays and this one you've initiated. And
 12 that, because it involves video conferencing,
 13 it can involve people from outside St. John's
 14 itself. What about even within St. John's, is
 15 there anything more within St. John's itself,
 16 in terms of kind of routine regular meetings
 17 between physicians where these sorts of things
 18 can be discussed?
 19 DR. SALTMAN:
 20 A. Yes, I think there is, I mean because it's,
 21 the medical school there, there are lots of
 22 rounds occurring, there's weekly surgical
 23 rounds and I don't know, I've been asked to
 24 participate in their lecture series, I'm not
 25 sure about the participation in these

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1 meetings, who goes and who doesn't go, but
 2 there are formal mechanisms there.
 3 COFFEY, Q.C.:
 4 Q. What ones do oncologists now routinely
 5 participate in, that's what I'm -
 6 DR. SALTMAN:
 7 A. Well I don't know, I know that oncologists are
 8 sometimes asked to, say, give lectures in the
 9 surgical, weekly surgical rounds or they may
 10 be asked to give some lectures to the
 11 gynecologist. I think those sort of things
 12 are happening. The oncologists are asked to
 13 give lectures to surgeons in training and
 14 other physicians, but getting back to the
 15 original question, I think there is lots of
 16 room to have more dialogue between oncologists
 17 and other people treating cancer, such as
 18 hematologists and surgeons and pathologists
 19 and I think, again, there's lots of good
 20 things about this program, but there are some
 21 deficits and I think it's, the care here is
 22 very centralized and I think there needs to be
 23 a serious look at decentralizing some of the
 24 services and I think, for example, there
 25 should be a real push to have a oncologist,

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1 possibly two oncologists but certainly an
 2 oncologist in Corner Brook and what that does,
 3 is it automatically starts that connection, so
 4 if you've got somebody in-house, that person
 5 is giving talks in the Corner Brook hospital,
 6 they are talking informally, but possibly
 7 formally, they're sitting on committees. It's
 8 one thing for an oncologist to go for a few
 9 days to Corner Brook once a month, but it's
 10 never the same as having someone in-house and
 11 I think you have the referral base there that
 12 you could easily support two oncologists. Now
 13 we have a competitive funding within this
 14 province for oncologists, I would hope it
 15 would not be too difficult to actually recruit
 16 oncologists to that area. And again, then
 17 you're going to start to get those dialogues
 18 between pathologists and surgeons. I think
 19 our program should really look at having
 20 surgical oncologists and pathologists as
 21 actually members of the Cancer Care Program,
 22 formal members.
 23 COFFEY, Q.C.:
 24 Q. I take it, if you could explain that to the
 25 Commissioner, I take it right now they're not

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1 formal members?
 2 DR. SALTMAN:
 3 A. There's nobody with an office or actually
 4 formally who are part of the Cancer Care
 5 Program. We certainly interact on a daily
 6 basis with pathologists in St. John's, but
 7 when Dr. Carter first expressed her desire to
 8 leave Eastern Health, I met with her and I was
 9 very candid, I said what would it take to keep
 10 you in this program, to keep you in Eastern
 11 Health and keep you in the province and she
 12 trained as an oncological pathologist, she was
 13 a breast cancer oncological pathologist, she
 14 did a fellowship and she didn't want to be a
 15 general pathologist, she wanted to work
 16 primarily in cancer care. And I approached
 17 the CEO of Eastern Health, Louise Jones, I
 18 sent an e-mail out to the Dean of Medicine,
 19 Ms. Jones to a number of other people saying
 20 we can't--we can't let this person go. If
 21 that's what she wants, we have to try to see
 22 if that's something we can facilitate and
 23 unfortunately that didn't come to fruition and
 24 Dr. Carter is now an oncological pathologist
 25 in a cancer centre in Vancouver. And this is

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1 somebody I think could have been the moving
 2 force for bringing pathologists, oncologists,
 3 surgeons and the like together in the Cancer
 4 Care Program within Newfoundland. So this
 5 would not be a precedent here, I mean, this is
 6 something that's common throughout Cancer Care
 7 Programs throughout the world. My
 8 understanding that if they don't have someone
 9 in-house, they may actually ask somebody
 10 within a host hospital to be an oncological
 11 pathologist. I think Nova Scotia has looked
 12 at this Commissioner of Inquiry and are
 13 dedicating a breast pathologist, realizing
 14 that that is an important part of their Cancer
 15 Care Program that they have an oncological
 16 pathologist dedicated to breast cancer.
 17 COFFEY, Q.C.:
 18 Q. And do you recall what the problem was or the
 19 challenges encountered in relation to what Dr.
 20 Carter wanted? What, if anything, did you
 21 know about it?
 22 DR. SALTMAN:
 23 A. Well I wasn't involved in the sort of
 24 discussions with medical directors of Eastern
 25 Health, but I think it came down to a job

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1 description and again, I wasn't part of the
 2 intimate sort of one-on-one discussions, but I
 3 think there was some reluctance on, not just
 4 on part of the Cancer Care Program, but also
 5 on the part of the Pathology Program of having
 6 a member who would be dedicated specifically
 7 to oncology, and again, you would have to
 8 speak to Dr. Denic about the nuances of those
 9 discussions. But I don't think we did enough,
 10 I think this was a big loss for this, for
 11 cancer care in Newfoundland, not just losing
 12 Dr. Carter, but I think it was an opportunity
 13 for us to finally come of age and say that
 14 oncology isn't just radiation and medical
 15 oncology, that many other disciplines now are--
 16 our surgeons are making a career out of
 17 oncology and they're often not fee-for-service
 18 physicians, they want to take a salary and
 19 they want to teach, they want to set
 20 guidelines, that's why it's important that
 21 they are physically within the centre. They
 22 want to work hand in hand with their
 23 hematology and oncology colleagues.

24 COFFEY, Q.C.:
 25 Q. And I take it that the position, she described

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1 it to you, pathological oncologist -

2 DR. SALTMAN:
 3 A. Oncological pathologist, yeah.

4 COFFEY, Q.C.:
 5 Q. Was in fact, when you first thought about it
 6 or were considering coming to Newfoundland,
 7 when you contacted St. John's, you asked to be
 8 put in touch with whomever he or she happened
 9 to be.

10 DR. SALTMAN:
 11 A. Right.

12 COFFEY, Q.C.:
 13 Q. And you were told, well there's no such
 14 position here.

15 DR. SALTMAN:
 16 A. Right.

17 COFFEY, Q.C.:
 18 Q. But then eventually your inquiries led you to
 19 Dr. Carter.

20 DR. SALTMAN:
 21 A. Right.

22 COFFEY, Q.C.:
 23 Q. And I gather Dr. Carter, you understood then
 24 was interested in creating in effect such a
 25 position?

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1 DR. SALTMAN:
 2 A. Yes. You know, I think Bev was generally
 3 interested and being in a role within the
 4 province of not just looking at slides, but to
 5 be an educator, to, like we co-chaired this
 6 meeting on synoptic templates, we sat down and
 7 within a couple of months we had every
 8 pathologist in a room and as a result of that,
 9 as I already told you, that has had impacts on
 10 patient care and practices.

11 COFFEY, Q.C.:
 12 Q. What, in the context of a Cancer Care Program,
 13 what is the advantage of having an oncological
 14 pathologist or the reverse?

15 DR. SALTMAN:
 16 A. Well many cancer care programs, I mean, it all
 17 has to do with size, it has to do with
 18 structure, but many programs will require,
 19 especially breast because of the complexity,
 20 colon cancer is very simple in the terms of
 21 pathology there isn't the need for
 22 immunohistochemistry. Usually 95 percent of
 23 all the cancers are one type, adnocarcinoma
 24 and it's fairly straightforward, although
 25 there are some nuances and--but breast and

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1 prostate are complex of the number of
 2 prognostic markers that you're looking at and
 3 this is only going to increase in breast as we
 4 start to look at gene profile and these sort
 5 of things. And so many cancer centres will
 6 require that all patients referred into the
 7 cancer centre have a secondary review because
 8 and certainly we know if you talked to experts
 9 in those fields that there are enough errors
 10 made that it may make a difference in how you
 11 decide to treat the patient. We know from
 12 hematology that this is really important.
 13 Every hematological malignancy, such as a
 14 lymphoma, really should be reviewed by a
 15 hematopathologist because of the error rate by
 16 general pathologists. But certainly in B.C.,
 17 in Ontario, in the larger cancer centres, if
 18 you're referred into the cancer centre, you
 19 automatically have secondary review, meaning
 20 that if someone has colon cancer resected or
 21 breast cancer and they're sent in to see an
 22 oncologist in St. John's from St. Anthony,
 23 then as part of that referral they'll have
 24 their pathology reviewed. Now, the BC Cancer
 25 Agency and in Ontario does not have enough

