COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

October 14, 2008

Appearances:

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

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Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)
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Regional Integrated Health Authorities

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MR. TERRY GULLIVER - RESUMES THE STAND

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OCTOBER 14, 2008
THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Registrar, if we could have, please, P-0565. Mr. Gulliver, this document is entitled "Review of ER/PR Service to date, August 10th, 2005", and it's a two page document and I believe this is your signature at the end?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. So did you prepare this document?
MR. GULLIVER:
A. Yes, I did.
CHAYTOR, Q.C.:
Q. And what was the purpose of this document?
MR. GULLIVER:
A. I think Dr. Williams had asked if I could just do a quick summary, and I think he wanted it for Mr. Tilley, just to give an overview. Again it's early August '05 as we're just starting to get into this whole issue.
CHAYTOR, Q.C.:
Q. And was this actually done on August 10th,

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2005?
MR. GULLIVER:
A. I guess so.
CHAYTOR, Q.C.:
Q. That's when it was drafted. I notice if we go to the end here, it just says, "July, 2005, Ventana sent in their technical expert for Canada and performed a complete review of our instruments, protocols, reagents, etc. A written report was submitted to Dr. Williams outlining that the system is working as it should be, and that our lab and technologists are as good as any in Canada. The only recommendation was to perform monthly and quarterly routine maintenance on the instruments", and I'm just thinking didn't that visit from Ventana happen the first part of August?
MR. GULLIVER:
A. I'm not sure if it was late July, the 31st, August 1st, somewhere -
CHAYTOR, Q.C.:
Q. Somewhere in that time?
MR. GULLIVER:
A. I think we made contact with her the last of

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July and she came in within a day or two.
CHAYTOR, Q.C.:
Q. And her report was dated the first part of August?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And for 1997 you've indicated, "Installed new DAKO semi-automated manual system for immunopathology service, one of the first labs in Canada". So the lab here in St. John's was one of the first DAKO semi-automators?
MR. GULLIVER:
A. To my knowledge back then, yes.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. And actually that should be 1998.
CHAYTOR, Q.C.:
Q. That should be 1998 that it was installed?
MR. GULLIVER:
A. I think it was May of '98 when it was actually installed.
CHAYTOR, Q.C.:
Q. Okay, and then in 1997, switched to ER/PR

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testing from biochemical assay which involved freezing tumour tissue, mashing tissue, then assay for ER/PR", and we've heard about that. You go on to say, "The new method involved the manual procedure to boil slides in a solution on a hot plate to unmask best possible antigen sites in the patient's tissue. There was no standard methodology across Canada. Our lab followed the DAKO procedure of boiling slides and other labs used microwave ovens to boil slides". In putting this together in August of 2005 for Dr. Williams, where would you be going for your information, what sources would you have used?
MR. GULLIVER:
A. For which particular information?
CHAYTOR, Q.C.:
Q. Well, for any of this. For example, the part that I just read to you about what was used for antigen retrieval.
MR. GULLIVER:
A. Well, just common knowledge that's up in your head that the antigen retrieval process, I knew there were labs in Canada that used microwaves to boil their slides. We followed

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the more traditional method that DAKO had recommended of boiling slides on a hot plate.
CHAYTOR, Q.C.:
Q. And at some point in time, did St. John's use other than the hot plate?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. "Even though it was recognized that ER/PR testing by immunohistochemistry would be more sensitive, previous samples performed in biochemistry were not retested because of the change in technology methodology". What do you mean by that?
MR. GULLIVER:
A. Again this is like early August '05, so you're trying to provide as much information to your Vice President or to the CEO--obviously it's people who are not lab people, so you're trying to give them basic information. I guess here what I'm indicating is that in 1997 when the ER/PR hormone receptor test switched methodology, you know, back in '97 you didn't do a retest of what was done in biochemistry.
CHAYTOR, Q.C.:

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Q. Okay, so what you're saying is that nobody went back when the IHC method for ER/PR was introduced, nobody went back and -

MR. GULLIVER:

A. Exactly, '97, yeah.

CHAYTOR, Q.C.:

Q. And was that in any way to suggest that the retesting that was happening in 2005 was because of any change in technology or methodology?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. "And in 2004", you write, "In January, new Ventana System which is fully automated with on-board antigen retrieval was installed in our laboratory. From January to March, staff were trained in Arizona on the new system, in addition to on-site training at the General Hospital", and I take it that's referring to some time in that time period. They weren't in Arizona from January to March, sometime in that time period.

MR. GULLIVER:

A. I bet you they wish they were, three months in

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Arizona.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. No, it was a -

CHAYTOR, Q.C.:

Q. Perhaps so, especially January to March.

MR. GULLIVER:

A. Yeah, it was a--I think it was a one week training provided by the company and that was included in sort of the reagent lease that we did with Ventana.

CHAYTOR, Q.C.:

Q. And the last sentence there, you write, "Hundreds of controls in patients were run on the system to correlate with the old methodology", and where would you have obtained that information to write about that in 2005?

MR. GULLIVER:

A. I would have gotten that verbally from the manager, Mr. Barry Dyer, from the pathologists, the technologists, just to verify that it was the answer that during that three months in correlating, verifying all the

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different antibodies that you use in that part of the lab, that it would have been hundreds of slides run in that three month period.

CHAYTOR, Q.C.:

Q. And were you able to find any documentation to verify that in August of 2005, that hundreds of controls in patients were run on the system to correlate with the old methodology?

MR. GULLIVER:

A. I don't know if I looked for documentation. I just took, you know, the manager and pathologists for their word, and I knew that they had done many, many, many slides during that time frame. I think since then you've gotten the logs from the Ventana computer system printed off.

CHAYTOR, Q.C.:

Q. Yes. If we could just look quickly for a moment, I think it's P-0078. This is the exhibit I believe we looked at last day, or some time in the past couple of days of your evidence, July 28th, 2005, and this was Ms. Predham writing to yourself and others on July 28th wondering about--the more I thought about it, she says, "I realize it's critical we get

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the results that we can, both systems", and I believe there wasn't actually--what you said, this hadn't happened, that both systems hadn't run and there hadn't been that kind of correlation back when Ventana came on?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. If we could go back, please, to P-0565. So how is it that--how is it that the controls and the patients were run on the system, I take it meaning the new system, to correlate with the old methodology, how did that actually happen?

MR. GULLIVER:

A. Well, what was done, you know, as you know there's over 100 different antibodies used for IHC testing, not just the ER/PR. So if you're switching systems from the DAKO system to the Ventana system, there were, you know, cases that were run, mostly Dr. Ejeckam overseeing this--there were multiple cases run. You would give the slides and control slides to pathologists and ask them their opinion, how they felt the stain looked, the slides looked

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coming off the Ventana system versus what they were seeing on the DAKO system, and again, you know, this is not--I'm not physically there in the lab, that's not my job, but I do know because I was a former pathology person, during that time frame I had, you know, stopped a lot of pathologists different times in the hallway over this few month period and asked them for general feedback, how were they finding the system, and generally the feedback was extremely positive, they said the slides were very high quality, the staining was very crisp, and that's the kind of comments that I got.

CHAYTOR, Q.C.:

Q. Okay, and then you go on into the 2005 period and you referred to, "In May a patient was retested on the new system and the results were positive on Ventana, were negative on the old boiling technique", and I believe that, in fact, her retesting took place in April?

MR. GULLIVER:

A. I wasn't sure exactly when her retesting took place.

CHAYTOR, Q.C.:

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Q. "In early July, I searched for all ER/PR tests performed by the lab from January 1999 through to July 2005. I sorted the approximate 2500 reports by date, ER/PR status, and patients from Health Care Corporation St. John's versus out of town patients. This provided a snapshot for the year, the number of tests performed, and positive versus negative rate", and we spoke about that last day and how you went about that. On the next page we have, "At the same time Dr. Carter had reviewed and requested 60 patients from 2002 to be retested on the new system. I have not seen the results, however, there seems to be some confusion on how many of those patients converted from negative/negative to positive", and what are you referring to there?

MR. GULLIVER:

A. Again, I mean, Dr. Carter was doing this at St. Clare's. I had--you know, she had not shared results with myself or the manager, and there seemed to be--no one really knew for sure was she retesting those 60 patients, were they all zero/zero like true negative/negative, or in those 60, were there

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patients who had already been reported with some degree of positivity, and then came back with a higher degree of positivity.

CHAYTOR, Q.C.:

Q. Okay, and, "Dr. Cook, Heather Predham, Barry Dyer, myself, have also contacted many other labs to inquire about their positive/negative rates. It was clear that no lab was able to give us this information". Would Mount Sinai have been contacted? This is now August 10th and they're going to be used as the lab for the retesting?

MR. GULLIVER:

A. I don't know, Ms. Chaytor, if Dr. Cook called Mount Sinai or not. I had made a couple of phone calls to people who I knew, just personal contacts, and they weren't tracking their positive and negative rates.

CHAYTOR, Q.C.:

Q. "Labs that have switched to the new automated system verified the same results as we have seen here, i.e. better staining quality, standardization and reproducibility", and how -

MR. GULLIVER:

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A. And I got that from--I called the Ventana person in Montreal. By this time in August '05, there are a fair number of customers especially in Quebec and Eastern Canada using the Ventana platform, and I spoke to the guy in Montreal and asked, you know, can he give me sort of a summary of what customers had been saying who had switched from the DAKO system to the Ventana system.

CHAYTOR, Q.C.:

Q. And you indicated here that by switching to the new automated system, "You've seen better staining, standardization, and reproducibility". How did bringing on the Ventana provide St. John's with improved standardization?

MR. GULLIVER:

A. Well, again as I testified earlier, the Ventana system really is a system whereas DAKO was more of, as you know, an autostainer which like dispensed liquids on the slides. The Ventana system provides optimized antibodies that are already pre-diluted, all their products are bar coded, so they all go on the instruments, the slides are bar coded. So all

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those aspects of the system really allows for overall better standardization.

CHAYTOR, Q.C.:

Q. The next paragraph, you indicated, "Barry Dyer and myself have double checked all reports from my original search and have created spreadsheets by year indicating patient's results for ER/PR", and you're writing this in August of 2005. How did you and Mr. Dyer go about double checking all your reports from your original search?

MR. GULLIVER:

A. I think what I'm saying here is that Barry had been away on vacation for the month of July, and I had done the original searches. When Barry came back I asked him to do--for him to do a search to double check my search parameters to make sure that what I had done is something that he would have done.

CHAYTOR, Q.C.:

Q. So he checked what you had done?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And you go on to say, "We've also created a

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separate spreadsheet for logging in blocks and slides being reviewed and consequently sent to Mount Sinai for retesting". So did you keep--you kept a separate sheet with all of the blocks and--blocks that were sent to Mount Sinai?

MR. GULLIVER:

A. That was--once the first spreadsheet, let's say, when I was finalized with it and Dr. Cook had reviewed any patients that were maybe iffy, should they be on the list, not on the list, Barry then took that and sort of recreated it for the technologists because then the next step of the work was to actually go to the old filing systems and start pulling and retrieving these thousands of blocks and slides.

CHAYTOR, Q.C.:

Q. So was there an actual list kept of everything that was sent to Mount Sinai?

MR. GULLIVER:

A. To the best of my knowledge, yes.

CHAYTOR, Q.C.:

Q. And was that done for outside of St. John's as well?

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MR. GULLIVER:

A. For outside St. John's, when they came in, myself and Mr. Dyer put them on a spreadsheet similar--exactly like what we used for the St. John's patients, and I think Mary Butler, who was pretty well the technologist who was doing a lot of this work with Barry, I think Mary did make up her own sheets for what actually was sent to Mount Sinai, the blocks.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. That were sent.

CHAYTOR, Q.C.:

Q. And did you and Mr. Dyer actually physically have to go and retrieve the blocks?

MR. GULLIVER:

A. I did not. Mr. Dyer did, along with two or three other staff.

CHAYTOR, Q.C.:

Q. And where would the blocks and slides have been stored?

MR. GULLIVER:

A. For St. John's patients?

CHAYTOR, Q.C.:

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Q. Yes.

MR. GULLIVER:

A. They would be stored in multiple areas. We have--again our policy is that we keep all pathology blocks and slides for 20 years, we keep pediatric blocks and slides for 50 years. So you can imagine how much storage we have.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. We have blocks that are stored physically in the lab at the Health Sciences for so many years. We have blocks that are stored down at the Miller Centre. We have storage space down at the Old Janeway Apartments.

CHAYTOR, Q.C.:

Q. Janeway Apartments?

MR. GULLIVER:

A. And we have storage over at St. Clare's. So they could be in multiple areas.

CHAYTOR, Q.C.:

Q. And was any issue encountered in terms of conditions under which the blocks were stored and whether or not that could impact their quality for retesting?

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MR. GULLIVER:
A. Not to my knowledge, no.
CHAYTOR, Q.C.:
Q. And you're not aware of any issue concerning the storage facilities for the tissues?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. For the blocks.
MR. GULLIVER:
A. What we're doing right now, actually--this has been an issue with the lab program for many, many, many years. Eastern Health are building an extension onto the DVA ward at the Miller Centre and in the lower level, the basement level of it, they're giving us space so that we can consolidate all of our long-term storage into one -- into one area.
CHAYTOR, Q.C.:
Q. Okay, but to the best of your knowledge, there's no issue with the conditions under which the blocks are stored or the slides. You go on to say, "Provided to Dr. Williams a logsheet of 2002 ER/PR tests by month. This showed that every month they were negatives

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and positives as it had been suggested that the laboratory did not report a positive report from mid June 2002 to November 2002", and I take it, Mr. Gulliver, that was the suggestion by Dr. Carter?
MR. GULLIVER:
A. I would assume, yes.
CHAYTOR, Q.C.:
Q. And this is the time period that she had suggested?
MR. GULLIVER:
A. I'm assuming, yes.
CHAYTOR, Q.C.:
Q. Well, did anyone else make any suggestion in that regard besides Dr. Carter?
MR. GULLIVER:
A. No, she was the only one, Dr. Carter.
CHAYTOR, Q.C.:
Q. Actually, I missed this part, "Provided to Dr. Williams a logsheet of 60 patients' original results that Dr. Carter retested from 2002. Of those 34 were originally reported as negative/negative and 26 were reported as weak positives of varying degrees".
MR. GULLIVER:

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A. Uh-hm.
CHAYTOR, Q.C.:
Q. "I have not seen the repeat results". So your understanding was that that was what Dr. Carter was keeping track of?
MR. GULLIVER:
A. Right, and again remember we seen earlier that no one really knew if the 60 patients from 2002 that she was focused on, were they truly all negative/negative or were there a mixture of some degree of positivity in those.
CHAYTOR, Q.C.:
Q. Because at this point in time in your mind in terms of the technical side of things, anything other than negative/negative was considered positive in your mind?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Is that--that's what you're differentiating here?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. I take it all of the 60 who were tested were

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deemed to be clinically negative by the people choosing the test?
MR. GULLIVER:
A. That's my understanding, yes.
CHAYTOR, Q.C.:
Q. Okay. I've already taken you to the last paragraph. So why in August of--August 10th '05 had Dr. Williams asked you to put together this chronology at this point in time?
MR. GULLIVER:
A. I don't know his exact reason why.
CHAYTOR, Q.C.:
Q. Last day I had asked you about how you went about identifying the patients who would need to be retested, and I'm wondering whether or not you encountered any problems or obstacles in going through that identification process, and if so, if you could tell the Commissioner about some of the challenges that you faced?
MR. GULLIVER:
A. You mean, in trying to identify the patients who should be on the list, or just in general try to pull together that list?
CHAYTOR, Q.C.:
Q. Well, a little bit of both. You've told us

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about how you physically had to pull all the pathology reports, for example, and go through them, and I'm wondering, for example, was there any issue because of the different hospitals that you were having to deal?

MR. GULLIVER:

A. Yeah, okay.

CHAYTOR, Q.C.:

Q. Like the Grace Hospital.

MR. GULLIVER:

A. So just in general.

CHAYTOR, Q.C.:

Q. St. Clare's, and yes.

MR. GULLIVER:

A. And I guess, you probably heard other people testify that parts of it were more challenging than other parts. You've heard that when--before 19--well, I guess it was sometime in 1999, Ms. Chaytor, when St. John's hospitals all started using the same Meditech computer system. So therefore, before that, the Grace had their own system; St. Clare's had their own system; and the Health Sciences had their own system. Doing the computer search in the Health Sciences system really wasn't that much

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of a challenge. To actually do the searches, identifying patients who had an ER/PR test done, from 1999 onwards, it was much easier because all three systems then were on the one database out of one platform. So what we had to do was, in the Health Sciences system, as I've indicated, you know, the other day, that when the Health Sciences lab received a block from the Grace or St. Clare's or from out of town, the Health Sciences lab would actually go into the Health Sciences computer system and they would create a surgical number for that block. They would perform the ER/PR test and then they would send the slides back to the Grace or St. Clare's or out of town for interpretation. So at least we had that list of referrals from the Grace and St. Clare's.

So I searched the Health Sciences system, for example, '97, '98, '99, and identified that list. Then we had to go back into the old Grace system and go back into the old Health Sciences system and then print individually the reports for everyone of those blocks. It became a bit more challenging to identify to make sure you had the right

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patients. St. Clare's system, when they were operating--for example, the Health Sciences, we always used a patient's MCP number as their primary identifier. The Grace didn't use MCP numbers. The Grace assigned a Grace kind of hospital number to a patient and you had to actually look for the MCP number of the patient buried somewhere in the reports. So that became--you know, that was a bit more of a challenge. Actually, it was just more time consuming to verify and go through that piece. So again, I would have to say, the '97, '98, '99 years were a lot more time consuming and a lot more challenging to try to identify patients that had an ER/PR test performed.

It was also a bit more challenging through the whole system because up until the St. John's platforms were all consolidated into one computer system, even at the Health Sciences, the procedure code and test code that was used was called immunoperoxidase other. It wasn't until during the consolidation did we have staff go through and create an individual procedure code for the over 100 different antibodies. So it also

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meant that we had to do double checks on all the systems, looking for patients who had the ER/PR procedure that were performed, and again, during the--you know, from July '07 onwards, when I worked extensively with NLCHI to create the provincial database, you know, as you know, there were some additional patients that were sent forth for retesting after the main batches and there might have been less than ten, but I mean, it wasn't a lot, but some of those patients, the reason why was that the patient did not have an ER/PR procedure like physically ordered in the system.

CHAYTOR, Q.C.:

Q. Right, and you originally -

MR. GULLIVER:

A. So my search didn't pick those up in 2005.

CHAYTOR, Q.C.:

Q. And that's how you originally identified, was according to the ordering of the test.

MR. GULLIVER:

A. Yes, yeah.

CHAYTOR, Q.C.:

Q. Were there also challenges in terms of how

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ER/PR was recorded? Some people may have referred to hormone receptor testing, others immunoperoxidase testing. Did that cause you any challenges?

MR. GULLIVER:

A. I don't--well, again, it made it more time consuming in having to physically read thousands and thousands and thousands of pages, if you take one breast cancer report, maybe an average of four or five pages long, and you've got almost 3,000 of them. It would have been much more helpful if there had been a standardized reporting format that had been used for all the years. It would have made it easier to read them. But there were some-- there were challenges there in that there just was no standardized way of reporting, you know, all the results. Some people said positive, some said negative, and then you didn't know. Some said weak positive. Some gave percentages. Some gave a percentage and might have said it's 40 percent, however it's weakly stained. So it did present some challenges.

CHAYTOR, Q.C.:

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Q. And in terms of having to read through pathology reports, had you ever had any experience in having to do that before?

MR. GULLIVER:

A. Well, yes, I mean, I worked--you know, even though I'm now program director, my technical background had been in pathology and I had been a pathology manager. So it's something that I would have seen many, many, many times.

CHAYTOR, Q.C.:

Q. You would have seen pathology reports?

MR. GULLIVER:

A. Different reports, yes.

CHAYTOR, Q.C.:

Q. But to actually have to read down through a report and identify certain patients based on the criteria that was given to you, was that an exercise that you had ever done before?

MR. GULLIVER:

A. I don't think, not like this magnitude.

CHAYTOR, Q.C.:

Q. And you said that you've worked, of course, fairly extensively with NLCHI since, in terms of the database that's been created, and through that exercise and otherwise, have you been able to identify any shortcomings in how you went about identifying patients in the first place or problems that were there that you perhaps didn't even realize at the time and which caused patients really to fall through the cracks, other than of course, the issue came up about there were tests done that had never had an order for those tests and there were a number of patients missed that way? Are you aware of other ways in which patients were missed?

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MR. GULLIVER:

A. Again, and it's almost, could be on an individual basis. The original searches I did in 2005, I think we identified--you know, it was close to 3,000 tests that were performed overall during that time frame, from '97 to 2005, that we actually had procedures ordered on those 3,000 patients. During the NLCHI exercise, which began last year, you know, I think that we came across--again, I can't say if it's 18 or 15 or 12, but there were a number, not a large number, of patients that they didn't have an original ER/PR procedures ordered in the system and that's not a system error. That's an input error that when a procedure is performed and completed, the technologists who were doing the procedures over these years, they should have went into the computer system and ordered the procedure, and if the procedure is not ordered in the system, well, the computer search is not going to find the procedure at all.

Some other challenges that we had, there were times where there was an ER procedure ordered but there was no actual result reported on the patient's report. We came across a couple of those. But again, I mean, there were some individual patients that, for various reasons, weren't picked up in the original searches. Again, there were some patients who had multiple specimens, like during this time frame, and it may have been on one specimen, not ordered on another specimen, and the specimen that it wasn't ordered on originally is what was used for the retest. So I can't give you the one answer for why patients were missed. There were multiple reasons and it's almost on an individual basis.

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CHAYTOR, Q.C.:
Q. Yes, and I wasn't asking for just one reason. I was asking for all of the reasons that you've been able to determine to account for the fact that we all know there were people missed.
MR. GULLIVER:
A. And again now, I'm referring to the specimens or patients that were based in St. John's.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. You know, I really can't speak to after-- during the NLCHI exercise, the majority of patients that were identified at a later date, I think most of them came from outside the St. John's area.
CHAYTOR, Q.C.:
Q. And you had had a list originally of those people and I think we spoke last day about there was no cross referencing of your list, and perhaps that could have been of some assistance at the time.
MR. GULLIVER:
A. I know, and it's something I've said to myself

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many times, is that, you know, I know that when I searched the computer system in St. John's that we had at least had, you know, a basic log of what was referred to us over the years from Carbonear, from Corner Brook, from Gander, from Grand Falls, and you know, I never even--to tell you the truth, I never even thought about just photocopying that list and sending it out to the regions, and even on the phone talking to some of the people in the regions, when they were organizing their blocks, neither they asked, nor did I even suggest it, and I can't tell you why I didn't.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, in 2005 when you were doing this exercise to identify the people, at the end of it, how confident were you that your search had been thorough and complete? Did you have any reservations at that point in time that -
MR. GULLIVER:
A. No, I didn't, no. I thought that, you know, when we as a group were trying to decide, well, who was going to identify the patients that should be or need to be retested, would it be the clinical side, i.e. the Cancer

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Centre or the oncologists or would it be the laboratory side. I think it was decided early on that the laboratory would probably have the most complete records of who had an ER/PR test done and I think that I searched in, to the best of my knowledge, the most complete way to ensure that we captured as many patients as possible. When we're talking about an eight-year period, using three different computer systems, you know, certainly I'm not surprised that there were, you know, 10-15 patients, maybe 20, over the eight-year period who we didn't pick up during that search methodology.
CHAYTOR, Q.C.:
Q. And the decision for you to search, as opposed to the clinicians, who made that decision?
MR. GULLIVER:
A. I don't--it wasn't one person. I had suggested at one of our meetings that -
CHAYTOR, Q.C.:
Q. That the oncologists look through their charts (unintelligible).
MR. GULLIVER:
A. - that the oncologists maybe should identify the patients that they felt should be

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retested, because they had done that for the 2002's, working with Dr. Carter and Dr. Cook, and I thought that they should just take that same methodology and expand it to all the years. But I remember at the meeting, Dr. Kara Laing, and verified by other people who were there, they said they didn't really feel that the Cancer Clinic had a complete computer record of all the patients. They said that oncologists had been--who were treating patients were--you know, had been gone and the amount of time it would have taken, I guess, to pull and identify every patient, pull their charts and read the charts, it was just decided the lab would be the quickest method to do it also.
CHAYTOR, Q.C.:
Q. And if we could look at P-2152, please? And I believe it's page eight, I believe, yes. This is the document I referred you to prior in your evidence, Mr. Gulliver, that we understand came from the DAKO computer, and this would indicate there's a field for patient name, but in this case, it's not there.

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MR. GULLIVER:
A. We don't use patient names. We just use a number.
CHAYTOR, Q.C.:
Q. Okay, and it gives the surgical number we talked about before.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And this patient, I think you told me, came from Central, the CNH here.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And the technician and the doctor is identified. The date of the test over here being 6/05/98, 06/05, so perhaps you know if that's June or May, whichever, and then the fact that it's an ER test and a PR test. The one to 50 and 30, I take it that's the dilution, one to 50 and--or do you know?
MR. GULLIVER:
A. I would assume.
CHAYTOR, Q.C.:
Q. And one to ten, the dilution.

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MR. GULLIVER:
A. And 30 minutes.
CHAYTOR, Q.C.:
Q. And 30 minutes.
MR. GULLIVER:
A. Incubation time.
CHAYTOR, Q.C.:
Q. And then the protocol used. So if you had had this information or the computer available to you from the DAKO machine, would that have made it easier for you to be able to get at every single test that was done on that DAKO machine in the time period that the DAKO was running, every ER/PR test could be identified from the computer records of the -
MR. GULLIVER:
A. No, it would have made it no easier, no. I mean, because the Meditech system, all this information, it's actually more complete information. That surgical number, you see the S1770-98?
CHAYTOR, Q.C.:
Q. Um-hm.
MR. GULLIVER:
A. So that would be inputted into the Meditech

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system and in that system, which is our permanent record, you know, and again, since we talked about this a few days ago, there are--you know, people seem to think that the patient records have been discarded, but that's--I mean, that's absolutely untrue. The only thing the PCU kept with the DAKO instrument from this computer was just the protocols that were run on the computer system. On the Meditech hospital system, that surgical number would have been inputted into the Meditech system. That's the number from Central.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. But there would have been a surgical number assigned from the Health Sciences, and the Health Sciences surgical number would be more important for searching than what the number was used out in Central or Corner Brook or Carbonear, somewhere else. The patient's name, MCP number, the pathologist that sent the referral in would be all documented in the Meditech system and that's kept permanently.

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So this really would not add anything.
CHAYTOR, Q.C.:
Q. Well, this would tell you every patient though. If you printed all those off, it would tell you every patient that had had the test on the machine.
MR. GULLIVER:
A. It would tell you the surgical -
CHAYTOR, Q.C.:
Q. If you had access to that.
MR. GULLIVER:
A. It would tell you the surgical number.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. I would still have to go to the Meditech system and then cross reference the surgical numbers at the Health Sciences with the referral numbers from outside St. John's.
CHAYTOR, Q.C.:
Q. Or you could send it to the region in question, Central for example, in this situation, and they could identify their patients.
MR. GULLIVER:

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A. You could, but it still would be better to use the Meditech system.

CHAYTOR, Q.C.:

Q. And would the patients who were missed because there was no order put on, they would have been identified had you gone through this method?

MR. GULLIVER:

A. I would think so. Again, but we don't have those.

CHAYTOR, Q.C.:

Q. Yes, we don't have them.

MR. GULLIVER:

A. They're not in--we don't have them, the protocols. But again, Ms. Chaytor, the ones with no ER/PR order, I don't know if they would be on a protocol like this here. I mean, it's possible that they are. It's more likely that they are, but maybe they're not. You know, when--you know, technologists, every procedure they perform in a laboratory, the procedure is ordered and then completed, because you capture your workload for all those procedures, and again, over the eight-year period in St. John's, there were, you

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know, maybe ten times or less, thereabouts, where over the eight years, their order wasn't ordered in the computer system. So you're talking about an average of one or two a year, and I can't explain why the technologist did not order it in the system. I can't -

CHAYTOR, Q.C.:

Q. I believe the Commissioner had a question.

MR. GULLIVER:

A. Oh, sorry.

THE COMMISSIONER:

Q. Mr. Gulliver, I just wanted--and I think I understood your reference to the number contained on page eight of P-2152. That would be the number from the region, correct?

MR. GULLIVER:

A. Yes.

THE COMMISSIONER:

Q. And your explanation was that you would then have to, in fact, trace it? You'd still have to find out what the number in St. John's was?

MR. GULLIVER:

A. Right.

THE COMMISSIONER:

Q. For your purposes. On Meditech, can you

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search on the basis of surgical numbers?

MR. GULLIVER:

A. You can search for--you can just put in one surgical number.

THE COMMISSIONER:

Q. Yes, that's what I'm wondering.

MR. GULLIVER:

A. Yes, you can. You can go in and put in--if you know the number, you just go in and put the number in and up comes that patient.

THE COMMISSIONER:

Q. Yes.

MR. GULLIVER:

A. I mean, you can search on surgical number. You can go in and do a number search and say "I want all surgical numbers from S1 up to S5000."

THE COMMISSIONER:

Q. Um-hm.

MR. GULLIVER:

A. And the system will pull those 5,000 reports in numerical order. Then you can print a hard copy of all 5,000.

THE COMMISSIONER:

Q. Okay.

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MR. GULLIVER:

A. But you really need to know what you're looking for in the report.

THE COMMISSIONER:

Q. Yes. No, I understand that. I was just trying to make the connection between this document and your records.

MR. GULLIVER:

A. Okay.

THE COMMISSIONER:

Q. And as I'm understanding it, that connection could have been made. Okay, thank you.

CHAYTOR, Q.C.:

Q. And Mr. Gulliver, on this one, the patient name is not filled in. Do you know whether or not that patient name was filled in on any of the other 25-2700?

MR. GULLIVER:

A. It wouldn't be filled in on the protocols for the DAKO instrument, no.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. It would be in the Meditech permanent record system.

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THE COMMISSIONER:
Q. On the matter of whether or not a similar document would be available for those persons who were missed, because there was no order, would the machine run if you didn't have an instruction or did not have this kind of information?
MR. GULLIVER:
A. I really can't answer that. I mean, I've never ever operated the machine.
THE COMMISSIONER:
Q. Um-hm. Well, it would just seem that since it contains protocols for every test that the machine would have done, one would sort of suspect that there has to be a similar documentation of the protocols run for a particular spot every day.
MR. GULLIVER:
A. I think the machine wouldn't run if you didn't have the actual template set up.
THE COMMISSIONER:
Q. Um-hm.
MR. GULLIVER:
A. For the run for that day. I really can't answer--I really can't say yes or no if it

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would run or not if this information wasn't inputted.
THE COMMISSIONER:
Q. Or if this information just automatically comes out -
MR. GULLIVER:
A. Right.
THE COMMISSIONER:
Q. - on the basis of a template in any event.
MR. GULLIVER:
A. Yeah.
THE COMMISSIONER:
Q. Thank you.
CHAYTOR, Q.C.:
Q. And Mr. Gulliver, and even though this information could be used to identify the patient, you're saying this--you don't consider this to be patient information?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. If we could have please, P-0573. And page 3 is the typed version of the notes. This is a meeting of August 17th, 2005, and it's between yourself and Dr. Williams. "All blocks pulled

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and reviewed at General Site by Dr. Dan Fontaine now waiting to send all for 1999 to first three months of 2004, all blocks given to Dr. Cook yesterday for St. Clare's and Grace site, 1999 to first three months of 2004." So I take it what's happening here is you're giving Dr. Williams an update as to where things are?
MR. GULLIVER:
A. Where we are logistically with this whole process.
CHAYTOR, Q.C.:
Q. And the last bullet says, "Note that Montreal's Ventana testing was done on semi-automated system and compares very closely to our DAKO results in the same seven patients." What was happening there? What did you understand was happening?
MR. GULLIVER:
A. I know there were, I think there were ten samples pulled and they were sent to Montreal to correlate results.
CHAYTOR, Q.C.:
Q. And they used the Ventana to retest or do the test and it correlated closely to the DAKO

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results?
MR. GULLIVER:
A. To our DAKO results, yeah.
CHAYTOR, Q.C.:
Q. "The reports provide excellent correlation of the DAKO and Ventana semi-automated systems, Mr. Tilley and Dr. Fleming advised." What did you understand Dr. Fleming's involvement to be?
MR. GULLIVER:
A. I have no idea.
CHAYTOR, Q.C.:
Q. Had you attended any meetings where he was in attendance as well?
MR. GULLIVER:
A. I don't know who he is.
CHAYTOR, Q.C.:
Q. Okay, I understand he is a physician--if it's the same Dr. Fleming, he's a physician with the Department of Health, but that's fine, so that wasn't discussed with you, I take it?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And Mr. Gulliver, in doing your work in

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reviewing all of the pathology reports, first of all, how long did it take you to do that, to I.D. the three thousand approximate patients, how long of a process was that?

MR. GULLIVER:

A. To do the spreadsheets?

CHAYTOR, Q.C.:

Q. Well to actually identify who might potentially end up on the spreadsheets, that piece?

MR. GULLIVER:

A. I can't give you an exact date, I know during this time frame I had been scheduled to take three weeks vacation and I didn't get any days vacation because during that whole time, this is what I was doing. I'm thinking it took three or four weeks of, I don't mean just regular days, like days and evenings, weekends. It was also very time consuming to, once you sort through and read reports and you've seen, you know, sort of the piles I've made of the positives, the negatives, out-of-towns and those things, then actually creating the spreadsheets were, you're then copying patient demographics, like name, MCP number,

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reading their report to see what the type of tumour was, reading their report to see if they identify what block was originally tested, reading the report to see if the pathologist had indicated on the report if they read the positive external control, did they identify that they read the patient's positive internal control, was there HER2/neu done on this patient. So each individual patient, I mean, it took a fair bit of time to write them on the spreadsheets. So it took weeks, it wasn't done in a matter of a few days.

CHAYTOR, Q.C.:

Q. And in terms of manually then having to take that information and put it into the spreadsheet, did Mr. Dyer cross-check your work and you cross-check his work in doing that? I take it that's the kind of thing that could be, you know, could be right for some sort of human error even to get a number wrong.

MR. GULLIVER:

A. I don't think we cross-referenced what we had on the spreadsheets, what we did was cross-

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reference what we had in the piles, just like if I had my year done, I would ask Barry, look, read through these here and to see if I got things sorted properly type of thing.

CHAYTOR, Q.C.:

Q. And in going through the pathology reports, did you come across people who had already had retests done in the past? So patients, we've seen a number of pathology reports here where patients had already had repeats.

MR. GULLIVER:

A. Yeah, I know I see, well, it runs the gamut. I seen patients who had ER/PR tests done on multiple specimens over a certain time frame, could have been on a biopsy, another biopsy primary tumour after surgery. I seen patients in there that did have, I guess we call it more than one original ER/PR result on the same specimen.

CHAYTOR, Q.C.:

Q. And in those, did you see that there were times when the result on retesting was different from the original test?

MR. GULLIVER:

A. I did, yes.

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CHAYTOR, Q.C.:

Q. And did you bring that to anyone's attention?

MR. GULLIVER:

A. I think just in general, I didn't bring it specifically to someone's attention.

CHAYTOR, Q.C.:

Q. Did you tell it to Dr. Williams, for example?

MR. GULLIVER:

A. I can't remember telling Dr. Williams, no.

CHAYTOR, Q.C.:

Q. And how about Ms. Predham?

MR. GULLIVER:

A. I don't remember, no. But again, I mean, in laboratories, I guess the thing is I wasn't surprised, you know, that I'm reading reports over a three year period where there's thousands of tests that I would have come across patients who had had a test repeated, you know, there are many instances in pathology and other parts of the lab where you do repeat a test. Again, to my knowledge of the ER/PR, the vast majority of time that pathologists would require a repeat would be if during the procedure the tissue had kind of boiled off the slide during antigen retrieval

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process.
CHAYTOR, Q.C.:
Q. Yes. But in terms of there being repeats with different results and, for example, we had examples here where there were four tests done within a three-month period that resulted in a different result, you would have come across those reports in reviewing them all, I take it?
MR. GULLIVER:
A. I don't remember them specifically, no, no.
CHAYTOR, Q.C.:
Q. And so that didn't stand out to you either as something that, well, was there something happening in this time period, perhaps we should have a closer look.
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And you didn't report that to anybody?
MR. GULLIVER:
A. Again, but I mean, at this time we're already decided to retest every single negative patient, so -
CHAYTOR, Q.C.:

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Q. Yes, but you also, I would hope you would be looking to try and identify any potential problem that could have caused this in the first place.
MR. GULLIVER:
A. I was not, no. My focus was just -
CHAYTOR, Q.C.:
Q. Well others were though.
MR. GULLIVER:
A. My focus on reading these reports was to identify patients who were reported as negative who possibly did not receive hormone therapy during that time frame and to try and get this done in as timely a manner as possible so we could get them retested.
CHAYTOR, Q.C.:
Q. But Eastern Health was certainly trying to investigate what caused any problem.
MR. GULLIVER:
A. I don't think there was like an investigation being undertaken at this time. What we're all focused on was patient care. Let's identify the patients first, let's get them done.
CHAYTOR, Q.C.:
Q. Well Dr. Carter was certainly undergoing an

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investigation at the same -
MR. GULLIVER:
A. I was not involved with Dr. Carter, so what she was doing is beyond my knowledge.
CHAYTOR, Q.C.:
Q. But at the same time that you were doing, identifying the patient, she was looking into any potential issues around the test.
MR. GULLIVER:
A. No, she was not. By this time Dr. Carter resigns from doing any reviews whatsoever.
CHAYTOR, Q.C.:
Q. By the 1st of August.
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. But weren't you involved in identifying the patients and going through the pathology reports, didn't that happen back in July?
MR. GULLIVER:
A. No, the ones that we seen in July was basically a skim through to look at patients who are positive or negative. I mean, in July, I wasn't sitting down in July reading each report indepthly to try and put them on

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spreadsheets and try to identify who should be retested. In July, it was basically doing the positive, negative overall rates by year and for the eight-year period.
CHAYTOR, Q.C.:
Q. So if we could just go back to P-0565 please? And this is your chronology that you put together by August 10th, and it says "In early July, I searched for all ER/PR tests performed by the lab from January, 1999 to July, 2005. I sorted the approximate 2500 reports by date, ER/PR status in patients from the Health Care Corporation verses out-of-town patients." And I took you through this earlier.
MR. GULLIVER:
A. Right.
CHAYTOR, Q.C.:
Q. And that provided a snapshot of the year, the number of tests performed and are positive, verses negative rate. So it was in early July that you were doing this piece of work?
MR. GULLIVER:
A. That was probably mid to late July. And again -
CHAYTOR, Q.C.:

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Q. So you weren't aware that Eastern Health was doing anything to try and investigate the cause of any problem?

MR. GULLIVER:

A. I don't know what Dr. Bev Carter was doing. When I finished with the reports at this point, I actually brought these reports to Dr. Carter at St. Clare's because she was going to now start doing the identifying patients in reading path reports of who could probably be retested. So what you're seeing here in August was when I had to go back to St. Clare's when she quit and stopped doing any review of patients -

CHAYTOR, Q.C.:

Q. Yes, and get the reports back, yes. But, Mr. Gulliver, I just want to be clear, so you weren't aware and up until then August, when you're identifying the patients, reviewing through the pathology reports, through that whole time period when you're seeing patients who had had repeats done in the past, throughout that whole time period, you're not aware that any one is going to be trying to figure out, well what happened here?

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MR. GULLIVER:

A. I would assume at some point that that would be one of our--that would be a focus that we would need to work on, but at that point in time, all we were all focused upon was trying to identify the patients who could be retested and who could be offered hormone therapy who weren't offered before.

CHAYTOR, Q.C.:

Q. And in coming then across those reports where there had been repeats done and whether or not they were done over a certain period of time, to you, at that point in time, that wasn't of any particular significance to you?

MR. GULLIVER:

A. Only if it was a negative, put on a sheet.

THE COMMISSIONER:

Q. I'm sorry, Mr. Gulliver, I just to make sure I'm clear on what you were doing there that summer. I know it was a very busy summer for you. So I'm taking it from the exhibit, which is currently here, the P-0565, that it says in early July, but you're saying it's more likely mid July.

MR. GULLIVER:

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A. Mid July when I started, yes.

THE COMMISSIONER:

Q. You identified the approximately 2500 reports and took copies and provided them to Dr. Carter who was then doing work?

MR. GULLIVER:

A. After--right, once I did my computer searches for ER and PR orders and had them all sorted by year, then I sorted within year patients who were positive, patients who were negatives, the weak positives, those in between ones and the patients who were out of town that we had no results. From that, I was adding, just doing numbers.

THE COMMISSIONER:

Q. Uh-hm.

MR. GULLIVER:

A. Adding up total tests, looking at how many were positive, how many were negative to get an overall positive negative rate.

THE COMMISSIONER:

Q. Okay.

MR. GULLIVER:

A. When I was finished with that exercise, those reports in the boxes, I actually drove to St. Clare's and gave them to Dr. Bev Carter because at that point, Dr. Bev Carter and Dr. Cook, those two pathologists, they were the ones who were going to review them and identify the patients who should be retested.

THE COMMISSIONER:

Q. Yes. Now subsequently Dr. Carter resigned from her position or her role as it was in the early stages, in any event, in re-examining in more detail what was done at the time and I take it then this same material came back to you?

MR. GULLIVER:

A. I drove back to St. Clare's and I got it from her office.

THE COMMISSIONER:

Q. Okay, so during that August when you, instead of going on vacation were emersed in this process of producing the spreadsheets, et cetera, et cetera, do I take it that the base that you would have used were the same -

MR. GULLIVER:

A. The exact same ones.

THE COMMISSIONER:

Q. - 2500 reports that you had produced in July.

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MR. GULLIVER:
A. Yes.
THE COMMISSIONER:
Q. That you had gone to Dr. Carter and then came back to you and you would have taken those same reports again and then--but this time, going through them in more detail because you were getting for the purpose of your spreadsheets, more information to record?
MR. GULLIVER:
A. Yes.
THE COMMISSIONER:
Q. And then Mr. Dyer comes back from vacation and he gets involved in the same process?
MR. GULLIVER:
A. Yes.
THE COMMISSIONER:
Q. Okay.
MR. GULLIVER:
A. He's helping me.
THE COMMISSIONER:
Q. Yes, okay, thank you.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. So the tests that you did come across that had been repeated,

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you said you would have only focused on those if they were negative, so any tests that originally had been negative but there had already been a repeat on the person's pathology report, you could see it had been repeated and it had turned positive. Would you have included the original negative test as part of the people who needed to be retested?
MR. GULLIVER:
A. I think I did, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. You think there were.
MR. GULLIVER:
A. I can't tell you a hundred percent, but I'm pretty sure I did.
CHAYTOR, Q.C.:
Q. So whichever of their tests was negative, it was sent for retesting?
MR. GULLIVER:
A. Yeah, and you may see too on some of the spreadhsheets, you may see two results in a little box, like a negative, negative, and then a positive there.
CHAYTOR, Q.C.:

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Q. And you were telling me about other things that you gleaned from the review of the pathology reports. I'm wondering did you see anything or any reference to problems with fixation?
MR. GULLIVER:
A. You mean that a pathologist, like actually dictated in the report that there was a fixation issue?
CHAYTOR, Q.C.:
Q. Yeah, well we'll start there, whether or not there was any reference to test result, some issue about the results may be unreliable because of a fixation issue or test difficult to interpret because of fixation issues?
MR. GULLIVER:
A. I would have to say, I think there might have been a couple, like it's not something that says, oh yeah, I've seen lots of those, no. I think there might have been a couple and to tell you the truth, I think there might have been some in the early years when Dr. Khalifa was doing them. It strikes me that there might have been a couple of times where he said something about fixation, but it's not

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something that was--that I came across very often about it, no.
CHAYTOR, Q.C.:
Q. And did you see any reference to fixation anywhere else other than the pathology reports?
MR. GULLIVER:
A. No, I didn't.
CHAYTOR, Q.C.:
Q. And any reference to fixation as being an issue, did you pass that information on to anyone?
MR. GULLIVER:
A. It being an issue because I read it in a report?
CHAYTOR, Q.C.:
Q. Yeah, if you saw that -
MR. GULLIVER:
A. I didn't see--it wasn't in the reports enough to even register up here to say, oh, you know, this is an issue.
CHAYTOR, Q.C.:
Q. What about afterwards when, of course, you end up with a copy of Dr. Banerjee's report and you're aware of what Ms. Wegrynowski found as

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well, at that point in time did it dawn on you and you think, well gee, I saw some references to fixation, perhaps we should go back and look at when that was, did it come up in that context?

MR. GULLIVER:

A. No, because the references in those reports, it was so infrequent, it's not something that stood out to me, no.

CHAYTOR, Q.C.:

Q. Were there any other things when you're reading through the pathology reports that stood out to you?

MR. GULLIVER:

A. I don't think that there was anything, any one thing in particular that stood out. I think the biggest thing that stood out was, I guess two things--well I would say three things. I guess one of the biggest things is that when you sit down and read all of those reports over an eight-year time frame that's been, you know, interpreted and reported by pathologists and it kind of hits home that I'm reading pathologists names who, you know, and I'm reading them and I'm like, "Oh God, yes, he

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used to work here and she used to work here and he used to work here."