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1 pathologists to do that, so what they do is
 2 they accredit external pathologists and they
 3 say that this person has developed the
 4 necessary expertise that they will do
 5 secondary review for us.
 6 So, that's one real advantage is to have
 7 that confidence, that somebody that you're
 8 very comfortable with. It's a very personal
 9 thing and you develop a relationship with a
 10 pathologist. You feel comfortable the same
 11 way you do with a radiologist and you say--I
 12 get this report back and I say, well, I feel
 13 comfortable because I know who did the report.
 14 I know that they're skilled and I trust that
 15 report. And so it's very important for
 16 oncologists and so having someone in house is
 17 important. It's also important that you can
 18 walk down the hallway and say, listen, you
 19 know, I'm not happy about this. Now, you can
 20 pick up the phone and in St. John's, it's only
 21 a little bit more of a walk because we're all
 22 in the same building, but I think as a program
 23 gets bigger and because we have a lot of
 24 patients referred from outside, I think an in-
 25 house person is an important thing. That if

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1 we can't do it at this point because there's
 2 not enough pathologists, fine, but that's
 3 something the program should be striving for
 4 in the future.
 5 COFFEY, Q.C.:
 6 Q. And Doctor, in relation to the issue of
 7 routine or regularly scheduled meetings
 8 between physicians and other clinical staff,
 9 potentially, at Eastern Health, to your
 10 knowledge, are there any mortality or
 11 morbidity rounds?
 12 DR. SALTMAN:
 13 A. I can't speak for Eastern Health for all the
 14 disciplines. I know that the Emergency
 15 Department at Eastern Health at the Health
 16 Science Complex has morbidity and mortality
 17 rounds and what that means is that someone
 18 comes into Emergency, they're in bay number 5
 19 and they're sitting there comfortably and next
 20 thing they've died and it's unexpected. And
 21 so that gets put into a file and at the end of
 22 the week or the month, all the doctors and
 23 medical students and residents sit down and
 24 say, right, that was an unexpected death or
 25 side effect. How can we learn from it? It

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1 may have been caused by human error, but the
 2 idea is not to blame, but to learn from that.
 3 Within the cancer care program, within
 4 radiation oncology, I met with the head of
 5 radiation oncology last night and they have a
 6 mechanism where they have delegated one of
 7 their members, a general practice associate,
 8 to collect charts and to review them on a
 9 regular basis. Within medical oncology, to
 10 the best of my knowledge and again, I talked
 11 to my colleagues yesterday, that we do not
 12 have morbidity and mortality rounds within the
 13 program as a provincial cancer care program;
 14 we do not have morbidity and mortality rounds
 15 per se.
 16 Which means if Mrs. Browne, who is my
 17 patient, comes into Stephenville, who is on
 18 chemotherapy, she's young, she's otherwise
 19 well and she gets seriously ill or dies, then
 20 if that's not directly due to her cancer, we
 21 need to know about that. We need to learn
 22 about that, not just as an individual case,
 23 but we need to sort of say, well, we see a
 24 trend here. We see that maybe there's
 25 something going on in Stephenville or maybe

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1 there's something going on with the treatment.
 2 Are people not getting the most appropriate
 3 treatment of follow-up?
 4 So, these are--this is not a new concept.
 5 Morbidity/mortality rounds should be an
 6 integral part of any program, whether it's
 7 oncology or cardiology.
 8 COFFEY, Q.C.:
 9 Q. And you're indicating, I take it, in this
 10 context, in particular, just don't, Mr.
 11 Coffey, just don't focus on St. John's. In
 12 fact, this should be a province wide -
 13 DR. SALTMAN:
 14 A. We're a provincial program. If I see somebody
 15 here and they go back to St. Anthony, unless I
 16 sign off on my chart that I'm no longer
 17 responsible which is what's called a most
 18 responsible person, MRP, I'm assuming it's the
 19 same in Newfoundland and B.C., but until I put
 20 that in the patient's chart, that patient is
 21 mine forever, as long as I'm in practice. And
 22 so if something happens to them in
 23 Stephenville or Corner Brook, even though I'm
 24 in St. John's, I'm ultimately responsible and
 25 that's why I need to know why they got sick;

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1 why they were admitted and why they could have
 2 died.
 3 THE COMMISSIONER:
 4 Q. Mr. Coffey, it's quite near to 5.
 5 COFFEY, Q.C.:
 6 Q. It's a good point to break, Commissioner. I
 7 understand we're going to break for an hour
 8 and a half and come back at 6:30.
 9 MR. SIMMONS:
 10 Q. Commissioner, if I might throw my (inaudible)
 11 out to the room (inaudible) get knocked down.
 12 I don't know how long Mr. Coffey thinks he
 13 might be, but if it was only an hour or so -
 14 COFFEY, Q.C.:
 15 Q. I prefer to break, myself, if I could, and
 16 come back 6:30 and come back. I just would.
 17 THE COMMISSIONER:
 18 Q. All right, if that's the plan, that's the
 19 plan. I think that was the one that was
 20 announced
 21 COFFEY, Q.C.:
 22 Q. Yes, it was.
 23 THE COMMISSIONER:
 24 Q. All right then, we'll break until 6:30. Thank
 25 you.

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1 (SUPPER BREAK)
 2 THE COMMISSIONER:
 3 Q. Please be seated. Mr. Coffey.
 4 COFFEY, Q.C.:
 5 Q. Doctor, in relation to initiatives on your
 6 behalf that you've started out on, have you
 7 been involved in the development of any forms?
 8 DR. SALTMAN:
 9 A. One of the--let me back up. We talked about
 10 the strengths and weaknesses of the cancer
 11 program and the strengths are its people, its
 12 nurses, its pharmacists, physicians.
 13 COFFEY, Q.C.:
 14 Q. Um-hm.
 15 DR. SALTMAN:
 16 A. But one of the weaknesses of this program and
 17 I think of big concern and one that differs
 18 from most provincial cancer care programs is
 19 that we don't have our own pharmacy program.
 20 In fact our pharmacy manager does double duty
 21 with Eastern Health management in non-oncology
 22 business, are two very well trained oncology
 23 pharmacists are, at least, one of them is
 24 having to rotate through the regular general
 25 hospital service. So, this is an unusual

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1 situation, but of equal concern is that we
 2 have a big discrepancy on how chemotherapy is
 3 ordered in this province. Within the cancer
 4 care program in St. John's, we order it
 5 electronically for most patients, that's for
 6 what's called parental therapy, IV therapy, as
 7 you know, in this province, non-parental
 8 therapy is not covered usually by the
 9 government except for exceptional
 10 circumstances. If you go within the same
 11 hospital, within the Health Science Complex,
 12 if you go up to the cancer ward where patients
 13 with lymphomas, leukemias, breast cancer, are
 14 treated an is-patients, how chemotherapy is
 15 ordered up there is different than it is
 16 ordered in the cancer centre in the same
 17 building. And there's some real advantages of
 18 electronic ordering in terms of reducing
 19 clerical errors. Once you start writing out
 20 chemotherapy orders, you introduce the
 21 possibility of errors. And there's lots of
 22 checks and balances, they get checked by
 23 pharmacists, pharmacy technicians, nurses, but
 24 the more times you're handwriting things out,
 25 the more times you're going to increase the

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1 risk of an error.
 2 Now, if you go to clinic in Grand Falls
 3 or Corner Brook or if you have a patient in
 4 Stephenville, you have a different system yet
 5 again of, again, more handwritten, then
 6 typing, then faxing, then more typing, then
 7 more computer entering. So, there's no common
 8 system in what is a provincial program.
 9 So, when I arrived in Newfoundland, I
 10 asked the leadership about this and we did
 11 talk about some potential solutions. I asked
 12 about why don't we have electronic ordering in
 13 the same building, in the same Health Science
 14 Complex and I'm not quite sure, to this day,
 15 why that's not the case. I was told by IT
 16 people that within a relatively short period
 17 of time in the other centres, but to my
 18 knowledge, this has not been done as of yet.
 19 So, one of the solutions I propose is
 20 what many other centres does and certainly
 21 what the BC Cancer Agency does, and that's the
 22 next best thing which are pre-printed orders.
 23 And these can be very comprehensive. Not only
 24 do they give you the actual chemotherapeutic
 25 agents, but they can give you the medications

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1 for nausea, what we call antiemetics. It's
 2 very useful for clerical staff in that they
 3 can book the patients. So, it's one-stop
 4 shopping using one form. And again, there's
 5 different ways to do things, but I proposed
 6 this as a potential intermediate step to, sort
 7 of help to bridge the period until we had the
 8 same common system whether electronic or paper
 9 throughout the whole province. And I even put
 10 them all together for each disease site group,
 11 for every type of cancer, and I spoke with the
 12 in-patient head nurse, with physicians and I
 13 even spoke to my hematology colleagues and
 14 there seemed to be a lot of support for this,
 15 but again, this never really got off the
 16 ground when it went to management.

17 COFFEY, Q.C.:

18 Q. And management in this context is whom?

19 DR. SALTMAN:

20 A. Management in the cancer care program is--
 21 again, I'm sure there's other committees
 22 within the centre, but management is what's
 23 called a leadership committee. And this
 24 cancer centre has a structured, has a clinical
 25 chief which is Doctor Laing. There's an

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1 operational head which is--it's called a
 2 director of oncology which is part of the
 3 operational team of the Eastern Health and I
 4 think you're going to speak with Ms. Smith at
 5 some point during this Inquiry. She can
 6 explain her role in the cancer care program
 7 and then there's various other members of that
 8 leadership team including myself and that's
 9 where these, as I talked before, a lot of
 10 decisions, a lot of ideas, filter into this
 11 committee and in my opinion, a lot of them
 12 stay there. These are often not executive
 13 type decisions. These are decisions that
 14 should really be generated from nurses,
 15 doctors, pharmacy technicians, whoever and
 16 communicate with each other, work on these
 17 things. It's something leadership has to know
 18 about, but it's not something that leadership
 19 actually has to rubber stamp.

20 COFFEY, Q.C.:

21 Q. Now, these forms, for example, the form for
 22 different disease sites that you developed,
 23 you did so, I take it, with a view to making
 24 them available to physicians, just within
 25 Eastern Health or throughout the province in

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1 terms of cancer care.

2 DR. SALTMAN:

3 A. Yes, anybody in the cancer care program, I
 4 discussed this with the clinics in Grand
 5 Falls, the doctors that work there; they
 6 thought it was a great idea, doctors in Corner
 7 Brook and there's just some real advantage to
 8 it. You either have an electronic system
 9 which most cancer centres don't have. Most
 10 people either have pre-printed orders. I'm
 11 sure there's probably still some places that
 12 hand write out orders which I don't think is a
 13 good thing to be doing anymore, but certainly,
 14 this would have been a province wide thing and
 15 in my opinion, would have added another
 16 element of safety into the system.

17 COFFEY, Q.C.:

18 Q. So, when you started to speak about this, you
 19 had gone to some IT people and spoken to them
 20 about the possibility of, I take it, putting
 21 in electronic or communicating electronically
 22 between, for example, St. John's and
 23 elsewhere, in relation to the pharmacy orders.
 24 Is that -

25 DR. SALTMAN:

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1 A. We have a system called OPIS which is used
 2 quite a lot in Ontario and it's electronic,
 3 there's an electronic ordering system.
 4 There's also a way of collecting--it's not
 5 really a true electronic chart, but it's a
 6 place you can store dictation, follow-up
 7 notes. Cancer care program really doesn't
 8 have an electronic chart and in my opinion,
 9 the paper chart is not a full paper chart as
 10 well, but chemotherapy can be ordered
 11 electronically through there. I spoke to the
 12 IT people who work with the cancer centre and
 13 I was told that certainly on the wards in the
 14 Health Science Complex, this was something
 15 that could be rectified very quickly. Even in
 16 places like Corner Brook, this is something
 17 that, you know, could happen within a matter
 18 of days, not weeks or months.

19 COFFEY, Q.C.:

20 Q. So, I take it the ward was within hours or
 21 days and it could be addressed -

22 DR. SALTMAN:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. - the IT people indicated. And outside St.

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1 John's within days or weeks.
 2 DR. SALTMAN:
 3 A. Yes, this is--a good IT person can sit down
 4 and do this relatively quickly and certainly
 5 in British Columbia because we deal primarily
 6 with pre-printed orders, we don't have
 7 electronic ordering, that we had this
 8 commonality. In fact, you didn't have to be
 9 in a cancer centre. You could be in
 10 Stephenville, the equivalent of Stephenville,
 11 Grand Falls, Twillingate. You can go to your
 12 computer and you download a pre-printed order
 13 which is accompanied by a protocol. And we
 14 have a system that if we wanted to treat
 15 someone with chemotherapy in Clarenville or
 16 Stephenville, there's a lot of, sort of, back
 17 and forth of handwriting, then transcribing,
 18 then entering into a computer. It seems to
 19 work, but it's--there's a much easier and I
 20 think safer solution.
 21 THE COMMISSIONER:
 22 Q. Excuse me, Mr. Coffey, but it's a case of just
 23 asking questions when they run through your
 24 head, Dr. Saltman, you talked about OPIS?
 25 DR. SALTMAN:

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1 A. Yes.
 2 THE COMMISSIONER:
 3 Q. And we've heard numerous references to the
 4 existence of Meditech.
 5 DR. SALTMAN:
 6 A. Right.
 7 THE COMMISSIONER:
 8 Q. Which I understand is not necessarily the
 9 same--they're not--the Meditech System, at
 10 least within the city, are not capable of
 11 talking to each other, so I would assume that
 12 the Meditech Systems that exist in other parts
 13 of the province don't talk to each other
 14 either, at least for the moment. If you are
 15 in the Cancer Centre, can you pull up both
 16 OPIS and the Meditech System? Do you have to
 17 do that and get a large paper chart? How do
 18 you deal with a patient who walks through the
 19 door who's got some history?
 20 DR. SALTMAN:
 21 A. Yeah. So the Meditech System is a clinical
 22 information system and can store dictations,
 23 lab tests, x-ray reports. It's been difficult
 24 sometimes to link Meditech with x-ray
 25 archiving system in some cases. I think we

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1 have a real problem in the province with the
 2 Meditech System, but I can't--it depends who
 3 you talk to, and again this is going back to
 4 the leadership of--not the leadership, but the
 5 way decisions are made in the Cancer Care
 6 Program in Newfoundland. I arrived here from
 7 British Columbia. I can sit in my office in
 8 Kelowna, I have an electronic, a true
 9 electronic chart because all my dictations are
 10 there, and although Meditech doesn't talk with
 11 electronic chart, the BC Cancer Agency scans
 12 everything in. So we have an electronic
 13 chart, we still keep a paper chart, but when I
 14 go into a visiting clinic or sit in my office,
 15 I would no longer use paper, even though it's
 16 there, I can all do it electronically, and the
 17 x-rays are fused in too. So everything is
 18 there. I can look at the pathology report,
 19 the x-rays, blood tests. What happened here
 20 in 2005 when they amalgamated all the health
 21 care regions into four, I think it's four
 22 health care regions, and even within Eastern
 23 Health, which I don't know, had "x" number of
 24 facilities, they did not--each Meditech System
 25 in Carbonear, Clarenville, whatever, had its

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1 own database, and in order for these to talk
 2 to each other, they would have had to have
 3 been fused together. In St. John's, the one
 4 from St. Clare's and the Health Science are
 5 fused together, I can sit at my desk and if
 6 someone had a blood test done in St. Clare's,
 7 I can pick it up. So when I arrived here, I
 8 just assumed because you had Meditech and this
 9 is within Eastern Health, the same health
 10 authority, and because it's a provincial
 11 Cancer Care Program, when I got my first call
 12 from Clarenville and talked to a doctor, he
 13 said I have a difficult problem, and I said,
 14 well, let me look up the patient, I realized
 15 that I can't look up their blood work, I can't
 16 look up their pathology report, or surgical
 17 report. If they already have an existing
 18 chart, I can try to get it, but as I
 19 mentioned, our charts--our paper charts are
 20 not up to date and, in my opinion, not
 21 complete. So I spoke to Meditech in Montreal.
 22 I said what's the problem. They said, well,
 23 it's not a technically difficult problem, it's
 24 a lot of work to fuse all these databases, but
 25 it can be done, but there is a step that you

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1 can take as an intermediary step, and I met
 2 with the IT people in Eastern Health and I
 3 said this is a big problem for us, it's a
 4 major problem, we can't--we're coming back
 5 again to communication, and I said, you know,
 6 can this be fixed because it just doesn't
 7 affect doctors, we have booking clerks who
 8 spend days upon days getting faxes and phone
 9 calls to put together a paper chart where as
 10 in the BC Cancer Agency it takes them an hour
 11 because they sit in the front of the computer
 12 and they go "path report, surgical report,
 13 blood tests, x-rays, here's your chart", not
 14 just a paper chart, but that's made into an
 15 electronic chart. I said we have two very
 16 hard working new patient booking clerks, we
 17 have doctors who want to be able to access
 18 people's results so they can communicate
 19 effectively, and I was told that it could be
 20 done. I said, well, why hasn't it been done,
 21 why hasn't anybody addressed this, and they
 22 said because nobody has asked us. I said,
 23 well, could you do it, and they've done it,
 24 and, you know, I approached the management and
 25 this is something that did happen relatively