CHAYTOR, Q.C.:

Q. So the number of pathologists that had gone through -

MR. GULLIVER:

A. The numbers of pathologists that were interpreting these here, it was a lot, I mean, there might have been 25, 30 or more than that. And, you know, I would say, "Oh, I remember when she worked here." That kind of thing. I think the second thing that stood out was the, you know, I'm going to have to say huge variability in how pathologists reported. There really was no standard template that was used, even within a site, you know what I mean, like even if the Health Sciences had a standard template and the Grace had one and St. Clare's had one and whatever -

CHAYTOR, Q.C.:

Q. Even within any given institution it wasn't standard.

MR. GULLIVER:

A. Yes, it wasn't standard, it was just, whatever the pathologist, however they interpreted and

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reported it is how they interpreted. I mean, that was a huge variability and I think and you know, I pointed it out to you on my last day and then taking all those reports and reading them all and sorting them all and then taking information and putting it on the spreadsheets, I really have to say that the only year that or the year that gave me the least amount of trouble or variability was 1997 and I really have to say it's because I think that Dr. Khalifa, we had him as pretty well the only pathologist who was interpreting and I think when you do have that, you know, expertise and you are relying upon one or two people, then that allows itself to be more standardized. You know, how can you standardize 30 different pathologists doing their interpretations? And I think that's something that we've all learned from this, that we now have a dedicated core group of breast pathologists, so it can allow for standard interpretations and standard reporting.

CHAYTOR, Q.C.:

Q. And in terms of any global, you being the

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person who looked at all the pathology reports, or all the relevant pathology reports, any other global trends or anything that you can see in them, that's it, those are the things that -

MR. GULLIVER:

A. I think those are the key ones, yes.

CHAYTOR, Q.C.:

Q. Did anyone else have all of the same pathology reports for review?

MR. GULLIVER:

A. Say that again?

CHAYTOR, Q.C.:

Q. Did anyone else also have--did you give copies of all the pathology reports to anyone else?

MR. GULLIVER:

A. No, just for the people to help me do that exercise.

CHAYTOR, Q.C.:

Q. Like, did Ms. Predham have copies of all the pathology reports, for example?

MR. GULLIVER:

A. I don't think so. I think Heather may have got copies of reports if she wanted them for certain patients, but I never gave Heather a

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copy of all, like, 3,000 patient reports.
CHAYTOR, Q.C.:
Q. So you were really the only person who would have done--had an opportunity to look through and see what may have been in the reports?
MR. GULLIVER:
A. Well, again, Dr. Dyer gave me a lot of help with this here, Ms. Butler helped me with it, but by and large it was us three. It wasn't like a large group and again, you know, Dr. Carter had these reports for maybe a couple of weeks in her office before I retrieved them.
CHAYTOR, Q.C.:
Q. Before you got them back, yes.
MR. GULLIVER:
A. And I don't know how much work she had done or if she had read reports in that time frame or not.
CHAYTOR, Q.C.:
Q. When the matter came up then in, by the summer of 2005 when you're involved heavily in it, in your portion of work, did--was there much, if any, discussion about what had happened back in 2003 with Dr. Ejeckam? Was that the subject matter--now, we've seen reference in

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some of the meetings to, you know, speaking to Dr. Ejeckam when he gets back from holidays, for example, is in one of the minutes, but was there much discussion about well, what was it in 2003 and is that relevant to what's happened, happening now or what we're discovering?
MR. GULLIVER:
A. No, not to my knowledge, no. I think at some point Dr. Williams asked, we'd speak to Dr. Williams about Dr. Ejeckam's intervention in 2003, but there certainly wasn't any discussion around anything else other than what happened in 2003, how did we respond to Dr. Ejeckam's intervention and that was pretty well it.
CHAYTOR, Q.C.:
Q. And when do you recall that took place, Mr. Gulliver, that you were asked about how you responded to his -
MR. GULLIVER:
A. Oh I couldn't tell you exactly, it was in -
CHAYTOR, Q.C.:
Q. Was it in 2005 or was it later on in '06?
MR. GULLIVER:

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A. I really couldn't tell you the exact date.
CHAYTOR, Q.C.:
Q. And if could just look at, please, P-1398 and I take it, it was Dr. Williams who was asking you how you responded?
MR. GULLIVER:
A. Yes, I remember meeting with him and talking about that.
CHAYTOR, Q.C.:
Q. Okay, and this is a handwritten note from Dr. Ejeckam--I'm sorry, Dr. Cook, and he says he spoke to Dr. Ejeckam with Terry Gulliver, I think it's morning of March 7th, 2006, "re: the hold on certain stains in 2003. I asked him what he meant by erratic. Dr. Ejeckam reported that it meant some stains worked days and didn't work on others. I asked him if he should have recommended a review of stains at that time. He replied to me that it wasn't his place to initiate or recommend a review." So do you recall, did you meet with Dr. Ejeckam and Dr. Cook in March of 2006 and discuss the issue?
MR. GULLIVER:
A. I guess I did, yeah. I can't recall anything

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specific other than what you're just saying here.
CHAYTOR, Q.C.:
Q. And at any point prior to March of 2006, had such a meeting or discussion taken place with Dr. Ejeckam?
MR. GULLIVER:
A. No, the only thing I remember Dr. Ejeckam, when he came back in the summer of '05, I think myself and Barry met with him and talked about, you know, does he know of any external proficiency testing that we can enrole in for IHC and that's how we started on the UK NEQAS program. But I don't remember talking about--with Dr. Ejeckam about anything else in 2003.
CHAYTOR, Q.C.:
Q. Sorry, about what had happened in 2003.
MR. GULLIVER:
A. Yes. I remember at some point though giving Dr. Williams sort of an update of how we responded to Dr. Ejeckam's concerns in 2003.
CHAYTOR, Q.C.:
Q. And at what point in time would that have been? Would that be around the same time that you're discussing it with Dr. Ejeckam or is it

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later again?
MR. GULLIVER:
A. I don't know, it might have been, I don't know exactly the time frame. I know I did do it.
CHAYTOR, Q.C.:
Q. So when did the Ejeckam memos become something that you do recall being discussed in this whole--in dealing with this whole issue?
MR. GULLIVER:
A. Okay, well obviously, you know, the three memos that we debated in 2003, I did have some discussion with Dr. Williams, you know, after the ER/PR we're starting all the review and retesting. I know at some point I met with Dr. Williams to give him an update of we had moved the lab and we got the new system. We started retraining technologists so we can dedicate the three techs in IHC. To be honest with you, I think the next time that they really became an issue is when Mr. Tilley called and his memos were being released to the media or something like that. And that might have been, that was like last year, like 2007.
CHAYTOR, Q.C.:

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Q. So that's May of 2007, yes, okay. And so Mr. Tilley called you about that?
MR. GULLIVER:
A. His office called, yes.
CHAYTOR, Q.C.:
Q. And what do you recall about that?
MR. GULLIVER:
A. Well I got a phone call saying that Mr. Tilley needed me over in his office, that apparently, you know, the Premier had one of these memos. I don't know which one of the three memos, I don't know if it was the two that were--his first two that weren't addressed to me or if it was the June 19th one that was addressed to me. But I was told that the Premier has one of the memos in the House of Assembly and the media are calling about them and would I come over with Mr. Tilley and go through them all and give him, I guess, brief him of really what transpired during that time frame.
CHAYTOR, Q.C.:
Q. And why were you asked to do that? Were you the only one asked? Was Dr. Ejeckam asked?
MR. GULLIVER:
A. Well, Dr. Ejeckam has been retired, he left -

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CHAYTOR, Q.C.:
Q. He was gone by them.
MR. GULLIVER:
A. - by this time. And I went over to corporate office and I think after I was there, I think Dr. Cook arrived, I'm not sure if Dr. Denic arrived or just Dr. Cook, or both of them.
CHAYTOR, Q.C.:
Q. And did you have copies of the memos?
MR. GULLIVER:
A. Well this is by 2007.
CHAYTOR, Q.C.:
Q. Yes. Did you make copies of the memos to take to your meeting with Mr. Tilley?
MR. GULLIVER:
A. I think I did, yes, I did. I brought all three because I think when I arrived there, I think the only one they had was the one that was addressed to me, June 19th.
CHAYTOR, Q.C.:
Q. And where did you have copies of the memos? Where did you go to get them?
MR. GULLIVER:
A. Well I had them in my office by this time because by this time, we've done a lot of work

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in providing documentation and discovery for the Class Action lawsuit.
CHAYTOR, Q.C.:
Q. So originally, though, in--when you had to first go and look for the memos, where did you go to look for them? Where did you find them?
MR. GULLIVER:
A. Originally when, in 2003?
CHAYTOR, Q.C.:
Q. Yes, well when you first--when this issue comes up and it becomes relevant to this issue for whatever reason, did you have copies, yourself, in your own possession or did you have to go and ask someone else -
MR. GULLIVER:
A. No, because I never ever received the first two memos. When he stopped testing in 2003, he never addressed it to me or copied it to me and I found out after the fact.
CHAYTOR, Q.C.:
Q. So where did you get your copies?
MR. GULLIVER:
A. And the same thing happened when he put testing back in place. I think I got copies over in the lab somewhere. I got them off one

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of the pathologists, I got them somewhere. I had the June 19th one because he wrote it specifically to me.

CHAYTOR, Q.C.:

Q. And so the meeting then that you end up at sometime in May of 2007 with Mr. Tilley, who else attended that meeting?

MR. GULLIVER:

A. Again, I'm pretty sure Dr. Cook arrived after I did and -

CHAYTOR, Q.C.:

Q. Was it Dr. Denic, you said?

MR. GULLIVER:

A. I'm not sure if Dr. Denic also came because, you know, Dr. Denic by this time is our new clinical chief replacing Dr. Cook, but of course, during this time frame of 2003, Dr. Cook would have been the clinical chief. Like Susan Bonnell was there, our communications person. There was another lady there from communications, I'm not sure which one, a couple of the vice presidents were there in the room.

CHAYTOR, Q.C.:

Q. So Dr. Howell, would he have been there?

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MR. GULLIVER:

A. Dr. Howell was not there, no. I don't know where Dr. Howell was.

CHAYTOR, Q.C.:

Q. I'm sorry?

MR. GULLIVER:

A. I don't know why he wasn't there, but I know he wasn't there. I think Stephen Dodge was there, like vice-president of Human Resources.

CHAYTOR, Q.C.:

Q. And what was the purpose of the meeting then at that point in time, was it to bring Mr. Tilley up to speed as to what the memos contained and what had happened in that time period?

MR. GULLIVER:

A. Pretty well and go through the historical, April 1 and then where he stops testing, go through--I brought over the--the one we got back from DAKO, you know, where DAKO talks about your controls seem to be fine.

CHAYTOR, Q.C.:

Q. Mr. Dyer and Mary Butler.

MR. GULLIVER:

A. Right. But your erratic staining is from the

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patient tissue. Then I go through the one of May where he put testing back in place, then I go through the June 19th where Dr. Ejeckam wrote to me and I updated Mr. Tilley from that memo that we had moved, physically moved the lab into its new space. We upgraded to new a new automated system, we retrained technologists to take over the grossing function and those kinds of things.

CHAYTOR, Q.C.:

Q. So did Mr. Tilley seem to have much knowledge about the issues discovered by Dr. Ejeckam in 2003 prior to this sit down with him?

MR. GULLIVER:

A. I don't think he had any, I mean, if you asked--this is just my opinion.

CHAYTOR, Q.C.:

Q. Yeah, what was your perception of his level and knowledge of the event?

MR. GULLIVER:

A. Just seemed like to me he didn't have any.

CHAYTOR, Q.C.:

Q. So this was the first time he was becoming aware of the issue that Dr. Ejeckam had dealt with in 2003?

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MR. GULLIVER:

A. I don't know, it's the first time I spoke to him about it, I don't know if he was aware before or not.

CHAYTOR, Q.C.:

Q. And how informed did he appear to be on the issue from your observations?

MR. GULLIVER:

A. He seemed to be completely uninformed.

CHAYTOR, Q.C.:

Q. And the DAKO memo that you brought over, the one that was written to Mr Dyer and Ms. Butler.

MR. GULLIVER:

A. And Mary.

CHAYTOR, Q.C.:

Q. Yes, you had been unaware, I understood, about that memo as well, yourself, was this when you first became aware or got possession of that memo?

MR. GULLIVER:

A. No, I knew before that because I had found out we're providing documentation to the Class Action lawsuit and this is how I came across, really all the memos and became really

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familiar with them.
CHAYTOR, Q.C.:
Q. So you had only recently come into possession of that memo yourself, the DAKO one?
MR. GULLIVER:
A. No, I knew back in 2003 that DAKO had sent something back. I knew back in 2003 DAKO said our controls were working fine. I knew that much.
CHAYTOR, Q.C.:
Q. And you told me about back and forth -
MR. GULLIVER:
A. I didn't really read the whole--I don't think I read the whole memo back in 2003.
CHAYTOR, Q.C.:
Q. Or to have actually seen the memo. When did you first become aware that that existed?
MR. GULLIVER:
A. Probably around--maybe around this time. I knew it existed, but I don't think I ever had a copy of it in my office.
CHAYTOR, Q.C.:
Q. Yes, well that was my question, when you came in possession of it. And so where did you go to get that memo?

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MR. GULLIVER:
A. I think I got it from either Mary Butler or Barry Dyer.
CHAYTOR, Q.C.:
Q. And so how long did this meeting with Mr. Tilley last?
MR. GULLIVER:
A. I mean, it was certainly about an hour. It may have been longer than an hour, you know, it wasn't fifteen, twenty minutes. It was a fairly lengthy meeting.
CHAYTOR, Q.C.:
Q. Okay, and if we could just go back, please, to P-2950? Were you surprised by Mr. Tilley's lack of knowledge on the issue of Dr. Ejeckam and any issues that he had detected in 2003?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. You weren't surprised that he wouldn't know that. And when you--this is the e-mail exchange between you and Ms. Predham that we discussed the last day, July 18th, 2005 and you understood or you said what you were intending to convey to Ms. Predham was that

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the Ejeckam letter shouldn't go from you, that it should go from others, not from you. So were you surprised that that hadn't happened, that it appeared Mr. Tilley perhaps did not receive the Ejeckam memos?
MR. GULLIVER:
A. Well this is July '05 and I went to Mr. Tilley, I think it was May '07, two years later and I don't even think I would have even thought about this.
CHAYTOR, Q.C.:
Q. Okay. Back in 2005 then in this time frame when Dr. Williams is asking you about the Dr. Ejeckam issue or what happened in 2003 with Dr. Ejeckam, were you surprised that Dr. Williams wouldn't have had his own direct knowledge or personal knowledge about the issue?
MR. GULLIVER:
A. I can't say one way or the other, you know, in 2003, again, when Dr. Ejeckam stopped testing, he neither consulted or informed the clinical chief or myself as program director. We found out about it after the fact. He did inform, he sent a copy of the memo to Dr. Cook after

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he already stopped testing. When he put testing back in place, he sent Dr. Cook a memo, you know, he copied Dr. Cook saying we're now putting testing back in place and he gave all the guidelines for interpretation and fixation. I didn't receive either one of those two. I would have assumed that Dr. Cook felt it was important enough to bring to Dr. Williams that he would have.
CHAYTOR, Q.C.:
Q. And during your meeting then in May of 2007 with Mr. Tilley on the issue, did you--was it discussed or throughout that process did you become aware of how the Premier ended up with one of the memos?
MR. GULLIVER:
A. No--yeah, it was at that meeting with Mr. Tilley to give him a briefing that someone said just that day, just that morning the Premier had one those memos in the House of Assembly.
CHAYTOR, Q.C.:
Q. Yes, and do you know how he came to have it? Was that discussed?
MR. GULLIVER:

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A. How who got it?
CHAYTOR, Q.C.:
Q. How the Premier obtained the memo?
MR. GULLIVER:
A. No, it wasn't discussed and I have no idea how.
CHAYTOR, Q.C.:
Q. Was there anything else then in that meeting with Mr. Tilley in May of 2007 of meeting ends and you've told him, I take it, whatever knowledge you had about Dr. Ejeckam and did you tell him you had met, for example, back in March of 2006 with Dr. Ejeckam and what Dr. Ejeckam had said at that point in time?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And why not, why didn't you -
MR. GULLIVER:
A. I don't even know if I would have remembered, you know, meeting with Dr. Ejeckam in 2006 with Dr. Cook.
CHAYTOR, Q.C.:
Q. And Dr. Cook, you think was present. Do you know whether or not he spoke about that?

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MR. GULLIVER:
A. I don't remember Don mentioning that at all, no. I'm not saying that he didn't, but I don't remember him saying anything about it.
CHAYTOR, Q.C.:
Q. And did Mr. Tilley express any concern that he was only now learning about this issue?
MR. GULLIVER:
A. No, he didn't really say much, he just wanted to--I mean, they were asking questions about the time frames, how do we respond to Dr. Ejeckam's, the June 19th one, you know, that was addressed to me. I don't remember hearing George express any concerns about this is, he's only now hearing about it. Because I don't know, I don't know if Mr. Tilley would have expected, at his level, to get a copy of every operational issue for the whole organization, I don't know.
CHAYTOR, Q.C.:
Q. Yes, but in terms of what had been happening since 2005 regarding the issue, whether or not he would have expected that kind of background information in dealing with the ER/PR issue, you don't recall him expressing any concern

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one way or the other?
MR. GULLIVER:
A. He didn't, no.
CHAYTOR, Q.C.:
Q. P-0595 please? This is a letter September 21st, 2005 written to you by Dr. Fontaine and I take it Mr. Gulliver, you see it's signed here, copied to Drs. Cook and Williams. Do you recall receiving this letter from Dr. Fontaine?
MR. GULLIVER:
A. I think so, yeah.
CHAYTOR, Q.C.:
Q. And Dr. Fontaine writes, "I write to you in response to the recent problems experienced with the immunohistochemical staining, specifically regarding estrogen and progesterone receptors. It is my opinion that the problem extends far beyond the estrogen and progesterone receptor status that has been identified." And he goes on to say what he thinks is "necessary to bring the laboratory to the standard whereby confident diagnosis can be delivered on the basis of immunohistochemical testing which is key to an

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accurate diagnosis. And patient management, a dedicated immunohistochemical lab is essential. This should include technologists who are the leading edge of the field who are trained to interpret and troubleshoot any possible inconsistencies with staining patterns. This would include participation in external quality assurance and monitoring program", and he goes on from there. And in the next paragraph he also mentions "Fixation is a key component of immunohistochemical staining. At the current time, there is a variety of practice patterns involving various pathologists to which there is no standardized approach to grossing specimens". And he goes on to say "With the consolidation of the technical services, all the grossing could be performed at the Health Sciences site." And in his last paragraph he writes, "Furthermore in support of pathology assistants, the Hay report and the recent accreditation of the program, there have been strong recommendations involving the implementation of pathology assistants. In view of the shortage of pathologists, this would be a more

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cost effective use of resources." So upon receipt of this letter, Mr. Gulliver, what did you do?

MR. GULLIVER:

A. Well I think I wrote Dan back and pretty well said that you're aware now, we have two reviewers who are coming into the laboratory and, you know, fully plan to whatever they recommend, that will be our plans to implement. Again, you know, I really want to say that Dan wrote this letter in pretty well writing in support of our laboratory. As the new site chief, he's reinforcing there that we need to have pathology assistants, he's reinforcing there that we should be partaking in proficiency testing, which again takes resources and money, and when he's saying it extends beyond ER/PR, I think what Dan is referring to there is that, you know, ER/PR is a product of the pathology laboratory, not just of the IHC lab, because as you know, the specimen comes in first to the gross bench, you have to make sure it's fixed properly, you have to make sure it's grossed properly, that proper sections are submitted, that they're

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proper thickness. So it's just--so that's what he's alluding to.

CHAYTOR, Q.C.:

Q. And those issues could affect many tests?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Not just ER/PR?

MR. GULLIVER:

A. Exactly, yeah.

CHAYTOR, Q.C.:

Q. So you received the letter and you responded to him?

MR. GULLIVER:

A. Well, I spoke to him about it too, I mean.

CHAYTOR, Q.C.:

Q. You spoke to him in the meantime, did you?

MR. GULLIVER:

A. And I knew before he wrote it, he was going to write it, so -

CHAYTOR, Q.C.:

Q. So you knew that this was coming?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

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Q. So what was the purpose then in him writing the letter?

MR. GULLIVER:

A. Again to--just to reinforce support for our laboratory, and to, you know, help us with getting resources really.

CHAYTOR, Q.C.:

Q. So did you ask him to write this letter?

MR. GULLIVER:

A. I never asked in particular, no, no.

CHAYTOR, Q.C.:

Q. But you knew he was going to write it?

MR. GULLIVER:

A. It wasn't like Dr. Ejeckam, when I asked Dr. Ejeckam to write me any further concerns, that June 19th one.

CHAYTOR, Q.C.:

Q. But it was a similar situation in that it would be support to you in looking for resources for the program?

MR. GULLIVER:

A. Right, and around this time also I'm starting to prepare a sort of a summary for Dr. Williams of what resources and what we'd need in our pathology lab.

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CHAYTOR, Q.C.:

Q. Yes, and I think that--you write that, or it's dated, you and Dr. Cook, October 13th. So you were probably working on it?

MR. GULLIVER:

A. I may be even working on it at this time frame.

CHAYTOR, Q.C.:

Q. So you spoke to--you spoke to Dr. Fontaine before this letter was written, and then you spoke to him after you received it, and then if we could have, please, P-0619. So basically his recommendations, he talks about the need for the techs to be, in his words, on the leading edge of their field?

MR. GULLIVER:

A. I know, and Dan is someone who also believed that the technologists in the IHC lab, that really we'd be better off if they were trained to actually read all the controls slides before it goes to the pathologist, and not have the pathologist verify them.

CHAYTOR, Q.C.:

Q. And he talked about the inconsistencies in the staining, the issues of fixation, grossing -

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MR. GULLIVER:
A. Again the pathology assistants -
CHAYTOR, Q.C.:
Q. The variability in grossing, pathology assistants?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. All of those issues. So it was really--it was quite insightful, I take it, his identification of issues, though, that needed to be addressed?
MR. GULLIVER:
A. I would say so, yes.
CHAYTOR, Q.C.:
Q. And when you think about the issues identified by the external reviewers as well around the same time period. October 4th, 2005, is your response to Dr. Fontaine, and you write, "In respect of his letter concerning recent problems experienced with immunohistochemical staining, specifically regarding the estrogen/progesterone receptors, as you are aware we have had an external quality review performed by the leader in pathology at BC

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Cancer Institute, and the chief technologist of the immunohistochemistry section at Mount Sinai Hospital. Dr. Cook, Dr. Williams, and myself, have received the preliminary assessment at a debriefing session with both these consultants. Their recommendations will be all encompassing and currently Dr. Cook and myself are putting together a strategy to deal with the issues they referenced, and the recommendations that we will be proposing will encompass the issues outlined in your letter". So what you're telling him is that--and you go on to thank him for his interest, and Dr. Cook would keep him apprised. I take it what you're telling him is that the things he's mentioned have also come up and been mentioned by the external reviewers as well?
MR. GULLIVER:
A. Well, you know--and I know Dr. Fontaine got to speak with and spend some time with Dr. Banerjee, so I'm sure they must have had discussions while he was here.
CHAYTOR, Q.C.:
Q. That's what I'm wondering, was it independent thought of Dr. Fontaine. Based on your

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discussion with him before he wrote the letter, did you understand that he was going to be putting in the letter his own observations over time or was he going to be putting in the letter what he understood Dr. Banerjee had found?
MR. GULLIVER:
A. I really--I don't know.
CHAYTOR, Q.C.:
Q. Why did you write him back? Why did you write him this letter?
MR. GULLIVER:
A. Why did I write him?
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. Well, pretty well to tell him that you knew we've had Dr. Banerjee in and Trish was in, we're expecting to get, you know, recommendations from those two.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. And that I expect that I will have full support from Dr. Williams to implement.