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1 quickly. I came back from holidays last week,
 2 I spoke to the booking clerks, and they said
 3 our job is exponentially easier because now
 4 they can put together a chart and now--I don't
 5 know if the physicians have access, but the
 6 plan is this is--they haven't fused the
 7 databases, but they've somehow been able to
 8 give the people here in the Cancer Centre the
 9 various icons for Meditech. So Meditech and
 10 OPIS are different, and we have Meditech for
 11 lab results, we can store x-ray reports, and
 12 if a surgeon or pathologist has a dictation,
 13 that's stored in there, but I can't access
 14 Grand Falls, I can't access Corner Brook.
 15 Where I have a great number of patients, I
 16 spend an awful lot of time on the phone trying
 17 to get lab tests directly from the nurse or
 18 have them faxed, or whatever. So we don't
 19 really have a true--one electronic charting
 20 here. OPIS is for collecting our dictations
 21 within the Cancer Centre, but there's
 22 something called OPIS 2000, which is an
 23 electronic ordering system.
 24 THE COMMISSIONER:
 25 Q. This sounds oddly (unintelligible) complicated.

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1 DR. SALTMAN:
 2 A. It doesn't need to be, it doesn't need to be.
 3 Now in British Columbia, we did the same thing
 4 in 2002. I don't know how many health care
 5 regions, but within the Interior Health, 30
 6 health facilities came together the same way
 7 they did in Newfoundland, and within one year,
 8 and you can follow--all this is on the web,
 9 the progress of fusing these databases because
 10 it was a priority for the health authority
 11 because they realized not just for
 12 oncologists, but for thoracic surgeons,
 13 everybody, that this was a--this had to be
 14 done so that we put all our clinical
 15 information into one site. Here we are now
 16 three years, going on four years, since the
 17 health care regions amalgamated within
 18 Newfoundland, we still don't have a provincial
 19 one stop shopping, but we don't even have it
 20 within Eastern Health, that the majority of
 21 physicians, if you're an ICU physician, a
 22 thoracic surgeon, a respirologist, you cannot
 23 access valuable clinical information outside
 24 of St. Clare's and the Health Science Complex.
 25 COFFEY, Q.C.:

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1 Q. Doctor, I take it in terms of the form, or
 2 your suggested form or forms, you still
 3 haven't heard back about those?
 4 DR. SALTMAN:
 5 A. No, I'm not sure I--you know, after a point,
 6 you just say, I'll do it for you, I'll try to
 7 facilitate this, people seem to be interested
 8 in it, but if it doesn't go anywhere, then
 9 that's fine, you know, I--that's all I can do
 10 is try to initiate these things.
 11 COFFEY, Q.C.:
 12 Q. Was any difficulty with your suggestion
 13 communicated to you? Did anybody say, well,
 14 that won't work, doctor, for the following
 15 reason or reasons?
 16 DR. SALTMAN:
 17 A. I don't remember specific comments, but I just
 18 felt that this was--you know, I just felt any
 19 initiatives like these were to try to get them
 20 to where they needed to go was a very
 21 difficult process because again it seem all
 22 filtered into a senior management team, and
 23 that's where it stayed. That decision really
 24 should have been a Head of Medical Oncology
 25 decision, and then going to operational people

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1 to make it happen. Really it's a clinical
 2 decision, from my point of view, and to use
 3 the operational management to facilitate that,
 4 not to decide whether or not it's a good
 5 thing. If the oncologists and the physicians
 6 around the province say we don't want to do
 7 that, fair enough, but I didn't get the
 8 impression that was the case.
 9 COFFEY, Q.C.:
 10 Q. And from your perspective, it should be the
 11 decision of the people who would actually be
 12 utilizing it, which is the physicians
 13 themselves?
 14 DR. SALTMAN:
 15 A. Yes. There's a very important role for
 16 operations and operational management, but
 17 this to me was do the clinical people feel
 18 that this would be useful; if so, yes, how can
 19 we facilitate it in a timely manner.
 20 COFFEY, Q.C.:
 21 Q. Doctor, you did--before we broke for supper,
 22 you did speak of electronic communication,
 23 particularly cell phones, e-mail, Blackberrys,
 24 that sort of thing as being, from your
 25 perspective, a useful tool for a clinician. I

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1 did want to ask you about that in relation to
 2 the idea of utilizing, in effect, an e-mail
 3 system as the potential for it to be utilized
 4 as, what I'll refer to, as a virtual tumour
 5 board. Is there a possibility of that, and if
 6 so, how might it work?
 7 DR. SALTMAN:
 8 A. Again we're going back to communication and
 9 how this can be very useful. It's not an
 10 esoteric thing, it's a real thing, and it's a
 11 patient care thing. So I'll go back to the BC
 12 Cancer Agency. You have four radiation
 13 oncology centres which--a lot of the cancer
 14 care given in BC, including seeing new
 15 patients, is done by internal medicine
 16 specialists, and a lot of administration of
 17 chemotherapy is given by family doctors, in
 18 some cases nurses, and once you're part of
 19 that system, you get a BC Cancer Agency e-mail
 20 address, and then you can communicate--I can
 21 be an oncologist anywhere and somebody can
 22 say, listen, I've got a little bit of a
 23 problem here, what do you think. I can be
 24 sitting in my office seeing patients, and I
 25 have my screen up, and between patients I can

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1 access my e-mail. So that's a very effective
 2 way of problem solving and helping colleagues
 3 and referring physicians outside the Cancer
 4 Centre, but we also used it as a virtual
 5 tumour board. So rather than having a fixed--
 6 we had fixed tumour boards for all the disease
 7 sites, which were videolinked throughout the
 8 whole province, but we also had disease site
 9 groups that what we did is--I was on the GI
 10 group, the neuro oncology group, the skin
 11 group, the lymphoma group, and if someone in
 12 Victoria had a difficult case, they sent an e-
 13 mail that went out to 30 people within the GI
 14 group, and within an hour or so seven or eight
 15 people responded to say, yeah, I saw one last
 16 week, or I'm concerned about--let's take your
 17 breast cancer, why we're here, lobular
 18 carcinoma that was ER negative; gosh, I
 19 haven't seen that for a while, maybe I should
 20 get--these are the sort of things that you can
 21 do virtually, and you may have a difficult
 22 case that you can't wait until Friday to the
 23 actual fixed tumour board rounds. Now there's
 24 no reason why we can't do this here. I found
 25 when I came here there were no distribution

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1 lists within the Cancer Centre for a GI group,
 2 for a neuro group, and these don't--these are
 3 not just people within the Cancer Centre, they
 4 would include the neurosurgeons, the
 5 neuropathologists--there are no distribution
 6 groups--e-mail distribution lists for those
 7 groups, and I've created those since I came
 8 and I've sent them to all the oncologists, and
 9 so it's a very effective way of communicating
 10 and it's certainly something that could be
 11 advocated here, but again we have an IT
 12 problem. Even if I want to access my e-mail,
 13 my Eastern Health e-mail in the clinic, I have
 14 to go into the web to access that. I just
 15 can't type in David Saltman and my password,
 16 and that screen comes up and that's mine, and
 17 my e-mail is there. Again there's a level of
 18 complexity, which I think a reasonable IT
 19 person, I would be able to approach them and
 20 between us we would be able to make a decision
 21 how to fix this, and then it filters up
 22 eventually to an executive committee to say,
 23 you know, this is what we've done.
 24 COFFEY, Q.C.:
 25 Q. And in terms of--this, of course, would

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1 involve sitting at a computer terminal?
 2 DR. SALTMAN:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. If Blackberrys were, for example, able to be
 6 utilized throughout the facilities, the
 7 physical facilities, I take it that if someone
 8 at least who was familiar with the usage of
 9 Blackberry or a similar device, the text
 10 messaging would allow you to do that, in
 11 effect carry on this virtual tumour board?
 12 DR. SALTMAN:
 13 A. Absolutely, and we're about to start this
 14 study, again I think to prove to Eastern
 15 Health and Newfoundland health authorities
 16 that somehow we're not different than the rest
 17 of the world, but that's it, you sit there
 18 with your Blackberry or you can even sit with
 19 a patient because they're--we've been doing
 20 now for 40 years, you go in a room and your
 21 pager goes off and you have to leave the room
 22 to find a phone; well, you can sit in the room
 23 and this thing doesn't ring, it gives a little
 24 red signal--you probably have a Blackberry, or
 25 it gives a little buzz, and you can quickly

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1 take a peak at it and say, well, that's an e-
 2 mail, I don't need--if I'm a nurse in Corner
 3 Brook, I don't need to answer it right away,
 4 but when I leave the room, I'll quickly
 5 contact her back. Yes, there is a computer
 6 terminal outside in the clinic, yes, there is
 7 a phone, but at least we should give health
 8 care workers the option of utilizing these
 9 technologies. That's not a possibility except
 10 through this clinical trial that we're going
 11 to be doing in the Cancer Care Program. There
 12 is another problem that there's a lot of dead
 13 zones within hospitals. In basements, we have
 14 lead lined rooms, these things, but, in fact,
 15 it turns out that you can get good reception
 16 in most of the clinical areas within the
 17 Cancer Centre.
 18 COFFEY, Q.C.:
 19 Q. Doctor, you had spoken or told the
 20 Commissioner about this--in dealing with Dr.
 21 Carter, you'd been able to arrange for one
 22 meeting, I believe it was back earlier this
 23 year, of all pathologists, all but one
 24 pathologist, and that I take it--would it be
 25 right, June?

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1 DR. SALTMAN:
 2 A. This was, I think, June 18th through the 20th,
 3 something like that.
 4 COFFEY, Q.C.:
 5 Q. Are there any plans for any more?
 6 DR. SALTMAN:
 7 A. Yeah, there was tremendous excitement by the
 8 pathologists about the idea that you could
 9 bring a group of people together like that,
 10 and, you know, you just don't chat about
 11 synoptic templates, there was a lot of
 12 discussion about a number of issues, and so
 13 the idea is actually to--I'm working with--as
 14 you know, Dr. Carter has moved on to the BC
 15 Cancer Agency in Vancouver, but I'm working
 16 with Dr. Ford Elms and we thought it would be
 17 a good idea to bring in an expert to talk
 18 about immunohistochemistry, and this time
 19 actually even invite the laboratory
 20 technologists to come as well. We would bring
 21 another speaker in to talk about quality in
 22 pathology, and again, pharmaceutical company--
 23 the Department of Pathology and I don't know
 24 about Eastern Health's budget, but certainly
 25 Pathology doesn't have the budget to do this,

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1 and I have approached pharmaceutical companies
 2 for unrestricted educational grants, and
 3 they're very, very interested in pathologists
 4 these days and because of these new targeted
 5 therapies and immunohistochemistry and all
 6 these things, they take a great interest. So
 7 getting monies from the private sector to do
 8 these educational sessions is not that
 9 difficult. We were going to do that actually
 10 in October and because of commitments with
 11 this Commission of Inquiry, Dr. Elms thought
 12 that we would delay that probably to the
 13 spring.
 14 COFFEY, Q.C.:
 15 Q. And had there been any discussion about who
 16 that expert might be?
 17 DR. SALTMAN:
 18 A. I've forgotten the names, because I'm not a
 19 pathologist, but there was somebody from
 20 Ontario and then there was somebody who was an
 21 expert with the--expert advisor, I think from
 22 Florida, a pathologist who's done a lot of
 23 work on quality within the field of pathology.
 24 COFFEY, Q.C.:
 25 Q. And if I was to say Bryan Hewlett?

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1 DR. SALTMAN:
 2 A. This is one person that came up, and then
 3 there's another person who has an East Indian
 4 name, who's an American expert in the field of
 5 quality.
 6 COFFEY, Q.C.:
 7 Q. And this was the--why I'm bringing this out is
 8 this, asking you about this is that you're
 9 involved in this because this generally will
 10 involve pathologists and, in this context,
 11 technologists.
 12 DR. SALTMAN:
 13 A. Right.
 14 COFFEY, Q.C.:
 15 Q. And you are neither of those.
 16 DR. SALTMAN:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. So how is it that you've gotten involved in
 20 it? Just if you could explain kind of why you
 21 feel the need or see the need to get involved.
 22 DR. SALTMAN:
 23 A. I see it as a role of somebody who's going to
 24 be part of the discipline of oncology. I
 25 worked as a scientist for a number of years.

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1 I have done a lot of these techniques,
 2 immunohistochemistry, fluorescent in situ
 3 hybridization, and so I have an interest in
 4 it, but for--I do it also for a very selfish
 5 reason, because I'm a practising medical
 6 oncologist and I want to make sure it's safe
 7 to practise in Newfoundland. I want the best
 8 practice and I want--if I get a report from
 9 Corner Brook, I want it as a synoptic
 10 template. I don't want to spend all day
 11 reading through paragraphs of pathology
 12 jargon. I want a concise report and I want
 13 them to look at the things that are important
 14 for prognostication, and if it's breast, it
 15 has to do with nodes and ER receptors. In
 16 colon, it's a number of other things. And so
 17 I have a vested interest as a physician, but
 18 also as somebody who's interested in education
 19 as well.
 20 COFFEY, Q.C.:
 21 Q. Doctor, in relation to matters relating to
 22 patient safety, you, in the past, but you've
 23 been here now eight months or almost eight
 24 months, has issues involving public safety
 25 ever come up in the way of, I'll refer to it

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1 as involving controversy? Have you ever been
 2 involved?
 3 DR. SALTMAN:
 4 A. Can you rephrase the question?
 5 COFFEY, Q.C.:
 6 Q. Okay. Well, in terms of have you ever had to
 7 deal with any situations where you've gotten
 8 into a disagreement about whether or not you
 9 should be involved in certain things involving
 10 patient safety, or from your perspective,
 11 involved patient safety potentially?
 12 DR. SALTMAN:
 13 A. As I mentioned earlier, I'm the academic head
 14 and then I'm a medical oncologist. I sit on
 15 the leadership committee, and this is a new
 16 venture and it's rather nebulous how the two
 17 fit together, but let me give you--try to
 18 answer your question.
 19 Recently, there's been a very good review
 20 talking--as a cautionary review about oral
 21 chemotherapy and how its dispensed, and this
 22 is from the context of the United States where
 23 most chemotherapies are dispensed through the
 24 retail sector, but they have multiple other
 25 ways that they're dispensed, and this was a

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1 good review saying "we need to be careful
 2 because these are not just chemotherapeutic
 3 agents any more. These have types of side
 4 effects which are unusual and we need to take
 5 a look at this."
 6 Now this was a very relevant article for
 7 Newfoundland because of the way chemotherapy
 8 is dispensed in this province. Anything
 9 that's not pumped in through an IV is what
 10 calls non-parental. It could be
 11 intramuscular; it could be subcutaneous; it
 12 could be oral, and we use more and more oral
 13 chemotherapies every year, and these are
 14 dispensed in Newfoundland primarily through
 15 the retail sector. We would dispense some
 16 from the Cancer Centre in St. John's, but
 17 primarily it's through the retail sector, and
 18 I have tremendous confidence in pharmacists
 19 and appreciate their job. They're very
 20 professional people, but you can appreciate,
 21 if you're given a prescription for a new oral
 22 chemotherapy that has potentially life
 23 threatening side effects, complex--some of
 24 these are very complex agents, and you send
 25 the patient back to Labrador City and it's

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1 dispensed at Shopper's in Labrador City, and I
 2 just picked Shopper's. I should say pharmacy
 3 X. And although that person can go online and
 4 look up something, they may have never
 5 dispensed it and they may not do it for
 6 another year or two, because cancer, although
 7 we think it's common, compared to diabetes or
 8 health disease, it's not that common.
 9 And so it's not just a concern in
 10 Newfoundland. Most of the western provinces,
 11 chemotherapy is dispensed through cancer
 12 centres or hospitals. You don't get it from a
 13 retail sector or very rarely, and so this is a
 14 safety concern for me and that when I--even
 15 before I got here, I was talking to Mr. Rick
 16 Abbott, who's the manager for the Cancer Care
 17 Pharmacy program, about this issue and he had
 18 some concerns as well, and we reviewed the
 19 Pharmacy Act. We looked and said well, maybe
 20 a starting ground is maybe we should see if we
 21 can eventually start dispensing chemotherapy,
 22 oral chemotherapies through hospitals and
 23 cancer centres.
 24 This would require a change in the
 25 Pharmacy Act, and I drafted a letter when I