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CHAYTOR, Q.C.:
Q. And you copied it to Dr. Cook and Dr. Williams?
MR. GULLIVER:
A. Well, because I mention them in the letter there.
CHAYTOR, Q.C.:
Q. Yes, and you--and I guess I'm just curious that you saw fit--you had already spoken to Dr. Fontaine afterwards about his letter when you received it, and had spoken to him about it before, and on this occasion you wrote him back as opposed to when we looked at the memo that you received or letter you received from Dr. Ejeckam back in 2003, you didn't write to Dr. Ejeckam. I'm just wondering -
MR. GULLIVER:
A. Well, there's thousands of letters and e-mails. Some I wrote back formally, and some I don't, I just speak to people.
CHAYTOR, Q.C.:
Q. And your purpose on this occasion, though, was to bring it forward to try and get the resources that you thought were necessary for the laboratory?

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MR. GULLIVER:
A. That's pretty well it.
CHAYTOR, Q.C.:
Q. And then by copying it to Dr. Williams, was that your intention, to make sure that he was aware of this?
MR. GULLIVER:
A. No, because Dr. Fontaine had sent a letter to Dr. Cook and Dr. Williams.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. So I just wanted to make sure -
CHAYTOR, Q.C.:
Q. But that he's aware of your response.
MR. GULLIVER:
A. That Don and Bob knew that I responded to it, yes.
CHAYTOR, Q.C.:
Q. Yes. If we could have, please, P-1944. Did you still feel--Mr. Gulliver, by 2005, when you're writing back October 2005 and then October 13th, 2005, you and Dr. Cook put together your proposal that I'll take you through, did you still feel that you needed to

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have support from a physician to get the resources for your lab program, that it was necessary to have, for example, someone like Dr. Fontaine to put those concerns in writing? I mean, I take it you would know you're going to be getting reports from Ms. Wegrynowski and Dr. Banerjee?
MR. GULLIVER:
A. I just think Dan was the new site chief, I think that he was showing his support overall for the laboratory--I mean, Dan, you know, is an excellent pathologist to work with, and I think any support would help.
CHAYTOR, Q.C.:
Q. Okay, and this is a meeting of your laboratory medicine program, yourself and Drs. Cook and Williams, and on page two there's reference to the ER/PR receptors, updates provided on current status of retesting, "Terry and Dr. Cook will prepare a proposal for Dr. Williams to implement a QA program for pathology. Dr. Cook will write the surgeons to ensure that breast surgeries are not performed on Friday afternoons", and we've had some evidence on that. So the fact that you were--you and Dr.

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Cook were going to prepare a proposal to implement a QA program for pathology, is that the October 13th document?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. That goes forward.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. And is this the first time then that pathology would be having a QA program implemented?
MR. GULLIVER:
A. I don't know if what's written here in the minutes reflects a QA program. I think what Dr. Williams was asking was, you know, review the pathology service, in particular the IHC lab, and bring forward any recommendations that we would have to--I guess, to meet, like, you know, a national standard like Mount Sinai.
CHAYTOR, Q.C.:
Q. And I take it then it was seen that it was something that wasn't in place at this point in time by September of 2005?

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MR. GULLIVER:
A. Well, by this time--no, I mean, I know Dr. Bev Carter had started some things, but there really was nothing--a full program in place, no.
CHAYTOR, Q.C.:
Q. If we could have, please, P-0605, and this is a memo from you to Dr. Williams, and this time it's dated October 3rd, 2005, and again we see some statistics here; 1997 and 1998, and you write, "For your information, Barry and I have the Grand Falls cases all sorted, organized, and ready for slides to be read. We also have all the 1997 and 1998 cases printed, sorted, spreadsheeted, and can start pulling blocks tomorrow morning. I will be able to give you the stat numbers for retest before lunch time, however, it looks very good". First of all, what's the reference here to having the slides ready to be read?
MR. GULLIVER:
A. Oh, when--when the blocks are pulled and the original H & E slides were pulled with them, Dr. Fontaine and Dr. Cook were--before the blocks were sent out for retest, they were

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reading the original H & E slides to ensure that the block that we're sending out -

CHAYTOR, Q.C.:

Q. Was the suitable block.

MR. GULLIVER:

A. Would be the best block in that case, and, you know, we're paying $100.00 per block to have them retested, so we felt it was important to send the appropriate block right from the beginning.

CHAYTOR, Q.C.:

Q. So that was the H & E slides that they're looking--that's what's being referred to?

MR. GULLIVER:

A. This is not the original ER/PR slides, no, no.

CHAYTOR, Q.C.:

Q. Right, this is the H & E slides, okay, and you indicate, "I will be able to give you the stats numbers for retest". What are you referring to there? You say that it looks very good.

MR. GULLIVER:

A. Oh, I'm saying--because, I mean, again we started with the most recent patients and we're working backwards. Again these are '97,

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'98. This is where we had to pull from the combined St. Clare's, Grace, Health Sciences systems. I think what I'm saying there we'll give you the numbers of cases that we need to send out for retest. You can see the positive rates there versus negative rates. I'm saying "very good" because there seemed to be, in volume, anyway, a lesser number of retests from '97, in particular, than other years.

CHAYTOR, Q.C.:

Q. Of course, this is dated October 3rd, 2005, so this is the day after The Independent article would have published?

MR. GULLIVER:

A. I have no idea.

CHAYTOR, Q.C.:

Q. Okay, well, that's a matter of record here, it's the day after, but throughout, are you still then on October 3rd, 2005, you're still pulling slides--this is for the outside cases or this is -

MR. GULLIVER:

A. This is St. John's cases.

CHAYTOR, Q.C.:

Q. These are St. John's.

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MR. GULLIVER:

A. For '97, '98.

CHAYTOR, Q.C.:

Q. Okay, so you're still in that process of gathering up the material?

MR. GULLIVER:

A. These will be the last ones. By this time, I think the '99 to '04 for St. John's are all gone, and we're in the process--also we received blocks and slides from outside St. John's that we're organizing, and these will be the last of the St. John's ones to go of the living patients.

CHAYTOR, Q.C.:

Q. And throughout this time period while you're identifying the patients, Dr. Williams had asked you to continue to calculate and identify -

MR. GULLIVER:

A. Well, each year that we did, yes.

CHAYTOR, Q.C.:

Q. Positivity rates.

MR. GULLIVER:

A. I did this at the same time.

CHAYTOR, Q.C.:

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Q. So you kept doing that throughout?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And why, why did you understand that those positivity rates, what relevance was that having at this point in time?

MR. GULLIVER:

A. It was having no relevance except for to have more complete data that, you know, in early--in mid July, we had done the positive/negative rates, like, for 2000, '01, '02, '03, '04, and now that I've done reports for '97 and '98, well, just felt that we should also give the update on the total positives and negatives also.

CHAYTOR, Q.C.:

Q. If we could have, please, P-0614.

THE COMMISSIONER:

Q. Excuse me, the material that came from outside of St. John's, you got blocks--did you get blocks and slides from outside St. John's, or blocks?

MR. GULLIVER:

A. We got the blocks.

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THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:
A. And we asked for their H & E slides.
THE COMMISSIONER:
Q. You asked for those as well?
MR. GULLIVER:
A. Yes.
THE COMMISSIONER:
Q. Okay. So were they reviewed in the same way by--internally?
MR. GULLIVER:
A. To the best of my knowledge, yes, that Dr. Fontaine or Dr. Cook also looked at the H & E slides before they went away.
THE COMMISSIONER:
Q. Okay.
CHAYTOR, Q.C.:
Q. And this is an e-mail from Ms. Predham, October 4th, 2005, and it's written to yourself, along with Drs. Williams, Cook, Ms. Pilgrim, and Ms. Bonnell, and she says, "I just wanted to update you on the database. On my list, I have 406 patients, 74 are confirmed as deceased. There are 37 on my list that

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were not on the list of patients that Terry gave me in August, but of that 37 we have gotten results on five. Terry, can you send me over a list of all the patients names that you have sent so I can make sure we haven't missed any". So this is fairly early then in the game in terms of it being the beginning of October, 2005. What was this about, and were you able to determine why there would have been discrepancies in your list and what was provided to Ms. Predham?
MR. GULLIVER:
A. I really -
CHAYTOR, Q.C.:
Q. She had 37 on her list.
MR. GULLIVER:
A. I don't know exactly what's there, no. I'm assuming that I would have sent Heather--Heather is looking for the list of patients that were already sent at this point in time.
CHAYTOR, Q.C.:
Q. She says she has 37 on her list that were not on the list of patients that you sent.
MR. GULLIVER:
A. Yeah.

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CHAYTOR, Q.C.:
Q. Or gave her in August, and she had results back on five. Do you recall anything about this?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And how that could have been?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And do you recall what--were you able then to give her a list of all the patients names that you had sent?
MR. GULLIVER:
A. I think at this time we gave her a list of--and this was the list that was generated by the technologists, by Mary and Barry, of the actual patients by that time who were actually sent and what block was sent on the patient.
CHAYTOR, Q.C.:
Q. Okay. So at this point in time, did it start to raise any red flags or alarms that, well, what's happening here, why are there discrepancies?

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MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. If we could look at, please -
MR. GULLIVER:
A. This is just getting--making sure we're all on the same page, okay, because when things went away and when results came back, they went back to Dr. Cook. Then Dr. Cook was coordinating with Heather Predham, and saying here's the patients that we have back now results on. I never--I never ever seen that piece of it. I didn't see the results when they came back, and what Heather is asking me here is, "Terry, can you give me a list of all the patients who have now been sent".
CHAYTOR, Q.C.:
Q. Where did you think she's got her list? She's got 37, she says, on her list that weren't on the list of patients you gave her.
MR. GULLIVER:
A. I know, but don't forget now, in early August Heather was also doing checking with the Cancer Clinic in the registry seeing how many patients had ER/PR testing done. So I'm

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assuming that's her list. She also got a list of deceased patients. I think she got it from the mortality base or some place like that.

CHAYTOR, Q.C.:

Q. Yes, but it didn't raise any concern to you that there may be people that are on a list that didn't come up in your list? You would have given her everyone, I would take it, anyone that you've been able to identify?

MR. GULLIVER:

A. At that point in time, but again it was ongoing. It's ongoing, it's ongoing.

CHAYTOR, Q.C.:

Q. And if we could have then, P-2961.

THE COMMISSIONER:

Q. Excuse me, before we leave this one, Ms. Predham says, "I just wanted to update you on the database", but it seems to me that there were several databases, if you want to look at that way. You had your list, which you arrived at in a certain way, which you were using for the purpose of sending things off.

MR. GULLIVER:

A. And Dr. Cook was using for results to come back.

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THE COMMISSIONER:

Q. Okay. Do you have any idea where Ms. Predham got her database?

MR. GULLIVER:

A. No, and I don't think we ever really had a database.

THE COMMISSIONER:

Q. Well, that was going to be sort of where I was going next in the sense of was there within the organization an accepted central source of data on these people, that everything -

MR. GULLIVER:

A. I don't think so, no.

THE COMMISSIONER:

Q. Flowed into in the sense of your material would go into there, and presumably the data coming through Dr. Cook coming back in terms of results, and perhaps data from other sources so that everything is -

MR. GULLIVER:

A. That did not take place, no.

THE COMMISSIONER:

Q. There was not one "official" database?

MR. GULLIVER:

A. No.

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THE COMMISSIONER:

Q. Okay, thank you.

CHAYTOR, Q.C.:

Q. And I believe 2961 is your response to Ms. Predham on the same date, and this you'll see is another copy of her e-mail to you and then your response is, "I have a complete list of all of our retests from the Health Care Corporation St. John's and out of town in my office for you". So your complete list were of all the people that you had identified for retesting?

MR. GULLIVER:

A. By that point and what was sent -

CHAYTOR, Q.C.:

Q. And what was sent in from the other regions?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And that's what was on your list?

MR. GULLIVER:

A. Yeah. Now that we're talking about this, Ms. Chaytor, I do--see I'm the main person coordinating with Mr. Dyer and Mary, but don't forget Dr. Carter was involved in this first,

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and Dr. Carter had already sent out patients that neither Heather Predham was aware or nor I was aware of. She was sending them out as consults to Mount Sinai through June and July.

CHAYTOR, Q.C.:

Q. And were those the original patients that were done, the original 60 or so?

MR. GULLIVER:

A. Yes, and from 2002, but after this has all been finished now, we also discovered that there are other patients besides 2002 that Dr. Carter and/or Cook had sent out individually by consult, and I think they got requests directly from the oncologist.

CHAYTOR, Q.C.:

Q. Yes, and there was eventually a consult list, I believe, was developed.

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. To try and capture those?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. But all of those should still be on your list?

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MR. GULLIVER:
A. Eventually -
CHAYTOR, Q.C.:
Q. You've identified everyone.
MR. GULLIVER:
A. Eventually most of them should end up on my list to go for retesting, and what happened is that a lot of those early patients that were sent out without my knowledge were actually resent back to Mount Sinai as batches, as a part of our large batches, and they got retested a second time at Mount Sinai.
CHAYTOR, Q.C.:
Q. So you understood that the patients, the original 60 or so that were done in house on the Ventana, they were all sent out?
MR. GULLIVER:
A. I think most of them got resent again.
CHAYTOR, Q.C.:
Q. In June and July, early on to Mount Sinai?
MR. GULLIVER:
A. But they got resent again in August/October.
CHAYTOR, Q.C.:
Q. And got sent again?
MR. GULLIVER:

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A. Yeah.
CHAYTOR, Q.C.:
Q. So they had two tests at Mount Sinai?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. Plus the Ventana test?
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And did that all get recorded on the patients' chart that they'd been -
MR. GULLIVER:
A. I think they did because, you know, I--I know at some point when we got them back the second time, that there were patients whose results significantly changed from the consult that Dr. Carter sent and that were sent again in the batches.
CHAYTOR, Q.C.:
Q. If we could have, please, P-1077, and this is an e-mail from Ms. Smith to Heather Predham, Ms. Pilgrim, Ms. Elliott, Dr. Williams, January 11th, 2006. Actually, it's the e-mail down here and I've jumped ahead a bit, but

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I'll take you back. Originally Ms. Predham's e-mail to the same individuals of the same date and she says she wants to give a heads up on another facet of the ER/PR crystal, "As you know, we have sent all the samples that were negative for ER from 1997 to April 2004 for retesting. These are the samples that were originally processed using our DAKO system, the manual system with all the steps. Mount Sinai uses the same system, but is the only lab in Canada to be accredited and participate in internal and external proficiency testing", and she goes on to then talk about a group of samples that were done on their automated Ventana system from April '04 to August '05 that were not validated by Mount Sinai. "The decision was made in the fall to send those samples up to Mount Sinai as well. We have a lady whose original samples showed a degree of positivity under the 10 percent level, so it was sent to Mount Sinai and came back completely negative. She has been informed and she was taken off Arimedex. We now have two more results back with the same situation. I guess you can say that these are false

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positive. These two will be panelled at Thursday's meeting. The explanation from the lab is that this can be expected because of the different platforms for testing, but it is, of course, a totally new aspect of this situation. I just wanted to make sure you are aware and I'll keep you updated. Signed, Heather". The explanation given from the lab that this can be expected because of the different platforms for testing, would you have been the source of that explanation to Ms. Predham?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Do you know who would have been?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. If we could have, please, P-351.
MR. GULLIVER:
A. Can I -
CHAYTOR, Q.C.:
Q. Sorry, did you want to say something?
MR. GULLIVER:

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A. In this memo here -
CHAYTOR, Q.C.:
Q. Yes.
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. You know, where we talk about we send things to Mount Sinai and they're using the same DAKO system, really--I mean, that's not really factual. They're using the same DAKO autostainer that we used, which is the machine that's used to dispense your antibodies onto your slides and to incubate them and whatever, but their whole testing process is not the same as ours.
CHAYTOR, Q.C.:
Q. Their standard operating procedures and their protocols that they had in place, and the systems that you had in place or -
MR. GULLIVER:
A. Well, their antigen retrieval process is different than ours, completely different.
CHAYTOR, Q.C.:
Q. Yes, at this point in time.
MR. GULLIVER:

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A. So they're using the same DAKO autostainer, but they're not using the same system or the same protocols that we were using.
CHAYTOR, Q.C.:
Q. And what did you understand they were using for antigen retrieval?
MR. GULLIVER:
A. Well, what I've gotten back from them, through all this retesting, is that, you know, we were following, you know, your basic standard DAKO protocols as you've all heard. I think it's 95 Celsius, you boil your slides at 95 C in your citrate solution for 20 minutes, and to my understanding, Mount Sinai were using 115 degrees Celsius, higher temperature. They were using a higher pH and they were doing it for a longer time and they were doing it using a pressure cooker.
CHAYTOR, Q.C.:
Q. And if we could have, please, 0351? And this is the review of immunohistochemistry lab, the General Hospital site, St. John's, Eastern Newfoundland, and it's prepared by--prepared for, sorry, Dr. Williams, and it's prepared by yourself and Dr. Cook, and it's October 13th,

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2005, and how did you come to prepare this? Were you asked to do so by Dr. Cook?
MR. GULLIVER:
A. No, I was asked by Dr. Williams.
CHAYTOR, Q.C.:
Q. I'm sorry, Dr. Williams is what I meant to say. And what was the purpose then of you putting this together for him?
MR. GULLIVER:
A. Well, I think he just wanted to have some kind of comprehensive document, I guess, for him to go forward to executive. You know, we're in the midst of ER/PR, this whole issue has started now for two months. By this time, obviously we don't have a hard copy of Dr. Banerjee's assessment or from Trish's report from Mount Sinai. But obviously they've both been in. We have, you know, spent time with them and we've met with them and they've given us sort of a debriefing.
CHAYTOR, Q.C.:
Q. And you attended both of their debriefings?
MR. GULLIVER:
A. Yes. And so, Dr. Williams had asked could I put together, you know, sort of a

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comprehensive proposal for our pathology laboratory.
CHAYTOR, Q.C.:
Q. And you start off and you indicate, of course, that there's approximately 100 antibodies utilized in that section of the lab for various investigations, related to most types of cancer, and the objective that you indicate, of the proposal, is "to identify the requirements needed to implement a complete quality assurance program for the immunohistochemistry lab, ensuring that we provide a standardized and reliable service equivalent to the Mount Sinai reference lab in Toronto." And then under methodology, you note that "work processes were reviewed internally by the lab program, including the pathology manager, technologists, site chief, clinical chief and program director. Additionally, suggestions from the QI review by Heather Predham and the on-site visits by Dr. Banerjee and Trish Wegrynowski are incorporated in the proposal." So in terms of gathering the information, I take it, as to what you would need -

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MR. GULLIVER:
A. That's who we spoke to and -
CHAYTOR, Q.C.:
Q. These are the people -
MR. GULLIVER:
A. - get suggestions from, yeah.
CHAYTOR, Q.C.:
Q. And what was the QI review by Heather Predham? What did she actually do? What does that refer to?
MR. GULLIVER:
A. This is, remember, going back to August where, I think, Dr. Williams had asked Heather to do some kind of QI review of the IHC lab, and really, I don't think it's a full review. I just think it's just observations that Heather had made in regards to the laboratory. I think at that point in time, Heather, I think at some point she said to Dr. Williams that, you know, this really is beyond her scope of knowledge to do like a full analysis from the QI department.
CHAYTOR, Q.C.:
Q. And so by October then, when you're writing this, did you have any document from Ms.

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Predham related to her QI review?
MR. GULLIVER:
A. I don't think so.
CHAYTOR, Q.C.:
Q. So have you ever seen -
MR. GULLIVER:
A. I may have, but I don't think so.
CHAYTOR, Q.C.:
Q. Have you ever seen such a document?
MR. GULLIVER:
A. Entitled IHC -
CHAYTOR, Q.C.:
Q. Anything at all to do with -
MR. GULLIVER:
A. - QI review by Heather Predham?
CHAYTOR, Q.C.:
Q. No, no, anything in writing that--any written--anything in writing that came out of her QI review?
MR. GULLIVER:
A. I can't say I have and I can't say I have not, you know.
CHAYTOR, Q.C.:
Q. So in terms of getting information from her as to what she may have gathered on that review,

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you did that verbally? You sat down and -
MR. GULLIVER:
A. It might have been just in all my discussions with Heather for--by this time, you know, we'd become kind of best friends in this six, eight-week period of constantly talking to each other and she's coordinating patients' results going back and forth and we're talking about lists and you know, up until ER/PR, I know who Heather Predham is and I've worked with her on a small time frame, but you know, pretty well two months at the hip during this, at this time. So it could have been just all the conversations I've had with Heather.
CHAYTOR, Q.C.:
Q. And under process review then, grossing and processing, you refer "currently, the gross dictation and dissection of surgical samples, about 30,000 a year, is performed by laboratory technologists and pathologist residents. Several years ago, due to shortages of pathologists, it was decided to assign grossing duties from most small biopsy tissue samples to the technologists," and you spoke about that previously in your evidence.

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"While this change in practice," and you go on in the next paragraph to talk about "three senior technologists were trained for this function and these technologists are the same three who also work in the immunohistochemistry section of the lab, and they rotate between these two sections." So I take it up to October 2005, they are rotating between these two functions or two sections?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. They're not?
MR. GULLIVER:
A. I think that should have been that they've been rotated, but a D on there.
CHAYTOR, Q.C.:
Q. Okay. So they're not rotating after--so is it back in October or sorry, 2003, is that when they stopped rotating?
MR. GULLIVER:
A. I think it was--no, it was probably in 2004.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:

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A. It took us time to retrain other people.
CHAYTOR, Q.C.:
Q. So it was during the--it was in the aftermath of what Dr. Ejeckam--Dr. Ejeckam's suggestions?
MR. GULLIVER:
A. Yes, after that time frame, yeah.
CHAYTOR, Q.C.:
Q. So this should actually read that "three senior technologists were trained for this function and these technologists are the same three who work in the IHC section of the lab, and they rotated between these two sections"?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. "While this change in practice helped with the pathologists' workload, the lab still had up to 18 different pathologists rotating through the gross bench along with the technologists. It did not provide any opportunity for the standardization of the grossing function and also placed a greater demand on the technologists' time allocated to the IHC section."

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MR. GULLIVER:
A. That's back when we first had our IHC techs trained to do the small biopsy grossing. So they were rotating and doing those functions. Again, I mean, back in that time, it took away more time for those techs to do the grossing. But that's what the pathologists wanted back then. After Dr. Ejeckam's intervention, we stopped the IHC techs from doing the grossing and we had to take other senior techs and retrain them to do the grossing for the pathologists, so the IHC techs can be full time in the IHC with Dr. Ejeckam.
CHAYTOR, Q.C.:
Q. Okay, and so your recommendations flowing from all that, and I won't take you through the entire what you've written there, but your recommendation is "most grossing, dissecting functions be performed by trained technologists (pathologist's assistants) and secondly, purchase gross work bench for the General site." So these are recommendations that would involve, I take it, additional resources and so you're highlighting those for Dr. Williams?

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MR. GULLIVER:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And then under technical processes, you refer "the lab processes approximately 15,000 slides per year in this section and continues to experience increased demands for this service, 20 percent over the past two years. As the provincial reference site, this section of the lab generates approximately 75,000 per year in revenue." So I take it that's from other regions?
MR. GULLIVER:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And you go on to say that "this section of the lab has more than 100 antibodies," which is also earlier in your report. "On any given day, the technologists may produce 80 slides using 15 to 25 different antibodies, including ER/PR, and these slides, when complete, are then submitted to the individual pathologist for interpretation and diagnosis. Known controls are performed daily with each batch of slides." And your recommendations coming

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out of that are that you're going to need three full-time dedicated--"full time equivalents be dedicated solely to the IHC section of the lab." Didn't you already have that at this point?
MR. GULLIVER:
A. By that point, I know we had two full time. Again, we're going through a time period, Ms. Chaytor, you know, a lot of transition in staffing taking place in pathology, as it is today. Peggy Welsh and Mary Butler were the only two techs that were trained for IHC. I know then Ken Green moved from St. Clare's to the Health Sciences and Ken was trained in IHC and grossing. I think Ken was also trained in muscle histochemistry too. Then we had three people who were able to be rotated through the IHC lab for vacation and sick relief and those things, and then at another point, Barry had other technologists then trained to do the grossing. However, the IHC techs also did the muscle histochemistry and I think Barry had to take another technologist and train her for so many months to do the muscle histochemistry so that Ken could be full time in IHC.

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CHAYTOR, Q.C.:
Q. And the second thing here on your list is "the technologists be trained to review all patient control slides before release to the pathologists" and I take it that was a recommendation coming out of the external reviews as well?
MR. GULLIVER:
A. Well, we hadn't received the reviews by this time.
CHAYTOR, Q.C.:
Q. But you've had your debriefing.
MR. GULLIVER:
A. But I've had--well, I spent time with them.
CHAYTOR, Q.C.:
Q. And that hasn't yet though, that hasn't happen, they're not to the point where that actually happens, that they review all the patient control slides?
MR. GULLIVER:
A. As of today?
CHAYTOR, Q.C.:
Q. Yes.
MR. GULLIVER:
A. I think they--well, see, Dr. Ejeckam was

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starting this at this point in time also. I don't know how far Dr. Ford Elms is with that piece.
CHAYTOR, Q.C.:
Q. So the status of the technologists reading the external controls, for example, before they go to the pathologists, you're not aware of where that -
MR. GULLIVER:
A. I know it was started. However, as you're well aware now since this whole time frame, we had three senior technologists in IHC lab and Ms. Butler, Mr. Simms have both retired. So while that process started with our three senior techs, since this has started, we now have two new technologists in that part of our lab.
CHAYTOR, Q.C.:
Q. And under pathologist's interpretation, it's written "there is a need for subspecialization of pathologists, particularly in breast cancer where interpretation of immunoperoxidase stains and monitoring of trends is crucial." And I take it that this would be more of Dr. Cook's section of the report, anything dealing

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with the pathologists? Would that be correct?
MR. GULLIVER:
A. Well, we're jointly responsible for the program, but obviously, I mean, Dr. Cook would be--he's directly responsible for the pathologists.
CHAYTOR, Q.C.:
Q. And the need for a single pathologist to oversee the service and to provide direction to technical staff and liaise and consult with pathologists. So one pathologist to be assigned the responsibility of all aspects, and that currently is Dr. Elms. So -
MR. GULLIVER:
A. Right now it's Dr. Elms. At the time, it was Dr. Ejeckam.
CHAYTOR, Q.C.:
Q. Yes, and "while all pathologists will continue to interpret, report immunohistochemistry cases, it is recommended that they be given the opportunity to subspecialize. Pathologists would interpret all breast cancers, for example, two or three pathologists would interpret all breast cancers." So at the time that it's being

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recommended that one pathologist be assigned the responsibility for IHC, that in fact was already in place? Dr. Ejeckam had been informally appointed or certainly a letter goes out around the same time as this.
MR. GULLIVER:
A. Yes.
CHAYTOR, Q.C.:
Q. And then under quality assurance, "currently, the lab runs known positive controls with each batch on a daily basis, depending on the antibody being tested for. These slides are reviewed by the individual pathologists. The lab does not participate in outside proficiency testing. The lab has never had the opportunity to participate in either conferences, teleconferences or able to network with other IP labs. It is recommended that the immunohistochemistry lab enrol in outside proficiency testing, such as CAP. All recommendations by Trish Wegrynowski be implemented, cutting blocks, documentation log books, equipment maintenance, etcetera, and recommend a separate CE budget be established for books, journals and conferences."

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So I take it it was recognized at this point in time, when you're developing this, Mr. Gulliver, that there hadn't been sufficient, if any, opportunity to participate in conferences and teleconferences with respect to IHC?

MR. GULLIVER:

A. I can't say there's been--there hasn't been none, but certainly, there's been no guaranteed dedicated funding for those staff to participate in conferences that would have to take place outside Newfoundland. Because when you're the only lab in the province and the only three technologists in the province who are doing the testing, well, you really got to go out of province to get any additional and keep up to new technology and new things coming out.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, and to ensure the quality assurance measures that you've indicated here in those three things, the enrolment in the external proficiency and Ms. Wegrynowski's recommendations and then the separate continuing education budget for books,

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journals and conferences, did you think about the quality manager position that you had wanted sometime before this? Why didn't you include that as part of what you would need for your -

MR. GULLIVER:

A. Well, the quality manager's position is for the laboratory medicine program. I mean, this is--I was asked to look at specifically the IHC lab.

CHAYTOR, Q.C.:

Q. Okay, and in terms of having any even portion of a position for that?

MR. GULLIVER:

A. Well, I think by this time, I'm not sure. I know Dr. Carter was working on some kind of quality assurance within the pathology lab.

CHAYTOR, Q.C.:

Q. Okay, so it wasn't put forward in this because you're asked what does the IHC lab need specifically?

MR. GULLIVER:

A. Right, and when you look at education funding, I receive an education allocation through our budgeting process for the program. For

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example, it's $22,000 a year and that's for 450 staff. What I'm asking for here is to set up a separate education fund dedicated for the pathology IHC techs and not to access the global $22,000 I get per year for overall staff education.

CHAYTOR, Q.C.:

Q. And why is that? Why was it deemed that that would be necessary?

MR. GULLIVER:

A. Well, in order to send one of those IHC techs, we want to send them to a national conference once a year and it's going to cost about $5,000.

CHAYTOR, Q.C.:

Q. So then -

MR. GULLIVER:

A. So I need additional funding for that.

CHAYTOR, Q.C.:

Q. Under space, "the immunohistochemistry section of the lab was physically located in the main pathology lab until mid 2003. Upon recommendation by Dr. Ejeckam, this section moved adjacent to the main lab in the former hormone assay lab space. Plans have been in

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place for several years to have the pathology lab as a whole renovated, incorporating the former hormone assay lab which had been identified as a new, separate immunohistochemistry lab." And so you're recommending that "the current space identified be dedicated for IHC services only and facilities management complete the proposed renovation." And Mr. Gulliver, has--did that then happen? Has that since happened?

MR. GULLIVER:

A. You mean, the facilities management piece?

CHAYTOR, Q.C.:

Q. That the current space, yes, be -

MR. GULLIVER:

A. Well, the current space has been occupied and used by the IHC lab ever since. We still have no physical upgrade or renovations completed. I'm assuming it will be done now in conjunction with the overall pathology consolidation for St. John's.

CHAYTOR, Q.C.:

Q. So then your overall impact analysis of the recommendations, "it will require four FTEs to

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be trained as pathologist's assistants and one FTE lab assistant to provide assistance for processing, labelling cassettes," and overall, the money that you break down here, "it is anticipated that the lab technician at St. Clare's will retire in the next couple of months. This position should be upgraded to a pathologist's assistant position, thereby three new positions need to be created." So three full-time equivalent PAs, including benefits, $183,600. One full-time equivalent MLA, including benefits, $45,600, and upgrade one lab technician position, additional 9,000, and replacement staff during training of PAs, 40,000. The cost to your gross work bench is $40,000, and the three FTEs dedicated solely to IHC of the lab, that's included, as outlined above. "The technologists be trained to review all patient control slides before release to the pathologists" and you're talking of sending one away for four weeks to Jewish General, and one time cost of $5,000.

And how would sending--is that a--you say it's a one-time cost to cover expenses of 5,000 to send one technologist. How would

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then the others learn how to do this?

MR. GULLIVER:

A. Well, this was just recommended in October. What actually happened was we sent Mr. Ken Green to Jewish General in Montreal, I think, for two weeks to review their practices, and we sent Mary Butler to Mount Sinai, I think for two weeks, to review their practices. It wasn't to go up to read and be trained to read control slides. It was decided that that should be done in house by the pathologists.

CHAYTOR, Q.C.:

Q. And letter E, "install a third instrument to deal with the patient volume increases and new requirements for additional control slides. Request quote from Ventana Medical Systems on increased cost to current reagent lease to install a third instrument" and that's $30,000. Has that happened?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And "one pathologist be assigned the responsibility for all aspects of the immunohistochemistry service" and you indicate

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that Dr. Ejeckam has already accepted responsibility in that regard, and "while all pathologists will continue to interpret/report IHC cases, it is recommended that they be given the opportunity to subspecialize, and the immunohistochemistry lab enrol in outside proficiency," and you are currently enrolled in CAP and the cost per year is 5,000 and Dr. Ejeckam requested to enrol in UK proficiency for an additional 7,000. And then "all recommendations by Ms. Wegrynowski be implemented."

MR. GULLIVER:

A. Again, at this point in time, we just got a verbal debriefing from her.

CHAYTOR, Q.C.:

Q. Okay, and then the recommendation for a separate continuing education budget for the IHC technologists, $10,000 and that's an annual pathology continuing education fund, and I take it, Mr. Gulliver, that's been approved?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

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Q. And you continue to receive that?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. So then, overall in concluding, you say "if all of the recommendations outlined are implemented, the General Hospital site should be able to offer an IHC service equivalent to that available at the laboratory at Mount Sinai. Some of those recommendations have already been implemented. Others can be done fairly quickly. It may take six to nine months to complete all recommendations." And I'm going to talk to you a bit about that, because you, I understand, were involved in the creation of the spreadsheets of the recommendations and the implementation or overseeing it.

So "overall adjustments required to add to our base budget came to a total of 282,200, one-time costs of 48,000 associated with staff training, and one-time capital costs of 40,000."

MR. GULLIVER:

A. And really, and you can see from, you know,

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all parts of this report, I mean, I was asked by Dr. Williams to do it and to do it in a fairly quickly manner, and it's mostly relating to what additional resources do you need.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. You know, this is not a report that assesses the laboratory operations at the time. This is asking me "what new resources would you need to start working towards the Mount Sinai equivalent?" because that was what we said to be our gold standard.

CHAYTOR, Q.C.:

Q. Yes, and that's what you say here, if all the recommendations are implemented then you should be able to offer a service equivalent to that available at Mount Sinai, and I guess what struck me, Mr. Gulliver, when I read it, and bearing in mind your comments about, you know, and I think it was a comment about a $600,000 deficit in terms of the overall budget that you would have not being that significant, and I guess when I read it, the

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thought of to bring the IHC lab in St. John's to the equivalent of Mount Sinai wouldn't cost a whole lot of money, in terms of your overall budget.

MR. GULLIVER:

A. It certainly--and it ended up costing more than this. We put in--you know, this is back October '05. Obviously we have put in even more resources since then, as in dedicated quality technologists for pathology. But you know, even if you added in what's been added since then, you know, the overall budget for laboratory is about 30 million dollars. So you're talking about, you know, three or four percent on my overall lab budget.

CHAYTOR, Q.C.:

Q. So why wasn't it done before? If this is what it needed to be operating at that standard, why wasn't it done before?

MR. GULLIVER:

A. I don't know. You're asking the wrong person.

CHAYTOR, Q.C.:

Q. Well, who would be the right person?

MR. GULLIVER:

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A. I guess you'll have to ask the vice--executive.

CHAYTOR, Q.C.:

Q. So you're saying you passed it on, you looked for it, and -

MR. GULLIVER:

A. Well, I think you've seen enough documentation over the years, whether it's complete enough, and I think you've heard enough witnesses here from the lab side to indicate, you know, how many times that we talked about requesting funding for pathology assistants or other resources to go into the laboratory, and you know, it's not until this event do we, you know, start receiving some new resources.

CHAYTOR, Q.C.:

Q. So you're saying that you went looking for it often enough, were turned down often enough. This event happens and then you get what you needed?

MR. GULLIVER:

A. Pretty well, yeah.

THE COMMISSIONER:

Q. It's a earlier then we normally have the break, but we started earlier this morning, so

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I suggest we take one, if this is a convenient spot?

CHAYTOR, Q.C.:

Q. Okay, sure.

THE COMMISSIONER:

Q. All right, we'll take 15 minutes.

(BREAK)

THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Registrar, if we could have, please, P-3095? And this is an e-mail from Ms. Predham to yourself, October 25th '05, and she writes "here's the list of names. Thanks, Heather." And of course, there's no names on what we have here, but it's a list. Do you recall what, by October 25th, 2005, the attachment says "results two, clarified." Do you recall what this was about, Mr. Gulliver?

MR. GULLIVER:

A. I don't recall it right now, what that one was.

CHAYTOR, Q.C.:

Q. Was there some cross referencing of names or

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checking lists at this point? We have name, MCP, address, one address, two--you're not sure what that's about, are you?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. Okay. And then I'd like to ask you a little bit about then, the external reviews and what the external reviewers found. I understand you attended both of the debriefing sessions, both with Ms. Wegrynowski and with Dr. Banerjee. And I guess overall, Mr. Gulliver, were you surprised by any of the findings?

MR. GULLIVER:

A. Well, I guess before the debriefing, I mean, I did have the opportunity to spend some time with Dr. Banerjee.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And I actually spent more time--well, probably a bit more time with Trish, you know, where she was--I'm a technologist and she's a technologist. And then during their debriefing, they just gave a, sort of, basic

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overview of what they had gone through and they gave us a basic overview of some of their findings. I don't think, it's not until we get their actual hard copies of reports, did we really get any details into their findings.

CHAYTOR, Q.C.:

Q. Yes. And so whether it's at the debriefing or when you received the reports, but overall, the findings of Ms. Wegrynowski and Dr. Banerjee, were you surprised by any of it?

MR. GULLIVER:

A. Well, I'd have to say no, you know, overall. You know, look at them individually, I mean, Dr. Banerjee--well, I guess while both of them had a similar purpose, both of their reviews were different. You know, we had asked Dr. Banerjee or at least to the best of my knowledge, Dr. Banerjee was reviewing some of the past cases and slides that had been done over the years during the review/retest process, ie., the '97 to 2004 and he was also reviewing some of the current slides off the Ventana system because there had been some question over the month prior to him coming in. We had stopped testing on Ventana and

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there was some question on the Ventana, is it getting too much--is there too much staining on the Ventana? So, he was also reviewing slides from the Ventana system to give us an assessment on our current system and should we or should not we continue testing in St. John's? Whereas Trish's report and while she was here for the first time, was really a lot more encompassing than Dr. Banerjee's. He was very focused on the past and the present. Whereas Trish was more focused on reviewing all practices in our pathology lab to the view that her standard of operating at Mount Sinai, which by that point, we were informed that Mount Sinai was pretty well the gold standard lab in Canada for performing IHC testing. And her review was to review all of our practices right from the specimen coming from the OR up to the slide going to the pathologist for an ER/PR test. And, you know, give us any recommendations for us to work towards the Mount Sinai operating practices.

CHAYTOR, Q.C.:

Q. And if we could just have a look then, please, at P-0596? And I take it you didn't take any

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notes in the debriefing, yourself?

MR. GULLIVER:

A. I don't think I did, no.

CHAYTOR, Q.C.:

Q. These are notes that have been provided to us by--this set here is Dr. Williams and it's September 22, 2005 and it appears that Dr. Cook, Dr. Laing, Ms. Predham, yourself, Mr. Gulliver, Dr. Williams and Trish, the Mount Sinai technical person, is in attendance. And in terms of--there's indication here of staffing issues, frustrated and overwhelmed, causes communications issues, do not understand the theory, need to work together as a group. And just those particular items that the staff would be frustrated, overwhelmed, causing communication issues, do not understand theory, was any of that of a surprise to you to be hearing on September 22nd from Ms. Wegrynowski?

MR. GULLIVER:

A. Well, I guess we really got to put it into context also that, you know, Trish is coming in to do a review of a lab. We have been now, by this time, three months pretty well working

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day and night. We've stopped testing. We're identifying patients that have been done over an eight-year period for retesting. And obviously, I mean, during--and Trish is right in the middle of all of this. By this time, the three technologists who are working in IHC, the senior tech, Mary, who has been the longest tech in IHC at this point, she was pretty well working with Barry doing all the patient review and pulling blocks, pulling slides. So she wasn't actively doing the IHC testing. So the two techs that Trish was pretty well talking to, Ken Green, Les Simms, and both of them had only been about two years in IHC lab, because Peggy Welsh, as you knew, resigned, who has been our longest, most experienced tech in IHC. So the two technologists that Trish is speaking to, Les and Ken, you know, I'm not surprised by that time that they don't have as much theory as what Trish would have, and I would submit that as much as what Peggy would have had, our tech who was doing this from 1986 to 2003.

CHAYTOR, Q.C.:

Q. So over the past two years, you think that

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this is referring, "do not understand the theory" is referring to Ken and Les being in the position for -

MR. GULLIVER:

A. I think over--I mean, obviously, Trish has come into a point in our work life where we're in transition. As you know, even though Les and Ken had a lot of pathology experience, they both worked at St. Clare's, which only exposed them to routine basic pathology. They've been at the Health Sciences now for a couple of years, which you know, is more than just IHC testing. There's muscle histochemistry. There's immunofluorescence testing. There's all kinds of other specialty testing taking place there that they were never exposed to before.

CHAYTOR, Q.C.:

Q. And do you know if she met with Mary Butler?

MR. GULLIVER:

A. I think she met with Mary also, yes, but I think Trish--and I think what Trish is assessing is probably overall, I would think it would be a correct statement.

CHAYTOR, Q.C.:

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Q. Which? They do not understand the theory, that statement?

MR. GULLIVER:

A. I don't--I disagree with they do not understand the theory. I think what she should be saying is they probably need some additional theory.

CHAYTOR, Q.C.:

Q. And so did you have that understanding prior to Ms. Wegrynowski pointing it out? That they perhaps needed additional understanding?

MR. GULLIVER:

A. I wouldn't say exactly, no, but I wouldn't be surprised that you've got, you know, two fairly new techs in that part of the lab, and you know, it's going to take a long time for them to garner and understand all aspects of that IHC lab.

CHAYTOR, Q.C.:

Q. So Mr. Simms came -

MR. GULLIVER:

A. As we've heard Trish testify, Trish started IHC testing at Sunnybrook somewhere in the late 80s. So that by this time, Trish has almost 20 years dedicated work in IHC. So I

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would suspect that there's not many technologists she's going to meet that's up to her theory level.

CHAYTOR, Q.C.:

Q. And did you understand that's what she was expecting though, that it's up to her level of understanding, as opposed to -

MR. GULLIVER:

A. I don't know what Trish was expecting, but what we were expecting was we asked Trish to review all practices of our laboratory and to give us any recommendations that would help us work towards maintaining--you know, offering a standard of operations as Mount Sinai.

CHAYTOR, Q.C.:

Q. And at this point in time, Mr. Simms would have been in the position since March of 2003 and -

MR. GULLIVER:

A. I think he was there a couple of years.

CHAYTOR, Q.C.:

Q. Yes, and Ken Green would have been there since 2002, so about three years.

MR. GULLIVER:

A. I know, but when Ken first came over to Health

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Sciences, Ken didn't go directly to IHC lab. Ken was trained in the grossing. Ken was trained in immunofluorescence testing. I know Ken was trained in the muscle histochemistry, especially part of pathology, and then into the IHC laboratory. It's not until after that Les comes over at some point, I think, that Ken then is sort of dedicated full time in IHC.

CHAYTOR, Q.C.:

Q. And her comments here about "frustrated, overwhelmed, causes communications issues." We've talked about "do not understand the theory." "Need to work together as a group. Need to understand who they should report to." Was that of any surprise to hear her state that?

MR. GULLIVER:

A. No, because, I mean, and you've also heard here that even though Dr. Ejeckam was the unofficial director of IHC lab, it had never been formally appointed, and again, I know--and I only know this because of my former background in pathology, you know, if this was a microbiology issue, I wouldn't be able to

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give you much input into it, because it's not my background. I do know that over the years that, you know, the practice had been you've got, you know, up towards 30 or 40 different pathologists coming through the lab over those time frame and really, there was no--after Dr. Khalifa left in 1997 and up until Ejeckam comes, there really is no direct communications line between the technologists and a pathologist.

CHAYTOR, Q.C.:

Q. And in terms of their level of understanding of the theory, had they ever had any competency testing?

MR. GULLIVER:

A. Well, there is no competency testing that you can give them, to my knowledge.

CHAYTOR, Q.C.:

Q. And has there been any inquiry into that? Because that's one of the things that Ms. Wegrynowski recommended in her report.

MR. GULLIVER:

A. Well, again, I mean, all I can say to you is no different than what Dr. Lynn Morris-Larkin testified last week, new things come into the

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lab. You've got your basic understanding of medical lab practices and a lot of things you learn, you learn on the job and you also learn by attending workshops or lectures. I showed you last week that, you know, a 20-page document I gave you where the technologists went through the basic theory of IHC testing. I know Friday, like you had Bryan Hewlett, a technical expert, in reviewing the lab. Matter of fact, I had Bryan in St. John's, he came to St. John's his first time in 1986. He did a full-day, one-day workshop for our technologists in IHC testing. So there's been a lot of occasions where we've had the opportunity to garner experience and theory for IHC testing. The techs have never gone away to do a certified training in IHC testing.

CHAYTOR, Q.C.:

Q. And after 1986, was Mr. Hewlett or anyone of his equivalent ever brought back? As you say, it's a changing area.

MR. GULLIVER:

A. I think, I don't know if it was 2001 that Bryan came back and did another session or it

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was another person who did another session.

CHAYTOR, Q.C.:

Q. In 2001?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Ms. Wegrynowski, according to Dr. Williams' notes, also goes on to talk about fixation, controls, "must be running positive and negative controls. Validation must be done," and she mentions record keeping. Were any of these things of any particular surprise to you or were they things that you had heard prior to this?

MR. GULLIVER:

A. Well, again, it's not a surprise. I mean, fixation, we all know, you know, fixation is the foundation of pathology. What Ms. Wegrynowski is saying here is that she found that the fixation and grossing protocols were different at St. Clare's than Health Sciences, and I think that's just what her overall assessment is, that we've got to standardize our fixation and grossing processes.