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1 got here. I sent it to the Minister of
 2 Health, never had a reply, but on the
 3 suggestion of Mr. Abbott, he thought I should
 4 get in touch with the registrar of the College
 5 of Pharmacy of Newfoundland. I called and he
 6 was out of town. I tried to arrange for a
 7 meeting. I wrote a letter, the same letter
 8 that I wrote to Mr. Wiseman. I wrote again,
 9 e-mailed again, spoke to a friend who is a
 10 friend of the registrar, and after about ten
 11 weeks or so, I e-mailed him and said "I want
 12 to write about this concern. I want to talk
 13 about it publicly," that may be also in the
 14 media, whatever, but I think there has to be
 15 transparency about these issues, and to talk
 16 about them openly. I got eventually an e-mail
 17 response from the registrar of the College of
 18 Pharmacy and said that "sorry for the delay.
 19 I wasn't quite sure who you were, if you
 20 really should be poking your nose around
 21 here," and that wasn't his words, that's my
 22 words, and this was copied to the head of
 23 Eastern Health's pharmacy and to the director
 24 of oncology at our Cancer Centre, and I
 25 received an e-mail shortly after that from the

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1 director of oncology cautioning me that I
 2 should not be talking about safety in public.
 3 COFFEY, Q.C.:
 4 Q. And the director of oncology in this, you're
 5 using that phrase in this context, that's not
 6 Dr. Laing?
 7 DR. SALTMAN:
 8 A. No, that's Ms. Smith, yeah.
 9 COFFEY, Q.C.:
 10 Q. And did anything else then transpire in
 11 relation to that?
 12 DR. SALTMAN:
 13 A. Well, I was a bit flabbergasted that as a
 14 chair of oncology, even as a physician, that
 15 you can't talk about safety in public.
 16 Anyway, that -
 17 COFFEY, Q.C.:
 18 Q. And if I could, in public in this context was
 19 what?
 20 DR. SALTMAN:
 21 A. Well, in public, could have meant that I could
 22 have talked to--given a talk about this,
 23 written a paper. I don't think Ms. Smith
 24 really knew, and I mentioned that I may want
 25 to talk, to write an article in the media or

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1 whatever, to--I get asked by the media or
 2 other people to write reviews, these sort of
 3 things. You'll have to ask her what she meant
 4 by public, but this to me was an outstanding
 5 really thing to say, regardless of the
 6 context, you must not talk about safety in
 7 public.
 8 Anyway, I was quite concerned about this.
 9 I'm here since March. I have an appointment
 10 with the University. I think it's my job to
 11 talk publicly, to be an advocate for patient
 12 care and for safety and so, I approached the
 13 university. I approached the person I report
 14 to, the Dean of Medicine, and I said I was
 15 quite concerned about this, and I told him
 16 that I was actually--I have had an office in
 17 the administrative suite within the Cancer
 18 Center and I said "I would like to have an
 19 office within the University." I'm concerned
 20 about these comments, and I'm in the process
 21 of getting an office in the Medical School.
 22 I don't think it's the role of the
 23 operational management of Eastern Health to
 24 get involved in these issues, and quite happy
 25 to talk to people about them, but for the

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1 operational management to be telling
 2 physicians or other health care workers they
 3 can't talk in public--not about a specific
 4 case in the Cancer Centre, we're not talking.
 5 We're talking about something that's of
 6 concern in the United States, the rest of
 7 Canada and Europe, about the safety concerns
 8 of dispensing oral chemotherapy.

9 COFFEY, Q.C.:
 10 Q. And Doctor, I want to ask you about your
 11 contact with, you know, other bodies that
 12 affect your work or potentially affect the
 13 work of oncologists and, for that matter, in
 14 some instances, pathologists and other people,
 15 and I'll refer to them as kind of non-clinical
 16 partners, in terms of cancer care. In
 17 relation to the NLMA, have you had any
 18 dealings with the NLMA here?

19 DR. SALTMAN:
 20 A. That's the Newfoundland -

21 COFFEY, Q.C.:
 22 Q. Newfoundland and Labrador Medical Association.

23 DR. SALTMAN:
 24 A. My only real relationship, other than to be in
 25 Newfoundland, you have to become a member and

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1 some other provinces, you don't have to become
 2 a member. You have to be a member of the
 3 College of Physicians and Surgeons, but you
 4 don't necessarily have to be a member of the
 5 medical association, but in Newfoundland, you
 6 do, so I'm a member. As you may remember,
 7 earlier this year, we had some pathologists
 8 resign. We had some threatened to resign and
 9 as oncologists, as you know, we work very
 10 closely with them, and so not just me, Dr.
 11 Laing and the entire group decided to advocate
 12 on their behalf and so we worked with the
 13 Newfoundland Medical Association, with Mr.
 14 Ritter from that organization, and worked with
 15 the government to try to save our
 16 pathologists.

17 COFFEY, Q.C.:
 18 Q. And in the course of meeting with the NLMA,
 19 have you gotten any feedback from your own
 20 cancer care program arising out of your
 21 contact with the NLMA?

22 DR. SALTMAN:
 23 A. There were a lot of sessions. Well, I didn't
 24 attend a lot of them. Almost on a weekly
 25 basis, the Newfoundland Medical Association

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1 was briefing the physicians about what was
 2 happening in the Inquiry, what was happening
 3 with negotiations with the government, for the
 4 pathologists, and at the same time, there was
 5 negotiations about a new salary package for
 6 the oncologists.

7 When I first came to Newfoundland, I made
 8 a point of going to visit the head of MCP, who
 9 was an old classmate of mine, and to have an
 10 informal discussion about how physicians are
 11 remunerated in this province and not the
 12 actual amount, but the actual structure. Most
 13 oncologists in Canada are paid a straight
 14 salary, sort of alternative funding plan, and
 15 it's done differently in each province, and
 16 the actual amount of money that they get is
 17 comparable to what the physicians were paid in
 18 Newfoundland. The way physicians are paid in
 19 Newfoundland is very complex, but I wanted to
 20 talk to her about creating an alternative
 21 funding plan so that all oncologists and
 22 hematologists, gynecologists, pediatric
 23 oncologists, could all fit into the same
 24 salary structure and be paid equitably.

25 And so one specific meeting we had with

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1 the Newfoundland Medical Association, we were,
 2 I think, in late stages of negotiation with
 3 the Government about potentially getting an
 4 alternative funding plan. There were also
 5 some talks about continuing the current
 6 funding mechanism, which pays oncologists a
 7 certain stipend and then an extra amount of
 8 money per patient.

9 And I was concerned about the tone of the
 10 meeting and I did mention to the oncologists
 11 and maybe I said it a bit too strongly, but I
 12 said you need to be more focused on this
 13 Cancer Care Program, I said, well I'll say it,
 14 it's the worse cancer care program--no, I
 15 didn't say program, managed program that I've
 16 worked in and that was not a reflection on the
 17 patient care, not a reflection on the program
 18 itself, but the management and I said you need
 19 to get more involved in committees, you need
 20 to be thinking about how we work more
 21 effectively with pharmacists, nurses--anyway,
 22 I regret using such a tone at the meeting, but
 23 I got a few vitriolic e-mails after that,
 24 which is fine, that's part of having a
 25 discussion and those people I worked very

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1 effectively with. But one of those was copied
 2 to Ms. Smith and again, I was sent an e-mail
 3 that in no way I would even within the Cancer
 4 Centre was I to criticize their program and
 5 again, I met with Smith after that and we
 6 discussed a number of issues, but there's a
 7 real reluctance, even for sort of the normal
 8 back and forth, even if there's confrontation,
 9 out of that usually comes a consensus and I
 10 think that's a healthy thing and I think
 11 that's something lacking in the system, that
 12 sort of dialogue.

13 COFFEY, Q.C.:

14 Q. Doctor, and I take it then from that
 15 perspective in terms of--why I'm canvassing
 16 this with you is this, it's your view, I take
 17 it, based upon your own experience that such a
 18 dialogue ultimately can be beneficial to the
 19 patients that you treat?

20 DR. SALTMAN:

21 A. I think saying some of the worse managed
 22 cancer program is inappropriate and I
 23 apologize for that, but I think having a
 24 lively discussion, whether it's in the
 25 management and having a different point of

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1 view is a very healthy thing. You've got to
 2 come out of it with consensus or it's a waste
 3 of time, but no, it's a very healthy process.

4 COFFEY, Q.C.:

5 Q. Doctor, the Canadian Cancer Society, in
 6 particular here in Newfoundland, the most
 7 public figure in terms of being identified
 8 with the society, I wouldn't be remiss, I
 9 think, in saying it's perhaps Mr. Dawe, Peter
 10 Dawe. Have you had any dealings with Mr. Dawe
 11 since you came to Newfoundland--or I should
 12 say came back to Newfoundland?