CHAYTOR, Q.C.:

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Q. And she goes on, according to these notes anyhow, there's fairly detailed conversations on different issues, and she also mentions the equipment maintenance needs to be done, and would you have been aware of anything lacking in terms of equipment maintenance prior to?

MR. GULLIVER:

A. At that point in time, no.

CHAYTOR, Q.C.:

Q. And here's the reference to the competency testing, and she suggests "give scenario to techs to see what they would do." So there appears to have been some discussion about how you would go about doing competency testing. Is competency testing taking place as of today?

MR. GULLIVER:

A. Not to my knowledge, unless the pathologists actually give the techs, you know, a case to run through. But you pretty well assess your competency today also as a part of your external proficiency testing where the technologists get sort of blind samples. They have to do their piece of it. The pathologists do their piece of it, and then

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you get feedback back from either UK NEQAS or CAP and they would talk about the technical component and they will talk about the clinical component.

CHAYTOR, Q.C.:

Q. And then it's written here, "ensure validation process is in place," and you recall the discussion around that, ensuring that validation process is in place?

MR. GULLIVER:

A. Certainly, yes. I mean, she's talking about that when you have any new antibody coming into your lab and into your inventory that it should go through a--and her big issue, I think, was more about documentation.

CHAYTOR, Q.C.:

Q. And if we could look at, please, P-1737? And documentation, I take it, to verify validation in fact had taken place?

MR. GULLIVER:

A. Had been done, yes.

CHAYTOR, Q.C.:

Q. And documentation along the lines of standard operating procedures?

MR. GULLIVER:

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A. Oh, obviously you seen her report. I mean, that's throughout the whole process.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. I mean, one of the areas that we were lacking in is the--it wasn't the fact that we weren't following procedures or protocols or that we weren't doing them. It was the fact that we just weren't documenting and verifying all the processes along the way.

CHAYTOR, Q.C.:

Q. And in terms of having a standard operating procedure though for the ER/PR tests, it was the document that we referred to last day that I brought up and showed you, the one that had been put in place prior to the machine, DAKO machine, actually coming in place?

MR. GULLIVER:

A. Right. Now by the time Trish is here, we're using the Ventana.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. And you know, Trish commented that, you know,

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the Ventana manual and protocols were all really good, as what the staff followed, but Trish also felt that we should take everything that's in there and create our own standard operating procedure manual and policy manual following the CLSI templates and those kinds of things. So it was sort of duplicating what we were already doing, but then also putting processes where you also then would be able to document everything that you're doing.

CHAYTOR, Q.C.:

Q. Yes, and I think she's spoken or given evidence to the Commissioner about what she intended. 1737 then, these are the notes, we understand, that Dr. Cook took of the September 22nd, 2005 meeting with Trish, and again, we have the recommendation for external proficiency testing and have frustrated, overwhelmed individuals.

MR. GULLIVER:

A. I think that's the technologists he's talking about there.

CHAYTOR, Q.C.:

Q. Yes, and again, it's the reference to "don't understand theory, work as a group. Need to

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have good lines of communication." So those are all things that we've talked about. "Need better fixation" and "the outside labs need to advise of their fixation."

MR. GULLIVER:

A. And that was Trish was talking about, you know, standardize your fixation policies. It needs to be applied to all pathology labs in Newfoundland, where we're the one testing site, and you know, you're all aware that, you know, fixation could be an issue with IHC testing.

CHAYTOR, Q.C.:

Q. Okay, and again, these are things we talked about, controls, validation, needing of textbooks. "No pipette calibrated," the issue of the pipettes not having been calibrated, were you surprised to hear that?

MR. GULLIVER:

A. Well, and it's something that we didn't do. Just, you know, plain and simple. All of our labs, not just pathology, we use--we buy commercially, you know, made pipetters and you know, sometimes they're $1,000 each and they're specifically made pipette or dispense

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like 100 microlitres or 1,000 microlitres or 50 microlitres. What Trish said that what they do at Mount Sinai is that you're able to get this calibrator and that at least once a year, you should just check to make sure that if the pipette is calibrated to dispense 100 microlitres, that you know, a year later it's still dispensing 100 microlitres, and that's been done now in all of our labs, not just pathology.

CHAYTOR, Q.C.:

Q. And so prior to Ms. Wegrynowski mentioning it, were you aware that that wasn't happening?

MR. GULLIVER:

A. I wasn't even aware that you could actually buy a pipetter calibrator and have it yourself.

CHAYTOR, Q.C.:

Q. And were you aware of the shortcomings in terms of the record keeping?

MR. GULLIVER:

A. I can't say and I can't say no. That you know, the level of documentation that--I guess I have to say I was surprised to see that the level of documentation that Mount Sinai goes

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through and because I have been to a lot of other medical labs in Canada. I've been to Halifax. I've been to Moncton. I've been to Edmonton. I've been to Calgary, and I've been to hospitals in Toronto, and you know, I had never seen other labs up to the level that Mount Sinai, that she was telling us.

CHAYTOR, Q.C.:

Q. And in terms of that though, Mr. Gulliver, in terms of what we did have here or what you did have here in St. John's and what she was finding was in many of these instances, a complete lack of any documentation, for example, around standard operating protocols, equipment maintenance. Is that what you were seeing in other labs? Is that what you're suggesting, that what you had here in St. John's was equivalent to what you were seeing in other centres?

MR. GULLIVER:

A. I'm saying that, by and large, what we were doing in St. John's was equivalent to what I've seen in most other labs in Canada.

CHAYTOR, Q.C.:

Q. In 2005?

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MR. GULLIVER:

A. And up into 2005, yes, and I'm not saying it's the right thing. I'm saying we agree with everything that Trish recommended, that we would like our laboratories in Eastern Health to be at the same standard as Mount Sinai.

CHAYTOR, Q.C.:

Q. When would you -

MR. GULLIVER:

A. And if that's better than most other labs in Canada, well, that's even better.

CHAYTOR, Q.C.:

Q. So in visiting other people's labs, you would have had an opportunity to observe what they had in terms of record keeping?

MR. GULLIVER:

A. Not--I don't know about their exact record keeping, but when you visit a lab, and I wasn't visiting labs in an official capacity as director of Eastern Health. I got the opportunity to visit a lot of labs in my volunteer work life, with my professional association. So it wouldn't be something I'm going in to sit down to a chemistry lab or hematology or pathology lab and say "can I see

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your record keeping?"
CHAYTOR, Q.C.:
Q. You've never carried out any kind of appraisal or audit of anyone else's lab?
MR. GULLIVER:
A. I have not been--I have not done an accreditation process of another lab.
CHAYTOR, Q.C.:
Q. And have you ever worked in any other lab?
MR. GULLIVER:
A. I worked in St. Anthony when I first started.
CHAYTOR, Q.C.:
Q. Yes, when you first started off.
MR. GULLIVER:
A. But still, when you go to visit a lab and you walk through and spend a half a day, you can pretty well get an assessment of how they're operating, in relation to your own.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, these are basically the notes then that Dr. Cook made, and I understand that you did receive copies of the two reports.
MR. GULLIVER:
A. Yes, from Dr. Williams.
CHAYTOR, Q.C.:

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Q. Yes, and you then also received their subsequent reports as well.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. If we could just look at P-2644, please? And this is the report from Dr. Banerjee, post implementation, external report, and -
MR. GULLIVER:
A. That's his second one.
CHAYTOR, Q.C.:
Q. That's his second one, and four copies were made, and you received three of four, it appears, and if we could look, please, at 1763, and this is Trish Wegrynowski, four copies provided and you received one of four, and I believe that's an '05 number. So this looks like it would be her original report. We understand that there were four additional copies made in May of 2007. Do you know who received those copies?
MR. GULLIVER:
A. I had no idea that was done. I wasn't involved in it.
CHAYTOR, Q.C.:

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Q. Do you know who received the copy?
MR. GULLIVER:
A. I've heard Dr. Nash Denic testify to say that he had them copied, I think, for Mr. Tilley.
CHAYTOR, Q.C.:
Q. So other than that, do you have any knowledge as to who received the copies?
MR. GULLIVER:
A. None whatsoever, no.
CHAYTOR, Q.C.:
Q. And if we could look at P-0047, please, and this is Ms. Wegrynowski's original report dated November 9th, 2005, and I'm not going to take you through all of it because I think a lot of it is captured in the notes that I've referred you to. If we look at page seven, she deals with immunohistochemistry laboratory, IHC staffing, and her recommendation is three technologists to be dedicated to perform IHC staining optimization, validation, and microtomy function to be evaluated at the pathology managers discretion. Mr. Gulliver, my question is at the point that Trish Wegrynowski are in, are they not already

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dedicated to the IHC staining?
MR. GULLIVER:
A. Yeah. I think Trish is just re-emphasizing the fact that, you know, now we got three technologists there and they should stay there.
CHAYTOR, Q.C.:
Q. If we could look at P-0046, please. This is Dr. Banerjee's --
MR. GULLIVER:
A. That's his first report.
CHAYTOR, Q.C.:
Q. First report, October 17th, 2005, and I haven't taken you through any of the notes from his debriefing. I'll just take you through parts of his report here. It's the issue of fixation again which we've talked about, the issue of internal controls, and conclusions then about the reasons for test failure. First he says--the first question is, "Is the DAKO system faulty--this is unlikely as there are many laboratories using the DAKO system successfully. The reason for test failure was most likely due to lack of test optimization, including antigen retrieval

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method and antibody detection system titration as positive controls showed weak staining in general, and internal controls failed in all of the false negative cases". Did anything about that surprise you, Mr. Gulliver?

MR. GULLIVER:

A. No, no, and again as I've testified, I don't believe there was anything wrong with the DAKO autostainer or the system, and what Dr. Banerjee is referring to here is really having--ensuring that all steps of the process are optimized, and even though you may optimize your procedure, you know, in one year, you still have to make sure that you're getting good staining, good crisp staining, and again critical here is he's talking about the internal controls.

CHAYTOR, Q.C.:

Q. Okay, so did you understand him to be saying that while the system itself should be fine, that there's an issue with how, in fact, the DAKO system was being utilized here in St. John's?

MR. GULLIVER:

A. Well, he's talking about optimizing the

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system, and optimization may mean optimizing your antibody dilution, it may mean optimizing your antigen retrieval depending on if there's a fixation issue or no fixation issue. Again, I mean, it's talking about the whole--you know, from beginning to end, and I think that I've got to also make you aware that when Dr. Banerjee was here the first time, he spent his first--most of his first day over at St. Clare's with Dr. Cook, and then the second day he spent a fair bit of time with myself and Mr. Dyer, and actually I got Dr. Williams over also to sit down and review some slides with us with Dr. Banerjee, that most of the cases Dr. Banerjee reviewed, the past cases of DAKO, were the 2002 cases that had already been retested and results changed. Dr. Banerjee didn't--was not, to my knowledge, was not given a sample of cases from '97, '99, 2000, 2001, every year. He was given multiple samples of the Ventana system to review and give us his opinion of the current staining and our current system. So really most of his assessment here is about what he had looked at with the no internal controls, and it's most

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of the cases that were done from 2002.

CHAYTOR, Q.C.:

Q. Yes, and is there any significance to that to you, that it would be 2002 cases? Does that make any difference?

MR. GULLIVER:

A. Well, because 2002 was the first--was the year that everyone thought maybe there was something wrong in 2002.

CHAYTOR, Q.C.:

Q. Yes, but would you expect 2002 to be any different than any other year?

MR. GULLIVER:

A. Well, now since, and we can see the statistics for every single year, 2000 and 2002 are the highest numbers of years that we have in highest numbers of zero/zero or negative/negative, and the highest number of results changes.

CHAYTOR, Q.C.:

Q. And have you figured out why that is, what was the -

MR. GULLIVER:

A. Have I figured out why?

CHAYTOR, Q.C.:

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Q. Has anyone, to your knowledge, figured out why that is in 2000 and 2002?

MR. GULLIVER:

A. Well, we also see result changes in 2003, and we see result changes in 2000.

CHAYTOR, Q.C.:

Q. Yes, so have there been anything in particular, though, 2000 and 2002 you're pointing out as being the two years in which your positivity rates, I take it, you're indicating were the lowest. Is that--is that what you're saying, was it your positivity rates were lower in those two years or you had a higher number of conversions?

MR. GULLIVER:

A. Well, it's one and the same.

CHAYTOR, Q.C.:

Q. Well, not necessarily.

MR. GULLIVER:

A. They were our lowest numbers of years for positives, they were our highest two years of really zero/zeros, and those two years led us to the most conversions.

CHAYTOR, Q.C.:

Q. I just want to be clear on that because what

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you're saying is 2000 and 2002 were the two years in which your positivity rates were the lowest, is that right?

MR. GULLIVER:

A. Yes, without looking at all right now in front of me, but, yes, they were the two years that stand out most.

CHAYTOR, Q.C.:

Q. Do you also understand them to be the two years, did you say, in which the most conversions took place?

MR. GULLIVER:

A. I think that--whether it's a percentage of not, but the number of patients that converted in 2000 and 2002 would also stand out.

CHAYTOR, Q.C.:

Q. And my question being whether or not anyone has analyzed why that was the case, whether or not there were any particular factors in -

MR. GULLIVER:

A. Well, you've been here since March listening to testimony. I don't think--you're not going to be able to point and say here's the one thing that you can say for sure that every single patient who had a result change, this

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is the reason why. I think -

CHAYTOR, Q.C.:

Q. So, Mr. Gulliver, the answer to my question is, I take it, you're not aware of anyone having looked at 2000 and 2002 to find out if there was anything in particular in that time period that may have caused those two years to be somewhat different than the other years?

MR. GULLIVER:

A. Not to my knowledge, of that level.

CHAYTOR, Q.C.:

Q. At any level?

MR. GULLIVER:

A. No, only for an overall assessment of looking at the big picture.

CHAYTOR, Q.C.:

Q. And are you able to indicate any particular factors then coming out of that overall assessment?

MR. GULLIVER:

A. Well, I think--I mean, your--I mean, if you read Dr. Banerjee's report, I mean, after the--I mean, the things that Dr. Banerjee are suggesting as what could be the possible causes of leading you to a false negative,

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because we know there are patients who will be false negative even if everything is optimized, if every piece is done properly, there will still be some false negative. I mean, everything he's telling us here, it's not something that is a shock to anybody. If he's saying--he's telling us that if your specimen is not fixed properly, it could lead to a false negative. Well, that's not something new that we don't know. He's telling us that if your sections are not grossed and appropriate thickness submitted, that could lead to issues and it could lead to a false negative.

CHAYTOR, Q.C.:

Q. And again that's not something new, he's not telling you anything new?

MR. GULLIVER:

A. Again, I mean, fixation is the foundation of all pathology. He's also saying to us that, you know, if you don't verify that the internal control, the patient's own control, is not working, if you see it's not working, you still report it, well, that shouldn't happen. He's also saying to us that -

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CHAYTOR, Q.C.:

Q. Is that something you would have known prior to this?

MR. GULLIVER:

A. No, what--the internal control piece, I really only--it was through Dr. Banerjee where I was made aware of the critical importance of the internal controls, but when you go through the actual testing side, when he's talking about optimizing antigen retrieval, and I mentioned to you this morning, you know, Mount Sinai's antigen retrieval process, to my knowledge, they've got two. They've got one as their standard like we had, and they have another one that's like a super antigen retrieval, I think that they used to deal with do they think they've got difficult cases. That's something -

CHAYTOR, Q.C.:

Q. Cases such as fixation issues?

MR. GULLIVER:

A. I think so, and, I mean, that's something, Ms. Chaytor, that -

CHAYTOR, Q.C.:

Q. And so they've optimized their system to

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accommodate for that?
MR. GULLIVER:
A. Exactly, and, you know, optimizing the antigen retrieval process, we followed the DAKO protocols, what most labs do. To be honest, I don't even think we were even aware that you could actually optimizing antigen retrieval and increase your temperature, increase your time and do those kinds of things. So he's talking about things here that all along this way you could have a system failure, and again he reviewed--most of the slides he's seen, the former cases were from 2002. Because I really got to say that while I agree with everything in Dr. Banerjee's assessment and his viewpoint, I really don't agree with it for every single year that we performed this testing because if I look at 1997 when we had Dr. Khalifa who put this original testing in place, I know for a fact that Dr. Khalifa ensured that the testing was optimized, I know for a fact that Dr. Khalifa made sure specimens were fixed and grossed properly, I know for a fact that Dr. Khalifa was reading the positive control and he was reading the

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patient's internal control, and he would not sign a case out if he seen an issue with either of them. So I cannot apply Dr. Banerjee's assessment to how Dr. Khalifa set this testing up, you know, right from the start in 1997.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, other than what Dr. Banerjee and Trish Wegrynowski found, are you aware of any other issues or problems that could have caused or contributed to the change in results in the hormone receptor testing?
MR. GULLIVER:
A. No. I mean, I think if you look at both of those reports, you know, they hit on all the major points that could attribute to leading you to a false negative from this testing.
CHAYTOR, Q.C.:
Q. On page five of Exhibit 46, Dr. Banerjee's first report, he refers to number five, "Disconnect between laboratory program director", and I take it that would be you in this context, "Division manager", that would be Mr. Dyer, is that right?
MR. GULLIVER:

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A. Yeah.
CHAYTOR, Q.C.:
Q. "Clinical site chief", that would be Dr. Cook at this point in time, and laboratory -
MR. GULLIVER:
A. No, Dr. Cook was the -
CHAYTOR, Q.C.:
Q. Clinical site chief.
MR. GULLIVER:
A. I think he means myself, Barry Dyer, the site chiefs for pathology.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. And that's Dr. Cook, lab director.
CHAYTOR, Q.C.:
Q. Okay, Dr. Cook, the lab director, yes, in decision making. "The organizational chart indicates a complete separation of reporting structures into technical and clinical streams with no matrix cross-reporting between technical and medical leadership. This leads to frustration and resentment on both sides, lack of communication, lack of accountability, and lack of buy-in. The division manager and

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program director appear enthusiastic and keen on modernizing the laboratory, but their efforts have not been appreciated by the pathologists and workflow changes have not been mapped out and implemented", and he refers to an example, express implementation has failed due to a lack of planning of workflow changes. "Superior outcomes could be achieved by ensuring better linkages between technical managerial and medical leadership". Mr. Gulliver, did you have an opportunity to discuss this issue with Dr. Banerjee when he was here in St. John's, the issue of the disconnect and lack of communication within your program?
MR. GULLIVER:
A. Well, he didn't--he didn't bring up to me a disconnect. You know, what he pretty well said to myself and--I think myself and Mr. Dyer met with him. He had been there a couple of days, and I think that he just sensed that there was no direct communication between the technologists in IHC lab and the pathologists, it was still in an environment where the pathologist picked up the phone or they went

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to the lab and they pretty well said I want something done this way, or this way, or this way. I certainly don't know what he means by, like, myself and Dr. Cook, who is the clinical chief. I mean, we certainly had lots of communication. We met on a regular basis. I just think overall in our pathology division, I think that's what his sense was, that, you know, our structure in pathology was not the same as the structure in our other six divisions, that we had--you know, we had our multiple site chiefs and the clinical chief, and I agree with him that we could actually streamline the organizational structure.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. And to get to the part, I guess, I mean, his assessment, he didn't say nothing to me that I and Barry seem enthusiastic and keen, this is what he wrote from meeting with us for a couple of days. I guess he probably also sensed some frustration from Barry and myself that lots of things that we have tried to do to improve pathology services, you get some

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pathologists who are against it, they want to practice just the way they always practised, and you get other pathologists who are newer, more advanced, and they want to move into new directions.

CHAYTOR, Q.C.:

Q. Coming out of the reviews then by Dr. Banerjee and Ms. Wegrynowski, there were recommendations set up on spreadsheets?

MR. GULLIVER:

A. Yeah, I did those.

CHAYTOR, Q.C.:

Q. And you were responsible for that, were you?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. If we could look at P-1330, please, and this is a letter, November 23rd, 2003, to yourself and Dr. Cook, and it's from Dr. Williams and he indicates he's had an opportunity to review in detail the reports of Dr. Banerjee and Ms. Wegrynowski with respect to the IHC services. "I wonder if you could prepare a spreadsheet to capture all the recommendations embodied in both these reports, i.e. this should include

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all recommendations, even ones such as refrigeration storage referenced on page four of Trish Wegrynowski's report. In preparing the spreadsheet and the current status with respect to implementation of these recommendations, you should assume that funding will be provided based upon the document you prepared, October 13th, 2005, and then once you've had the spreadsheet developed and the current status of our implementation, I would like to meet with you as soon as possible to review where we go from here, especially in dealing with the institution of the immunohistochemistry services". If we could look then, please, at P-0277. I take it, Mr. Gulliver, you were tasked then with not only developing the spreadsheets, but also seeing that the recommendations, in fact, were carried out?

MR. GULLIVER:

A. Well -

CHAYTOR, Q.C.:

Q. You and Dr. Cook?

MR. GULLIVER:

A. Myself and Dr. Cook, yes. I mean, we're the

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program leadership team, so that would be our responsibility.

CHAYTOR, Q.C.:

Q. And this is an example of one version updated to April 25th, 2006, and I take it this is the spreadsheet that you came up with, recommendation, who it was recommended by, whether you agree with it or not, the current status of it, and expected date of completion, and in coming up with the recommendations, what was included in here? Was it all the recommendations from the reports, and was it anything other than that?

MR. GULLIVER:

A. Most of what you see here--again if you actually read Dr. Banerjee's report and Trish's reports, and if you only sort of took out what they called recommendations, you'd probably see--there would be a lesser number than what you see here. I read both reports, paragraph by paragraph, and if there was anything in there that I felt we needed to make sure was put on the spreadsheet that we either needed to implement or wasn't sure about, I wanted to make sure that everything

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would be captured.
CHAYTOR, Q.C.:
Q. Okay, and -
MR. GULLIVER:
A. And there was a couple of things we put in here just to keep everything tidy in one package that we were working on, ER/PR, type of thing.
CHAYTOR, Q.C.:
Q. And this particular version has 30 recommendations as of April 25th, 2006, and if we could look at P-0050, please, I think this might be the latest version that we have.
MR. GULLIVER:
A. It's probably 50 something, I think.
CHAYTOR, Q.C.:
Q. Yes, April 26th, 2007, or certainly a later version, and there's 52 on this, and that's after, I take it, Ms. Wegrynowski has been back in and Dr. Banerjee has been back in?
MR. GULLIVER:
A. I think so, yeah.
CHAYTOR, Q.C.:
Q. So there were additional recommendations added, were there, after Ms. Wegrynowski's

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second visit?
MR. GULLIVER:
A. And I don't know if it was additional added. I just think the second one is more complete where I make sure that anything recommended even in the body of the reports is put onto the spreadsheet.
CHAYTOR, Q.C.:
Q. Okay.
MR. GULLIVER:
A. Some of them are kind of duplicates also. They're linking back one to another.
CHAYTOR, Q.C.:
Q. Then perhaps you could tell the Commissioner about how you went about then seeing that these recommendations were, in fact, implemented and how long it took, and any particular challenges you met along the way?
MR. GULLIVER:
A. Well, I think the biggest challenge--I mean, the biggest challenge was that the majority of the--the vast majority of the people who would be tasked with actually doing the work, some required new resources which meant, you know, bringing in new staff, and the maybe

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retraining other staff to backfill those people, okay. The biggest task was that we were undertaking these recommendations, however, we're still dealing with the ER/PR issue, and that in our pathology department, the pathology laboratory, some of our pathologists and technologists, and IHC technologists, who had to be doing all this stuff here were still doing the day to day work that comes into the laboratory, and were still working evenings, nights, and weekends in pulling blocks and pulling slides or reviewing or refiling, and responding to the whole ER/PR issue. So, I mean, that just made it much more complicated that if these recommendations we had put these in a spreadsheet and, okay, as of tomorrow that's all we had to do, obviously the time frames would be shorter, but when you've got to do all this here and still do everything that you're currently doing and more besides, it's taking a bit longer to get all these recommendations in place. Some of them all got started, but the completion dates were some of the issues.

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CHAYTOR, Q.C.:
Q. And did you take that up with Dr. Williams?
MR. GULLIVER:
A. Dr. Williams was well aware. For example, just take our pathology assistants, you know, we got the approval for funding for pathology assistants, you know, then we got to go through the formal human resources process, you know, create a new job description because they are new positions, advertise the positions, get applicants, interview, and do the selection process, and then we knew the four PAs, that once they even got into the PAs, that it could be as long as 18 months before they were fully trained as a full PA. So, I mean, that was going to be at least a two year completion date. We started right away, the recruitment process, and the approval process, but, you know, the end time is what would take long in some of these cases. Just take our SOPs and policies, you know, you've gotten the document submitted to you with we now have all of our old procedures and all of our old policies that are all now updated in new formats and templates,

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rewritten and signed off, I mean, that process takes months and months and months and months to get those done. Now that we have it done, you know, in the next cycle where it's time to now review and update your SOPs and policies, I mean, that would be much shorter than having to create them all and put them all in place to begin with.

CHAYTOR, Q.C.:

Q. If we could have, please, P-2033, and this is January 6th, 2006, meeting of your laboratory medicine program, Drs. Cook, Williams, and yourself. If we come down under ER/PR receptors, "Terry updated on status of recommendations for this service to be reinstituted. Dr. Cook is planning a meeting in early February to determine internal consensus to put ER/PR testing back in service. Terry is currently compiling a list of deceased negative patients and cross-referencing our master list". First of all, Mr. Gulliver, with respect to the status of recommendations, and at that point Dr. Cook planning a meeting in early February, so this would be February '06 to determine if there's

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consensus to put the testing back in service. Was it envisioned, and we could look at your spreadsheets, all of the recommendations obviously weren't implemented as of January, 2006 -

MR. GULLIVER:

A. No, and we knew they wouldn't be.

CHAYTOR, Q.C.:

Q. You knew they wouldn't be.

MR. GULLIVER:

A. I mean, we had to prioritize also, I mean, what can be worked on first. We went through the list and looked at things that could be implemented in a very sort of painless very quick manner, and then we prioritized what was there on the list.

CHAYTOR, Q.C.:

Q. And had the standard operating procedure for fixation been brought in by February, 2006, or January, 2006?

MR. GULLIVER:

A. I don't think there was a standard one done, but don't forget that in 2003, you know, I thought one of the big--one of the good things that Dr. Ejeckam had done in 2003 was he sent

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out to all pathologists who were interpreting ER/PRs, not only interpretation guidelines, he sent them fixation guidelines and protocols and I really think if you look at it from that point forward, that the quality of specimens that were coming into the laboratory from around the province were much improved.

CHAYTOR, Q.C.:

Q. And you're not suggesting, though, that that would substitute for any standard operating procedure for fixation?

MR. GULLIVER:

A. Oh, certainly not. I mean, we still had to put a standard protocol in place.

CHAYTOR, Q.C.:

Q. And whether or not -

MR. GULLIVER:

A. And then roll it out across the province.

CHAYTOR, Q.C.:

Q. And with the turnover of pathologists, whether or not the people who may have received it in the first place were even still in place?

MR. GULLIVER:

A. I wouldn't know who received it or didn't receive it, no.

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CHAYTOR, Q.C.:

Q. And by February of 2007 when the test is reinstituted, has the standard operating procedure for fixation been signed off by that point in time?

MR. GULLIVER:

A. I'm not 100 percent sure, but don't forget, I mean, this is January '06, that we've had Dr. Banerjee in, and if you read Dr. Banerjee's recommendations, he's telling is that there's nothing wrong with your Ventana system and you can put testing back in place immediately, in October of '05.

CHAYTOR, Q.C.:

Q. Well, he says if certain things--it's a conditional. I don't think--his second report you're referring to.

MR. GULLIVER:

A. And he says "with improved fixation".

CHAYTOR, Q.C.:

Q. Yes, yes, with that caveat.

MR. GULLIVER:

A. And you can read that--I know you can read it two ways. You can say our fixation, does it need to be improved at that point in 2005, or

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is it the fact that he's aware of that fixation has improved.

CHAYTOR, Q.C.:

Q. And the discussion that we had earlier about the DAKO and the DAKO system being something broader than the actual machine, would you include your system--wouldn't your system include all your pre-analytical parts to carrying out your tests?

MR. GULLIVER:

A. No, no, when I say the Ventana system, I would mean specifically the parts of the pieces involved with the Ventana system and perform the actual procedure from the antigen retrieval to the slide being produced. That would not include, you know, your fixation and grossing stuff.

CHAYTOR, Q.C.:

Q. I take it, though, it would be important to have those things standardized before you set up your--reinstitute your test?

MR. GULLIVER:

A. It would be, but Dr. Banerjee reviewed slides off our Ventana system, multiple slides, and he didn't see any issues with fixation and he

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said that the quality of the slides were as good as any he had seen in Canada.

CHAYTOR, Q.C.:

Q. And if we could look at P-2033. Do you know where those slides came from?

MR. GULLIVER:

A. They came from--Mr. Dyer pulled a whole bunch of recent cases that were done on Ventana because we had been operating it since April of '04.

CHAYTOR, Q.C.:

Q. And whether or not they're all St. John's or not, would you know?

MR. GULLIVER:

A. I wouldn't know if they were all St. John's. I would say if they were randomly pulled, I mean, it could be a mixture of in town and out of town, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Because it's about 50/50, the total testing split.

CHAYTOR, Q.C.:

Q. The other part of this exhibit that I wanted

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to show you is the issue of you currently compiling a list of deceased negative patients and cross-referencing our master list. What is that referring to?

MR. GULLIVER:

A. Again by this time, and as I mentioned to you about having to put these recommendations in place, we're still dealing with the ER/PR issue. Now we're starting to do the retesting and identifying retesting of patients who have been deceased. As you are well aware, the first focus was on patients who are still living, and who could benefit from a change in hormone therapy. We're now starting the process to identify the patients who have not been retested that we know have passed away.

CHAYTOR, Q.C.:

Q. With the intention of then having the deceased retested as well?

MR. GULLIVER:

A. Retested, yes.

CHAYTOR, Q.C.:

Q. And if we could have P-2077, please. Sorry, that's not the right exhibit, Mr. Gulliver. If we could have 1749, please. Sorry, that's

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not the right exhibit, Mr. Gulliver. This is March 6th, 2006, and it's an e-mail written from Dr. Williams to yourself and Dr. Cook, Dr. Denic, Mr. Dyer, and Ms. Predham. He writes, "Further to my e-mail below with respect to Trish Wegrynowski, Terry, I wonder if you would follow up with her directly as she would like to have some information to update her on our progress prior to her arrival. I advised her that we have a spreadsheet of issues we are working on in updated format. When you talk to her, that may be sufficient to help her prepare for her visit", and this, of course, was her upcoming second visit to St. John's in March of 2006. So perhaps you could just tell us what discussions you had with Ms. Wegrynowski in preparation to her coming back, and what if any material you provided her with?

MR. GULLIVER:

A. I didn't have any discussion with her. Mr. Dyer did that.

CHAYTOR, Q.C.:

Q. Okay, so you delegated that to Mr. Dyer?

MR. GULLIVER:

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A. Yes, he's the pathology manager.
CHAYTOR, Q.C.:
Q. And do you know whether or not he provided her with any material?
MR. GULLIVER:
A. I can't say for sure, and I would suspect if he gave her anything, he may have gave her a copy of the spreadsheets, the basic spreadsheets, but I can't verify that for sure.
CHAYTOR, Q.C.:
Q. And if we could then have 1133, and I think it's fair to say that Ms. Wegrynowski stated that she was disappointed on her return visit with the little progress that had been made in the standard operating procedures, in particular. There were a number of other issues, but in particular with the progress that had been made, and I take it from what you're saying, Mr. Gulliver, is that's because the people who were having to do that also had their full time jobs to attend to and were having to do this and find time to do it basically on the side or in addition to their full time duties?

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MR. GULLIVER:
A. And not just in addition to their full time duties. You know, a part of that responsibility for the recommendations would fall, you know, to me as program director, and to clinical chief, will fall to the manager, Barry Dyer, it will fall to the technologists who are directly involved, because when you're writing SOPs and policies, really the people who should be writing are the people who use them, the end users, and they're the ones that know best, and again the end users in our pathology lab were dealing with the current workload and volumes and were still dealing with ER/PR. You know, I can't emphasize enough during this whole time frame that we're not only doing our assigned duties, that we are working almost every single evening, every single weekend, just trying to keep on top of the whole ER/PR retesting, the documentation of it, the reviewing of slides, and then we're going to start to come into a time frame, you know, from the class action lawsuit--there's now new documentation they need to get provided. We're going to get to a period

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where all the original slides, had to be thousands and thousands and thousands of slides be re-pulled and re-documented to go to expert pathologists to interpret. It's just-- it's been non stop.
CHAYTOR, Q.C.:
Q. And you communicated--in the time period that you're trying to get the recommendations implemented, you communicated that to Dr. Williams in terms of--and I guess then afterwards his successor, Dr. Howell, the difficulties and the workloads that people -
MR. GULLIVER:
A. I think we told Trish too when she was in the second time that, you know, we've got some things done, but we're going to need time to get them done.
CHAYTOR, Q.C.:
Q. And the idea of having additional resources assigned or people dedicated to that, was that idea--was there ever any request, I guess, for that?
MR. GULLIVER:
A. Well, it's so hard for me to try and articulate to you that who--where are the

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additional resources going to come from? Because the people who are going to need to respond to the recommendations, you need people who have got a lot of pathology experience. The people who we had with pathology experience are doing the current work and working on the ER/PR retesting. If there was a bunch of people over in another lab or over somewhere else that we could say, well let's pull them in now because they could actually help us with this here, it would have been done. But there was no--anybody with pathology experience, even our temporary staff who had worked for summer relief, they're all pulled from other parts of the lab to go into the pathology lab to help us get through this time frame.
CHAYTOR, Q.C.:
Q. And ultimately Lynn Wade's position is created?
MR. GULLIVER:
A. Lynn is created in July of '07, but her focus is for Dr. Howell's portfolio, but her first primary focus is laboratory medicine, but she's responsible for quality for laboratory

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medicine, diagnostic imaging and pharmacy.

CHAYTOR, Q.C.:

Q. But that doesn't get created or come on until July of 2007.

MR. GULLIVER:

A. Until July of '07.

CHAYTOR, Q.C.:

Q. Did anyone ever request anything along those lines prior to that being created in 2007?

MR. GULLIVER:

A. I don't know, Ms. Chaytor because just before this time frame in October of '05, none of us have a job, you know, I had to--I lost my position as program director for St. John's, Mr. Dyer lost his position as pathology manager for St. John's and we had to reapply for Eastern Health to apply for position. I had to go through the interview process, as did the managers, and to become the program director for Eastern Health for the whole region.

CHAYTOR, Q.C.:

Q. Okay, so Mr. Gulliver, I take it the idea of Lynn Wade's position, that comes up sometime in 2007 and then she's put in place in July of

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2007?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. If we could have, actually I think this exhibit is supposed to be P-1133. And this is a letter of May 25th, 2006 to yourself from Dr. Williams and it's copied to Dr. Denic and it's following up on the recommendations of Trish Wegrynowski. "I'm writing concerning a number of issues with respect to quality issues within the Laboratory Medicine Program. Now that we have had an opportunity to review the report from Trish Wegrynowski, I wonder if you would review each of her observations and recommendations. I especially want to make significant progress in the next few weeks on completing the policies and procedure manual for the ER/PR testing service. We'll need to make a decision soon on re-instituting this testing and I want to ensure that all issues within this area have been dealt with. It would be productive to send a copy of the final manual to TW when it is completed. I realize from reviewing the report that

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significant progress has been made as outlined, however, we need to finalize all issues. And the other issue we need to pursue is enroling in the Ontario Laboratory Accreditation Program." Mr. Gulliver, the idea of sending the final manual to TW when it is completed, did that ever happen?

MR. GULLIVER:

A. I don't think it's happened yet, no.

CHAYTOR, Q.C.:

Q. And in this letter, obviously Mr. Williams is giving direction to concentrate on the procedure manual and getting that done. So what happens after that, after -

MR. GULLIVER:

A. I think around this time, then we get funding to create a new position for technologists in pathology to be dedicated to doing this work. So what has to happen is the work that technologists is currently doing, a new employee has to come in to be trained in order to release that person to start working on this initiative for the SOP's and policies. At the time, I think it was Ms. Catherine Parnell who was first.

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CHAYTOR, Q.C.:

Q. And if we can look at P-0101 please? And this is a letter that Dr. Carter wrote, December 7th, 2005 and she wrote it to Dr. Williams, but she copied yourself and Dr. Cook and Dr. Ejeckam on this. And she says, "She was most recently asked by Dr. Cook to comment on the suggestion of Mr. Barry Dyer who had stated he felt the Ventana testing for estrogen receptor, progesterone receptor and HER2/neu could be started at any time. I find this comment quite startling in the face of the two fairly damming reports sent by Dr. Banerjee and Trish Wegrynowski on their review of our IHC lab, with special emphasis on the predictive factors for breast cancer patients." And she says, "As stated by Dr. Banerjee and Ms. Wegrynowski and vehemently supported by me, there are multiple major issues that must be addressed prior to any breast testing being reported from our IHC laboratory." And she goes on and lists a number of them, including the need for dedicated technologists and to have them educated at an acceptable training

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institution. And she lists a number of things that she doesn't think is in place as of December, 2005. Upon receipt of this letter, were you engaged in any discussions about how you could address this correspondence or the concerns raised?

MR. GULLIVER:

A. I think I spoke to Dr. Williams about it and, you know, at the very beginning there, I don't know if it was Mr. Barry Dyer's suggestion. Again, we stopped testing on the Ventana system in, you know, end of July '05. By this time in December, you know, when Dr. Carter wrote this letter, I guess I spoke to Dr. Williams and Dr. Cook that my first thing was, you know, the four reports that--the reports that we had received, that there were four copies, it looked like to me that Dr. Bev Carter had actually copied things from the reports directly into this letter and I wouldn't have known how she would have seen or have had copies of the reports. And it wasn't Barry's Dyer's suggestion, it was just in general comments that we were, myself, Dr. Cook, Dr. Williams were discussing at the

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leadership level, well when can we put testing back in place? And by December, you know, we now have Dr. Banerjee who is the breast expert for pathology for British Columbia. He tells us in his report that there's no issue with the Ventana system. The slides, the quality of the slides are as good as any slides he sees in Canada. He does mention about fixation, but fixation is pretty well the pathologist's area of responsibility and by this time, we've already enrolled and received back through Dr. Ejeckam, who is a director of IHC lab, we've received our NEQAS UK results and have scored really well, so the issue is, well why do we not have testing back in place? If Dr. Banerjee says there is nothing wrong with our system, if the external proficiency people are giving us good scores -

CHAYTOR, Q.C.:

Q. And were those on ER/PR or HER2/neu tests?

MR. GULLIVER:

A. On the ER/PR, yes. So I mean, what else needed to be done for us to put testing back in place and I would say even though Dr. Carter outlines, kind of just rewrites what's

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in some of Dr. Banerjee's and Trish's report, in my opinion, you know, there's two sides of ER/PR testing. It's the technical side and clinical side and in my opinion -

CHAYTOR, Q.C.:

Q. And I believe she addresses both in her letter.

MR. GULLIVER:

A. I know, and in my opinion the technical side was fine with the Ventana system and the results that we got back for UK NEQAS and CAP and Dr. Banerjee's assessment of the Ventana system.

CHAYTOR, Q.C.:

Q. And is the technical side, though, wouldn't be just limited to your Ventana system. Her issue here seems to be also looking at the technologists, she writes here, "The most important of these is organization of the immunohistochemistry laboratory. Our technologists need to be dedicated" -

MR. GULLIVER:

A. She's rewriting things that hadn't been done for a long time. We got three techs in the IHC lab, they're well organized. Dr. Ejeckam

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has been appointed director of the IHC lab, which Dr. Carter, I think, wasn't too supportive of, but I mean, things were in place.

CHAYTOR, Q.C.:

Q. But she says that her "most recent HER2/neu, ER/PR validation with them, booked in advance, required taking one of them, one technologist from the frozen section room and one from the grossing room and one of them should be deemed the charged technologist or other equal term." So she seems to be saying that they're not in fact dedicated and it's not quite as straightforward.

MR. GULLIVER:

A. Well you would just have to ask her, because I mean, at that point in time, they're dedicated in IHC, that's all they do and you'd just have to ask Dr. Carter exactly what she's talking about there.

CHAYTOR, Q.C.:

Q. I guess more importantly, Mr. Gulliver, was did you ask her or did you ask Mr. Dyer, well what's going on here because I understood our staff are dedicated. What did you do after

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receiving this letter, these are her concerns, did you just dismiss it or did you follow up on it?

MR. GULLIVER:

A. I spoke to Dr. Cook and Dr. Williams about it. I did not speak to Dr. Bev Carter directly about this particular memo, as I didn't speak to her directly about the one where she resigned in August.

CHAYTOR, Q.C.:

Q. And did you speak to Mr. Dyer who would be reporting to you to determine whether or not in fact this is accurate, that your technologists -

MR. GULLIVER:

A. Yeah, I speak to Barry every single day during all this here.

CHAYTOR, Q.C.:

Q. And so what -

MR. GULLIVER:

A. And no one ever--Dr. Ejeckam is a director of the lab, Dr. Ejeckam never came back to say he had any issues with the staffing levels in the pathology--in the IHC lab. He never came back to say he had any issues with their quality of

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their work. He never came back to say he had issues with their level of theory or their knowledge and he was the one who I relied upon and Dr. Cook relied upon as the director of IHC lab.

CHAYTOR, Q.C.:

Q. And did you go specifically to Dr. Ejeckam and ask him those things, whether or not he had such concerns?

MR. GULLIVER:

A. I don't know if I asked him about concerns, about the technologists and I never asked him about concerns about the pathologists either.

CHAYTOR, Q.C.:

Q. Well the technologists, I take it, would be more within your domain.

MR. GULLIVER:

A. Generally, yes. I had full confidence in the technologists who were over there and Dr. Ejeckam.

CHAYTOR, Q.C.:

Q. So after this, you did speak to Dr. Cook and what did you -

MR. GULLIVER:

A. And Dr. Williams.

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CHAYTOR, Q.C.:

Q. And Dr. Williams, and what was the nature of your discussion with them about this letter?

MR. GULLIVER:

A. Well again it was in general discussion about we had stopped testing and we had been talking as the leadership group, well, when are we going to put testing back in place? And by this time, as I just said to you earlier, we-- Dr. Banerjee says there's nothing wrong with our system, the quality of our slides are as good as any he has seen in Canada. We've scored very high on external and proficiency testing and it's the leadership team's responsibility to make a decision to put testing back in place.

CHAYTOR, Q.C.:

Q. If we could have, please, P-1166? And then, Mr. Gulliver, the decision obviously doesn't happen, that's December 2005 that Dr. Carter wrote that and the testing isn't actually re-instituted until February, 2007. And why is that, why is it over a year later?

MR. GULLIVER:

A. I just think it took that long for the

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pathologists to get their house in order and to decide who amongst the pathologists will be dedicated for reading ER/PR's and who will be the breast subspecialty group.

CHAYTOR, Q.C.:

Q. So it wasn't to allow an opportunity for all of the recommendations or most of the recommendations to be put in place?

MR. GULLIVER:

A. Not to my knowledge, no. Most of the recommendations were either, you know, even during this time, were either--they were agreed with, they were being worked on and/or being implemented or plans put in place -

CHAYTOR, Q.C.:

Q. They certainly weren't mostly in place, though.

MR. GULLIVER:

A. Not all of them, no.

CHAYTOR, Q.C.:

Q. So your understanding is it doesn't happen until February of '07 because of the pathologists and what the pathologists had ben working on -

MR. GULLIVER:

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A. To the best of my knowledge, yes.
CHAYTOR, Q.C.:
Q. And you would have been, in terms of the decision then to re-implement it, you would have been, I take it, involved in that?
MR. GULLIVER:
A. I was involved in the process along the way. I know before testing went back in place, we had discussions with the regions outside of St. John's, are we going to put a testing back in place for St. John's patients only, for the whole of the province? And the decision was to put St. John's testing back in place to see how it goes. But to understand that the whole province are sending out their ER/PR's and HER1/neu's to Mount Sinai. So for a place like, for example, Western, for Western to say, okay, St. John's is now doing ER/PR testing so we're going to send our blocks back into St. John's, but that still meant we weren't doing HER2/neu. They would have to send a block into us for ER/PR testing, then get the block back and then send it to Mount Sinai for HER2/neu testing. So it was felt for the labs outside of St. John's to be more

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efficient, they would continue sending their HER2/neus and their ER/PRs as a hormone receptor panel, still send to Mount Sinai.
CHAYTOR, Q.C.:
Q. And that included Clarenville and Carbonear labs?
MR. GULLIVER:
A. To my knowledge, yes.
CHAYTOR, Q.C.:
Q. And were you aware, by the way, that Clarenville all along had been using Mount Sinai throughout most of the years that the review took place?
MR. GULLIVER:
A. I did not know who Clarenville were using, I know back in, you know, again, back in the late 90's, I know when Dr. Khalifa first put the testing in place and he was doing all the interpretation reporting for all the province, when it was decided that each pathologist in every laboratory would have to do their own interpretations, I know that's around the time frame where Clarenville decided to send theirs out for testing and interpretation.
CHAYTOR, Q.C.:

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Q. And were you involved in any discussions at that time as to why they made that decision?
MR. GULLIVER:
A. I wasn't involved in no direct discussions, no.
CHAYTOR, Q.C.:
Q. But do you know why Clarenville decided to stop using St. John's services at the time?
MR. GULLIVER:
A. No, they stopped using St. John's because they were not going to get interpretations.
CHAYTOR, Q.C.:
Q. And who told you that or where did you learn that?
MR. GULLIVER:
A. It was just in my general knowledge and I know, I'm thinking who was there in '98, Ms. Chaytor, I think it might have been Dr. Horner who was there as the pathologist, the main pathologist in '98.
CHAYTOR, Q.C.:
Q. So the pathologist, whoever it was in Clarenville, to the best of your knowledge made the judgment call that he or she didn't or shouldn't do the interpretation and it

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should be done somewhere else?
MR. GULLIVER:
A. That was my understanding, yes.
CHAYTOR, Q.C.:
Q. When the testing resumed in February 2007, did you have to do any kind of, give any kind of presentation to Dr. Howell or review the list of recommendations with him to satisfy him that in fact the IHC lab was ready to resume the testing?
MR. GULLIVER:
A. I think myself and Nash, Dr. Denic, gave an update to Dr. Howell or maybe sat down and went through them with him and I think Dr. Denic did a presentation and Dr. Ford and I was involved in or during those presentations they presented to the board and to the physician staff about ER/PR testing in general type of thing.
CHAYTOR, Q.C.:
Q. And if we could look then at this exhibit, P-1166? And this is an e-mail communication that originates here with Ms. Pilgrim, August 7th, 2006. It's not to yourself, it's to Sharon Smith, Heather Predham and copied to a

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number of other individuals, but you do have an honourable mention at some point. Here we go, on page 3 of the exhibit, the last bullet, "touching base with Terry Gulliver, re: today's The Current broadcast, I have spoken with Terry who is just back from two weeks annual leave. He did not hear the program, but I told him what was said by Ches Crosbie, re: it is harder to attract good people. He will see what the response is in the lab, if any. I also discussed the issue re: the lawyer seemingly getting his information from the 'inside'. He indicated he has already had to talk to his staff re: Dr. Hutton being over in the lab asking questions. I told him he needs to follow up with Nash to ensure the message gets out that no one should be talking about this outside of the official group." And Mr. Gulliver, what do you recall about this?