13 DR. SALTMAN:

14 A. Came back to Newfoundland, yes. I met Peter
 15 Dawe and I didn't know him before I left
 16 Newfoundland. I left in 1982 and I've never
 17 worked in the province up until recently, but
 18 I went to meet Peter Dawe and the reason I
 19 went to meet Peter Dawe is that the Canadian
 20 Cancer Society is one of the biggest funders
 21 of cancer research in Canada. And as a
 22 medical oncologist interested in research, as
 23 Chair of oncology at the university, this is
 24 an invaluable partner, so Peter and I met at
 25 his office and we talked for a couple of hours

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1 and we agreed to work together and we have
 2 been working together, I don't know when we
 3 met, it was sometime in the spring, and Peter
 4 and his organization is very relentless in
 5 trying to get people to stop smoking and we've
 6 been working together to try to get Eastern
 7 Health to ban smoking on their premises.
 8 This, I think, is a huge disgrace for such an
 9 institution, the largest health care facility
 10 in the province, the home of the medical
 11 school, the home of the cancer centre and yet
 12 at any one time there's five to 20 people
 13 smoking and littering with cigarette butts and
 14 within Newfoundland, the Labrador Health
 15 Authority, the Western Health Authority have
 16 taken the lead of a comprehensive ban and here
 17 we are, the biggest hospital in the province
 18 and the home of the cancer care program and
 19 this does not seem to be an issue for the
 20 management. It doesn't seem to be an issue
 21 for the Cancer Care Program. So I've been
 22 working with Peter, we've been advocating,
 23 we've been sending letters to Eastern Health
 24 and so far, nothing has happened, but we've
 25 had a few indications that something may

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1 happen in the future.

2 COFFEY, Q.C.:

3 Q. Now with respect to your dealings with Mr.
 4 Dawe, has that given rise to any problems or
 5 concerns?

6 DR. SALTMAN:

7 A. I've only met with Peter once during that
 8 meeting, we communicate frequently by e-mail
 9 and I have been working primarily with one of
 10 his managers who is dealing with the smoking
 11 advocacy, but I've had no problems working
 12 with Peter Dawe or the Canadian Cancer
 13 Society. I think their initiative, the
 14 Daffodil Place is a fantastic thing. I'm not
 15 from St. John's, I know what it's like to have
 16 to come in here to stay for a week or two, if
 17 you're coming from Labrador or anywhere in
 18 Newfoundland, right now it's very expensive
 19 for our patients and this is a tremendous
 20 initiative that's been done in a relatively
 21 short period of time and his organization and
 22 Peter should be commended for it.

23 COFFEY, Q.C.:

24 Q. Have you discussed your working with Mr. Dawe
 25 in the Cancer Care Program, have you discussed

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1 it with others?
 2 DR. SALTMAN:
 3 A. I haven't.
 4 COFFEY, Q.C.:
 5 Q. And is there any reason that you haven't?
 6 DR. SALTMAN:
 7 A. I think the relationship between the Cancer
 8 Care Program in Newfoundland and the Canadian
 9 Cancer Society is very, very strained. Now
 10 historically there may be reasons for that, it
 11 may not be just a one-sided affair, but this
 12 is a very, very, very important relationship
 13 where you've got to put your differences aside
 14 and work together because we're talking about
 15 two organizations which are very, very similar
 16 in their mandate and I think, I don't--I
 17 haven't sat in on any meetings at the Canadian
 18 Cancer Society, but certainly at the Cancer
 19 centre itself, I think the attitude towards
 20 Mr. Dawe is not a very professional one.
 21 COFFEY, Q.C.:
 22 Q. And why do you feel that?
 23 DR. SALTMAN:
 24 A. Well I think there have been some derogatory
 25 comments made. Now what people say in their

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1 offices or in the privacy of their office or
 2 in the hallway, that's their business, but
 3 I've attended leadership meetings, this is the
 4 most important committee within the Cancer
 5 Care Program where comments have been made
 6 about Mr. Dawe which I just thought were very
 7 unprofessional and especially within this
 8 atmosphere of the Commission, the breast
 9 cancer inquiry, I just thought those were very
 10 inappropriate.
 11 COFFEY, Q.C.:
 12 Q. Doctor, is there anything that you wanted--
 13 anything else that you wanted to tell the
 14 Commissioner in terms of, you know, better or
 15 best practices. I appreciate you've outlined
 16 a number and I suspect that you could list a
 17 lot more, but in terms of is there anything
 18 else in terms of the ER/PR, the relationship
 19 of oncologists with pathologists and with
 20 other people involved in treating breast
 21 cancer that we haven't covered that you think
 22 the Commissioner should know from yourself?
 23 DR. SALTMAN:
 24 A. Well what I, this is a very personal thing for
 25 me, this isn't me as Chair of the Oncology, as

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1 an oncologist. My mother was diagnosed with
 2 breast cancer in 2000 and the luck of the draw
 3 she was ER positive and that's in
 4 Newfoundland. She got treated with Tamoxifen,
 5 she's alive and very well at this time, but it
 6 could have been a very different story. I
 7 have friends in this province who have had a
 8 mastectomy because they were told they were ER
 9 negative when--and because of concerns about
 10 getting cancer in the other breast, have had a
 11 mastectomy on an unaffected breast. You know,
 12 I know people, it's a very personal thing for
 13 me. I can't go back retrospectively, it's
 14 very easy to do that and say what would have
 15 happened in 1997 or 2003, but to me, there
 16 seems--it comes back to communication, it just
 17 seems that the communication between
 18 oncologists and other people working in cancer
 19 care has not been optimum. There has been a
 20 huge turnover of physicians, oncologists,
 21 pathologists, other types of physicians,
 22 that's Newfoundland, we're always going to
 23 have that problem. But if you have a system
 24 in place that you have these meetings, you
 25 have these ways of communicating, even in the

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1 times when you're short two or three
 2 pathologists or oncologists, that at least you
 3 have that system in place that you have your
 4 meetings, your way of communicating. Back
 5 then we may not have had the same electronic
 6 capabilities, but now we do and I'm just
 7 concerned what has happened to women with
 8 breast cancer is just a symptom of a system
 9 that is not working as optimally as we could.
 10 We have the potential to be a good cancer
 11 centre. We have very good oncologists. For
 12 the first time, I think in the history of
 13 Newfoundland, we almost have the full
 14 complement or radiation oncologists. We have
 15 medical oncologists who are coming back here,
 16 who are in training or coming back and so
 17 we'll have a good complement of medical
 18 oncologists. And my hope is that the Cancer
 19 Care Program will start to think about having
 20 oncologists in other centres, not just
 21 everything is centred around St. John's, but I
 22 think to avoid these sort of things, we've got
 23 to have better communication, we've got to
 24 have, in my opinion and I haven't discussed
 25 this with anybody else or very few people, I

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1 think we need a different management
 2 structure. I think to incorporate the Cancer
 3 Care Program into a regional health care
 4 authority simply because they were in the same
 5 building in 2005 was a bit short-sighted.
 6 Maybe they were forced to do that, maybe there
 7 were financial considerations, but we have an
 8 organization with a provincial mandate which
 9 is incorporated into a regional centre without
 10 the proper communication tools. We talked
 11 about Meditech, we talked about ordering
 12 systems and here we are, three years later,
 13 and a lot of these things have not really come
 14 to fruition that would be very, very helpful.
 15 I'm not sure if this is the right management
 16 structure. I'm not sure it's the right idea
 17 to have this Cancer Program incorporated into
 18 a regional authority. The old Newfoundland
 19 Cancer Treatment Foundation was not perfect,
 20 it was an autonomous or semi-autonomous
 21 organization and it had problems as well.
 22 There's many different models, but I think
 23 there has to be a provincial organization,
 24 either if it continues within Eastern Health,
 25 it has to have more of a say at the table, at

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1 the executive table and less middle management
 2 to stifle all these ideas about IT and
 3 communication and communicating with each
 4 other and ideas filtering from below and
 5 things getting done in a timely fashion. I
 6 think that's where we need to get people
 7 working together and this middle management
 8 needs to be pared down or re-defined, so to
 9 have someone, whether that's Dr. Laing or
 10 whatever, at that very top who is making key
 11 decisions with the government and then a
 12 different management structure within the
 13 provincial Cancer Care Program. And that's
 14 going to help lessen the chance of these sort
 15 of tragedies happening, okay.
 16 There was a very good letter, a very
 17 short letter put on the BC Cancer Agency
 18 Breast Website before I left BC. It was put
 19 on there by a colleague of mine in the breast
 20 cancer group and basically what it said was to
 21 the patients and the families in BC because
 22 they were getting a lot of calls, this is not
 23 just, as you know a provincial story, it's a
 24 national or international story, getting a lot
 25 of calls, what about BC, what about my

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1 estrogen receptors? We put a letter there
 2 explaining why this was unlikely, it's always
 3 possible, but unlikely to happen in BC because
 4 of that level of redundancy, because of
 5 pathology review, because of the way that
 6 cancer centre is structured and because they
 7 were participating in a quality assurance
 8 program for a number of years in the United
 9 Kingdom.
 10 So I think we need a different management
 11 structure. I think the breast cancer tragedy
 12 is a symptom of a system that really needs a
 13 lot of work, and again, this is no reflection
 14 on the people working in the system. Great
 15 nurses, great pharmacists, health care records
 16 workers, nurses who work in the periphery,
 17 fantastic radiation and medical oncologists,
 18 physicists, whatever, we have great people but
 19 the system really needs, I think, an overhaul
 20 and people need to be participating more in
 21 the decision-making process.
 22 COFFEY, Q.C.:
 23 Q. Thank you, Doctor. Those are the questions I
 24 have, Commissioner, thank you.
 25 THE COMMISSIONER:

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1 Q. Thank you. Ms. Brazil?
 2 BRAZIL, Q.C.:
 3 Q. No questions, Commissioner.
 4 THE COMMISSIONER:
 5 Q. Mr. Simmons?
 6 MR. SIMMONS:
 7 Q. I know we're back on leaving, but I wonder if
 8 we might have a five or ten minute break, I'd
 9 like to consult with my constructive clients
 10 in order to -
 11 THE COMMISSIONER:
 12 Q. Yes, of course, we can do that. We'll take
 13 ten minutes. Mr. Simmons, if you need longer,
 14 you can just let -
 15 (RECESS)
 16 THE COMMISSIONER:
 17 Q. Mr. Simmons.
 18 MR. SIMMONS:
 19 Q. Thank you, Commissioner. We just had notice
 20 yesterday that Dr. Saltman would be appearing
 21 here. His notice of anticipated evidence we
 22 received lunch time and it didn't have any of
 23 the particulars of much of the evidence that
 24 we heard from Dr. Saltman, it's a lot of new
 25 information that hasn't been particulars of

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1 incidents and so on that haven't been
 2 previously addressed in evidence and that we
 3 haven't had an opportunity to consider. And
 4 in particular, I haven't had an opportunity to
 5 prepare to be able to cross-examine Dr.
 6 Saltman on much of what he has said and I
 7 think I would like an opportunity to do that.
 8 I'm going to propose that we can proceed with
 9 the other witnesses that are scheduled for
 10 tomorrow, in particular Ms. Smith and it may
 11 be after Ms. Smith has given her evidence I
 12 will be able to give you an idea if it would
 13 be necessary to bring Dr. Saltman back, but if
 14 it is, I would ask that my examination be
 15 deferred until I've had an opportunity to do a
 16 proper preparation in order to be able to deal
 17 with these issues.
 18 THE COMMISSIONER:
 19 Q. How long a deferral are you looking at? You
 20 know that we think we're going to close on
 21 Friday morning.
 22 MR. SIMMONS:
 23 Q. Yes, Commissioner, I don't think I could do it
 24 justice to be prepared to proceed tomorrow.
 25 There are many issues that require some

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1 investigation, there will be documents that
 2 may have to be--e-mails and so on that have
 3 been referred to by Dr. Saltman that I want an
 4 opportunity to review and investigate. That's
 5 not going to happen between now and tomorrow.
 6 We can make some headway with it tomorrow, but
 7 it may be that after we hear from Ms. Smith
 8 that some of these issues may have another
 9 perspective on them and that may eliminate the
 10 need to examine Dr. Saltman on some of these
 11 issues.
 12 THE COMMISSIONER:
 13 Q. Okay, have you and Mr. Coffey had a
 14 conversation about the availability of the
 15 witness.
 16 MR. SIMMONS:
 17 Q. I've just informed Mr. Coffey that this would
 18 be my request, Commissioner.
 19 THE COMMISSIONER:
 20 Q. In the US, this would be called a sidebar.
 21 MR. SIMMONS:
 22 Q. Mr. Coffey advises me that Dr. Saltman has
 23 understandable commitments that would mean
 24 that if I can't proceed tomorrow, it would
 25 have to be at some later time to be

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1 determined.
 2 THE COMMISSIONER:
 3 Q. Uh-hm.
 4 MR. SIMMONS:
 5 Q. Which is satisfactory to me. I don't think,
 6 as I said, I could do this justice if we had
 7 to proceed tomorrow morning and as I said, it
 8 may be that after Ms. Smith, that may reduce
 9 the necessity or even eliminate the necessity
 10 of examining Dr. Saltman. I can't say that
 11 for sure, but that's my preference,
 12 Commissioner.
 13 THE COMMISSIONER:
 14 Q. Well I take your point about the timing in
 15 terms of the information provided in respect
 16 of what Dr. Saltman might say because he is a
 17 recent addition to our witness list, so I do
 18 have some sympathy for your request. Where I
 19 don't have some sympathy, you might recall
 20 would be--or agreement that all submissions to
 21 the Commission have to be in 30 days from the
 22 last day of our hearings, which I think is
 23 Friday.
 24 MR. SIMMONS:
 25 Q. I'm quite willing, Commissioner, to agree that

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1 the clock will start to tick then and if Dr.
 2 Saltman has to come back, it will not postpone
 3 those 30 days, so I have no difficulty with
 4 that.
 5 THE COMMISSIONER:
 6 Q. All right and in the meantime, let's find out
 7 from the others in the room whether or not
 8 they have a similar problem or are in a
 9 position to tell me whether or not they want
 10 further questions of Dr. Saltman. Mr. Browne,
 11 are you in a position?
 12 BROWNE, Q.C.:
 13 Q. Commissioner, at this point I have no
 14 questions for Dr. Saltman, there may be
 15 something arising from Mr. Simmons' cross-
 16 examination, but at this point, I have no
 17 (inaudible).
 18 THE COMMISSIONER:
 19 Q. Mr. Pritchard?
 20 MR. PRITCHARD:
 21 Q. We have no questions for Dr. Saltman and in
 22 respect of Mr. Simmons' comment about
 23 submissions, we're certainly in agreement with
 24 that as well.
 25 THE COMMISSIONER:

1 Q. Well as you realize, my deadline isn't going
 2 to move, so that's what I'm being very firm on
 3 Friday. Ms. Newbury?
 4 MS. NEWBURY:
 5 Q. My position is the same as Mr. Browne, is that
 6 I don't anticipate any questions, unless it's
 7 something that arises and we're also agreeable
 8 to -
 9 THE COMMISSIONER:
 10 Q. The clock running from Friday?
 11 MS. NEWBURY:
 12 Q. I have no problem with that, yes.
 13 BROWNE, Q.C.:
 14 Q. Sorry, Commissioner, I didn't address--I have
 15 no problem with the 30 days from Friday.
 16 THE COMMISSIONER:
 17 Q. Okay, do you have a similar position on the
 18 clock, Ms. Brazil?
 19 BRAZIL, Q.C.:
 20 Q. That's fine with the with the province with
 21 respect to the matter, Commissioner.
 22 THE COMMISSIONER:
 23 Q. All right, thank you. All right, Mr. Simmons,
 24 I will leave it to you to advise counsel
 25 following the evidence tomorrow of Mrs. Smith,

1 CERTIFICATE
 2 I, Judy Moss, hereby certify that the foregoing is
 3 a true and correct transcript in the matter of the
 4 Commission of Inquiry on Hormone Receptor Testing,
 5 heard on the 29th day of October, A.D., 2008 before
 6 the Honourable Justice Margaret A. Cameron,
 7 Commissioner, at the Commission of Inquiry, St.
 8 John's, Newfoundland and Labrador and was
 9 transcribed by me to the best of my ability by
 10 means of a sound apparatus.
 11 Dated at St. John's, Newfoundland and Labrador
 12 this 29th day of October, A.D., 2008
 13 Judy Moss

1 what your position is in respect of that and
 2 then we will do our best to accommodate
 3 whatever that is and communicate it to the
 4 witness as well.
 5 MR. SIMMONS:
 6 Q. Thank you, Commissioner.
 7 THE COMMISSIONER:
 8 Q. So I guess that ends the session for this
 9 evening and I will see you all at 9:30
 10 tomorrow morning, thank you.
 11 Upon conclusion at 7:50 p.m.

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