MR. GULLIVER:

A. What time frame is this?

CHAYTOR, Q.C.:

Q. This is August 7th, 2006.

MR. GULLIVER:

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A. 2006, so you're talking about Dr. Hutton in particular?

CHAYTOR, Q.C.:

Q. This whole piece that's here that Ms. Pilgrim indicates that she's spoken to you.

MR. GULLIVER:

A. I didn't know what The Current broadcast is about.

CHAYTOR, Q.C.:

Q. She also says that she talks to you about, she tells you, I guess, on The Current, there was some comment by Mr. Crosbie, it's harder to attract good people and you were going to see what the response in the lab was.

MR. GULLIVER:

A. I'm thinking he's talking about hard to attract good pathologists. I kind of remember that statement being made.

CHAYTOR, Q.C.:

Q. And the second part is, "She also discussed the issue of re: the lawyer seemingly getting his information on the inside."

MR. GULLIVER:

A. Right, from Dr. Hutton.

CHAYTOR, Q.C.:

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Q. And some issue about Dr. Hutton. So what do you recall about that?

MR. GULLIVER:

A. Dr. Hutton was a practising pathologist for years at the Janeway and he left the Janeway and he became our, at the Health Sciences, he then was awhile was our medical examiner at the Health Sciences' pathology lab. And when Dr. Simon Avis became the fulltime provincial medical examiner, Dr. Hutton still stayed on part time, so Dr. Hutton is someone who is around the pathology lab at the Health Sciences, but his only responsibility is to perform autopsy work and to assist the medical examiner. To my knowledge, Dr. Hutton was retained by Mr. Crosbie as his, I guess, pathologist expert in the Class Action lawsuit. And there has been occasions where Dr. Hutton would actually go into the main pathology IHC lab and he'd be asking the technologists questions and looking for documentation. And I had to speak to Dr. Hutton, I had to inform Dr. Williams several times that Dr. Hutton should be informed that, you know, his role here is in the autopsy area

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and really he should not be down in the main pathology lab asking staff questions about ER/PR testing and looking for documentation.

CHAYTOR, Q.C.:

Q. And who did you understand, it says here that she told you, Ms. Pilgrim told you he needs to follow up with Nash to ensure the message gets out that on one should be talking about this outside of the official group. Who did you understand the official group to be?

MR. GULLIVER:

A. No idea who the official group would be.

CHAYTOR, Q.C.:

Q. Did you follow up with Dr. Denic?

MR. GULLIVER:

A. I'm assuming she means people like myself, Dr. Denic, Dr. Williams, Pat Pilgrim, George Tilley, Susan Bonnell, Heather Predham, you know, Sharon Smith, I mean, the key people who had been working on this issue for up to this point.

CHAYTOR, Q.C.:

Q. And did that official group, were there times there were certain people that were in the official group and other times, depending on

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what needed to be happening -
MR. GULLIVER:
A. I think depending on the issue who'd be in the group. I mean, sometimes we had meetings where the oncologists were there because it was dealing with the oncologists, a clinical issue. We had lots of meetings where the oncologists weren't there.
CHAYTOR, Q.C.:
Q. Did you consider yourself to be part of the official group throughout?
MR. GULLIVER:
A. I never even thought about it as part, just part of the lab.
CHAYTOR, Q.C.:
Q. But in terms of the official group that was dealing with the lab issue?
MR. GULLIVER:
A. I never knew there was even an official group appointed or called an official group.
CHAYTOR, Q.C.:
Q. In terms of the group that--so you never had any understanding that there's anybody officially appointed to be handling this issue?

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MR. GULLIVER:
A. Oh, at some point, Pat Pilgrim does accept that role. She's appointed where she's the chief executive from our executive team lead where she'll be the executive team lead for ER/PR issue for Eastern Health.
CHAYTOR, Q.C.:
Q. And that's in 2007.
MR. GULLIVER:
A. I'm not sure exactly when it happened, but it happens.
CHAYTOR, Q.C.:
Q. So 2005, 2006, did you understand there was anyone in charge or dealing with the issue?
MR. GULLIVER:
A. My direct lead was my vice-president Medical Services.
CHAYTOR, Q.C.:
Q. And did you understand that he was the person in charge of management of the issue?
MR. GULLIVER:
A. Yeah, to my knowledge, yes.
THE COMMISSIONER:
Q. Ms. Chaytor, wherever you can find a convenient spot, we'll take the luncheon break.
CHAYTOR, Q.C.:
Q. Did you take this issue--here, in this e-mail, it suggests that you follow up with Dr. Denic. Did you do that?
MR. GULLIVER:
A. I did with Dr. Denic and I think, at this time, I think Dr. Williams is still VP, and Pat, all three of them, and then I went back and told Pat that I had spoken to Dr. Hutton and that I spoke to all staff in the laboratories, instructed all staff that Dr. Hutton is not to be asking questions outside of the autopsy area.
CHAYTOR, Q.C.:
Q. Okay, and if we could have, please, P-2130? And this is minutes of a Joint Laboratory Medicine Discipline and Programs, September 13th, 2007, and I'm thinking that's not the right one. Perhaps we'll take the break there and I can figure this out then after lunch.
THE COMMISSIONER:
Q. All right. We'll take the luncheon break and meet again at five after two. Thank you.
(LUNCH BREAK)

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THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Good afternoon, Commissioner. Good afternoon, Mr. Gulliver.
MR. GULLIVER:
A. Good afternoon, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Commissioner, I understand there are two new exhibits to be entered, P-3049 and P-3050, please.
THE COMMISSIONER:
Q. Entered.
EXHIBITS ENTERED AND MARKED P-3049 AND P-3050
CHAYTOR, Q.C.:
Q. Thank you, and if we could have, please, P-2007? Mr. Gulliver, this is an e-mail, February 16th, 2006, from yourself to Ms. Predham and you write to her, "all of these cases were logged in our master list. None of them were negative negative and did not meet the send-off criteria for retesting. The original results are on our sheet, and all these patients have a line going through them." And you'll see that it originated with

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Ms. Predham to yourself and Dr. Cook, "please find attached patients who have not received results from us yet from Central."

Your response to her that "none of them were negative negative and did not meet the send-off criteria for retesting," the send-off criteria for retesting being referred to as negative negative, just wondering what you would be referring to there?

MR. GULLIVER:

A. I'm not sure exactly, Ms. Chaytor. I don't see the rest of the document, but I see the original results on our sheets and they have a line going through them. That indicates to me that I put lines through out patient list if the patient was identified as being deceased. Therefore, they weren't sent off in the original batches. So I'm thinking Heather has probably got a list of deceased patients from Central.

CHAYTOR, Q.C.:

Q. Yes, but my point being that to indicate that they were negative negative, people being negative negative to meet the send-off criteria for retesting.

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MR. GULLIVER:

A. See, this is again, this is my typing. None of them were negative negative, that could be "or did not meet the send-off criteria for retesting."

CHAYTOR, Q.C.:

Q. Okay. So at no point in time did you identify people for retesting on the basis of them being strictly negative negative? You were using the ten percent and 30 percent criteria?

MR. GULLIVER:

A. Through the whole process. Anybody who was negative negative was an automatic retest.

CHAYTOR, Q.C.:

Q. Right, and so I just want to make sure that there was no confusion or anything in terms of -

MR. GULLIVER:

A. No, no.

CHAYTOR, Q.C.:

Q. - you weren't looking for people who were negative negative?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

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Q. And there was nobody overlooked because of that?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-2658? And this is an e-mail from Ms. Barrington to a number of people including yourself, and it's October 20th, 2006. "Attached is an article on ER/PR that appears in this week's Independent. I'm going to begin to put together a communication strategy around the release of rate of error results as well as the announcement of us beginning to retest. After speaking with Heather, we would like to aim for an end of November announcement. Terry, Nash, will we be ready by then?" So what is it, at this point in time then, Mr. Gulliver, it's October 20th, 2006. What is it that you're being asked--what portion would you have to have ready before there can be a public announcement of any results?

MR. GULLIVER:

A. I would only guess that they're looking for, by that time, do we--is it probably numbers,

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looking for how many patients were originally tested, how many patients were sent off for retesting and then how many in that category came back with a changed result.

CHAYTOR, Q.C.:

Q. So were you involved then in getting ready for the numbers that were released ultimately in December 2006, were you involved in compiling the data?

MR. GULLIVER:

A. I would think I'm a part of the group who could be involved in it.

CHAYTOR, Q.C.:

Q. So the part that you're having to get ready, this is asking "will we be ready by then?" and it's asking the question of you and Dr. Denic, your work that you would be getting ready would be looking at the number of tests altogether and how many had changed results?

MR. GULLIVER:

A. That's my best estimate, yeah.

CHAYTOR, Q.C.:

Q. Okay, and then when that piece actually happens, in December of 2006, and the announcement is made, had you worked on that?

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Had you provided the figures to anyone or was that someone else's work?
MR. GULLIVER:
A. I would think that someone asked me, "can we give them an idea of how many patients were originally tested, how many patients to date have we sent off for retesting, and do we know how many of those patients have result changes?"
CHAYTOR, Q.C.:
Q. Okay, and would you -
MR. GULLIVER:
A. I was not asked to give them a number specifically for any kind of media release or nothing like that.
CHAYTOR, Q.C.:
Q. But you were asked to get--collect information as to how many people had changes in results?
MR. GULLIVER:
A. Well, I mean, during this time frame, you've seen lots of documents where I've been asked to, you know, update, count, recount, re-update, so it's nothing--to me, it was no different than another piece of the equation.
CHAYTOR, Q.C.:

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Q. But were you getting the results? Were you--was that going into your spreadsheet or your database?
MR. GULLIVER:
A. No, no, no, no.
CHAYTOR, Q.C.:
Q. Because I understood that was something Dr. Cook was doing.
MR. GULLIVER:
A. I didn't get results. That's something that Dr. Cook and Heather Predham--when results came back from Mount Sinai, they would know then how many results had changed.
CHAYTOR, Q.C.:
Q. So how could you be of assistance in providing any number in terms of changes in results?
MR. GULLIVER:
A. No, I would have to give him the numbers of how many original tests were done, how many have we sent off for retesting.
CHAYTOR, Q.C.:
Q. Okay, and you did not give any numbers in terms of changes in results?
MR. GULLIVER:
A. No, I didn't know those numbers.

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CHAYTOR, Q.C.:
Q. You didn't have that information?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. That's what I wanted to be clear on. And if we could have, please, P-2110? And this is December 11th, I believe, 2006, which happens to be the same date of the media technical briefing, and this is Pathology Quality Management Committee meeting and you're not present, but Doctors Carter and Denic are present. By the way, did you attend the media technical briefing?
MR. GULLIVER:
A. No, I did not.
CHAYTOR, Q.C.:
Q. Okay, and in terms of the getting anything else together or prepared for public release in that time period, other than giving the total number of tests and the number sent for retesting, did you have any other involvement in any decisions as to what would be released?
MR. GULLIVER:
A. None.

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CHAYTOR, Q.C.:
Q. Okay. This Pathology Quality Management Committee, and I won't take you through the entire document, you're not in attendance then. If we could look also at P-2364, and this appears to have been the first meeting of that committee, from the records we have, and then 2364 is another meeting, January 17th then, 2007, I guess, and again, you're not present at that time, and I think when we look through most of the minutes for that committee, Mr. Gulliver, it doesn't appear that you actually attended.
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. You didn't attend those meetings?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. Okay, and at some point, there's reference in the minutes to you becoming an ad hoc member instead of the committee, and what was that all about? Why is it that you--it appears you were to be a member of the committee, but you

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don't attend any of the meetings, and then ultimately you become an ad hoc member.

MR. GULLIVER:

A. I think when they first set it up, they would just send me, just more like an FYI that there is a monthly meeting or a meeting, you know, at this particular time for the Pathology Quality Management Committee, just where I'm the program director. You know, within our division, within the program, there are other meetings like this that take place in other divisions and I don't attend the divisional meetings. It's important that the--for example, pathology, it's important that the technologist in charge of the quality control, Catherine Parnell, Tracy Chafe is the administrative assistant to Bev Carter, and the pathologists are there, and Janet Laidley is our QI department person.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-2111? And this is a meeting of Medical Laboratory Sciences Advisory Committee, December 13th, 2006, and you are the chairperson of this committee, and there's a number of

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individuals, and this is on the College of North Atlantic letterhead. Perhaps you could tell us, what is the Medical Laboratory Sciences Advisory Committee?

MR. GULLIVER:

A. Well, CONA is the provincial training program for medical lab technologists, and within their health sciences study programs, which includes medical lab technologist, diagnostic imaging technologist, respiratory therapist, you know, they have--this is their link to the clinical placement groups within the province. So the group you'd see here would be representatives of laboratory people from across the province, and we meet generally twice a year, and it's talking about the training of medical lab technologists for Newfoundland. In particular, talking about the clinical placements and when they come into the different labs and hospitals for their clinical component.

CHAYTOR, Q.C.:

Q. And are you still chair of that group?

MR. GULLIVER:

A. I still am, yes.

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CHAYTOR, Q.C.:

Q. You're still chair, and -

MR. GULLIVER:

A. This might have been the first meeting I chaired, I think. I'm not sure.

CHAYTOR, Q.C.:

Q. Okay, and the mandate, in terms of does it look at then the curriculum for laboratory technologists?

MR. GULLIVER:

A. No, this committee doesn't. Pretty well the curriculum for the training of medical lab technologists, it's based upon the Canadian Society of Medical Laboratory Sciences. They have an entry level, as you see here, entry level competency profile. So all training programs in Canada, they must ensure that their students in training are able to meet that national competency profile. When they finish their training, then the students write their national CSMLS exams and then they're a certified medical lab technologist.

CHAYTOR, Q.C.:

Q. Okay, and do you know whether or not there's been any plan to revise the program to include

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an IHC component for technologists?

MR. GULLIVER:

A. To my knowledge, no.

CHAYTOR, Q.C.:

Q. And has that ever been the subject of discussion with your committee or to your knowledge at all locally?

MR. GULLIVER:

A. No. For the training of med-lab technologists, it's at the entry level. Within med-lab sciences, certainly when technologists come into the workplace, all parts of our program have specialty areas. For example, in biochemistry, when you graduate here, if you went to work in biochemistry, our biochemistry lab at the Health Sciences, for example, we have specialized training and staff who do fertility testing. We have specialized technologists who are trained to do protein electrophoresis. There are lots of--we have biochemical genetics, which is another specialized part of biochemistry, and those kinds of things are the kinds of things that technologists are expected to sort of learn on

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the job or additional training.
CHAYTOR, Q.C.:
Q. And in terms of IHC technologists and to come to the level of IHC, and we've had some discussion about what would be required, how does a technologist get to become an IHC technologist within Eastern Health? How are you promoted to that?
MR. GULLIVER:
A. Well, first of all, I mean, again, we work within a unionized environment, so all jobs within the bargaining unit have to be, you know, posted. People apply for them. Within pathology, IHC testing is a specialized part of our pathology laboratory. You must have a minimum number of years--you must be, first of all, a certified med-lab technologist and then you must have pathology experience, in order to go into that part of our pathology lab, and within that lab then, there are lots of things where you would have to learn while you're on the job.
CHAYTOR, Q.C.:
Q. And Mr. Gulliver, in many provinces across the country, your profession is regulated, and

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have you been involved at all in any effort in Newfoundland Labrador to have the profession regulated?
MR. GULLIVER:
A. How much time do you have? When I was president of our Newfoundland Society of Medical Lab Technologists, I was one of the-- at the time, I was one of the first technologists with a small core group, I think Robin Power and Ms. Lynn Wade might have been with me. We did a presentation to the Government for to license medical lab technologists in Newfoundland, which would include like a full regulation with a regulatory body. We hired a lawyer to do all the legal piece for us, and that pretty well didn't go anywhere.
Governments change. I think the Liberals were in power then, and governments changed and we did another presentation in the late '90s, again to government, you know, indicating the need for medical lab technologists in Newfoundland, that we should be in a regulated licensed profession, similar to most other professions in the health care

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system. And again, I think in 2001, again there's some different key players involved. I know most recently, Ms. Goldie Fagan, whose name is right here, Goldie who has been the most recent past president of our Newfoundland society, she has spent about two years doing presentations, meeting with government, again indicating that we, as a professional group body, would certainly be in favour of having a regulated licensed profession in the province, and to date we still have not achieved that.
CHAYTOR, Q.C.:
Q. And why is it important to you, how do you think it would be beneficial?
MR. GULLIVER:
A. I don't know--I can't say it's important to me personally individually. I think that it's very important that, you know, medical lab technologists to me--I mean, we are the third largest health care profession in Canada behind nurses and physicians, and to me if you want to make sure--we have a national training program, we have a national competency profile where all of our techs are able to move from one province to another and practise, however,

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within each province you have different ways that you have to practice and different requirements, and again ultimately the main reason why you would want to have a regulated profession is really to protect the public.
CHAYTOR, Q.C.:
Q. And how would that make a difference, how would the public have greater protection if you had a regulated licensed profession?
MR. GULLIVER:
A. Well, what we have here in Newfoundland, it's pretty well the employers who require that you hire staff that you know meet a national certification level, but if you're in another province that's regulated, it means that the lab has to be licensed and accredited, it means that each individual staff person has to be licensed, and it means that on a three year --every three years each individual staff employee must maintain their licensure which means they must do so many hours of continuing education. I think Ontario, it might be 900 hours over a three year period and--which is really mostly saying to medical lab technologists that, you know, it's incumbent

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upon you to also self-educate, that you have to participate in distance education programs or attend lectures or workshops, and not necessarily be forced to do it by an employer.

CHAYTOR, Q.C.:

Q. And Mr. Gulliver, to your knowledge, what's the current state of affairs in terms of trying to move forward with regulation in this province?

MR. GULLIVER:

A. It's the same today as it was in 1993.

CHAYTOR, Q.C.:

Q. And have you heard articulated any reasons as to why it hasn't happened?

MR. GULLIVER:

A. I think the last time that our professional group went to government, what came back from government is that they're looking at doing a whole new legislation for regulated professions and that medical lab technologists would be reviewed in that light. I do believe now, I mean, since this inquiry, I think I've heard government officials pretty well say that their intention is that our province will become a regulated licensed profession.

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CHAYTOR, Q.C.:

Q. If I could have, please, P-0642. Mr. Gulliver, this is an attachment of an excerpt or a news piece by Carolyn Stokes and it's back in mid October, 2005. So the story had broke October 2nd, 2005, and you'll recall that there was some media around the issue back then, and this is by Deborah Thomas-Pennell to Dr. Williams, "Here's the exact NTV story from the website. The reporter should have said the technology is more sensitive instead of "accurate", but we can't put every word in their mouths, unfortunately", and you're quoted in this. Do you recall doing an interview or speaking to Ms. Stokes?

MR. GULLIVER:

A. It wasn't really an interview. I remember getting a phone call from our communications people saying that this lady wanted to come in. Obviously, the story was broken within the public domain and she was interested in coming in to actually see the lab and see where the testing takes place. So I was the one who I was asked would I meet with her and just walk her through the steps of the

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laboratory process, and I think one of our communications people was with me.

CHAYTOR, Q.C.:

Q. And so did anyone other than yourself speak with Ms. Stokes?

MR. GULLIVER:

A. I'm not sure. I mean, she came into the pathology lab, we took her through the front end grossing area of the lab, she went through the main pathology lab, to the IHC lab, and took pictures of the instrumentation and stuff. I mean, along that way, I don't know if other staff spoke to her.

CHAYTOR, Q.C.:

Q. And it starts off, she says, "There was no mistake. New sophisticated technology became available and produced more accurate results. That's basically Eastern Health's explanation for why they are retesting eight years worth of breast cancer samples taken from patients in this province". Would you have given that?

MR. GULLIVER:

A. I would never have said what's written there like that. She--obviously, we explained to her that we do have new technology, it is more

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sophisticated. She actually seen the new technology.

CHAYTOR, Q.C.:

Q. And would you have told Ms. Stokes anything else in terms of what might potentially be an explanation for the changes in the results?

MR. GULLIVER:

A. I don't think I was ever asked that question.

CHAYTOR, Q.C.:

Q. Were you asked the question as to whether or not it was technology that may be the explanation?

MR. GULLIVER:

A. I don't remember being asked that question specifically, no.

CHAYTOR, Q.C.:

Q. And do you recall having said something, though, to Ms. Stokes, whether it's exactly what's written here as reported that you conveyed to her? You pointed out to her--you say you showed her the new equipment, and did you convey to her the sentiment that this is due to technology, or largely attributable or anything along those lines?

MR. GULLIVER:

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A. I don't think so. I mean, I would have explained to her that this is new equipment, we had older equipment, but I've testified here that I certainly don't believe our old equipment had anything to do with it, so I can't see how I would even say this here.

CHAYTOR, Q.C.:

Q. So why were you pointing out the new equipment to Ms. Stokes?

MR. GULLIVER:

A. Excuse me?

CHAYTOR, Q.C.:

Q. Why would--why were you pointing out to her the new equipment and the fact that there's new equipment?

MR. GULLIVER:

A. Well, she wanted to come in to get an overview of the whole pathology lab, and the IHC lab where it takes place. You know, I guess it's pretty--you know, I thought it was important there that this is newer equipment that we've had in place for the last year or so.

CHAYTOR, Q.C.:

Q. This is the middle of October, October 13th, 2005. What's wrong with telling Ms. Stokes

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what you knew up to that point in time in terms of what may be causative factors or what may have contributed to the issues?

MR. GULLIVER:

A. I don't think she ever asked me directly, like, what went wrong, or what is it.

CHAYTOR, Q.C.:

Q. Do you recall what discussion you did have with her then around that issue?

MR. GULLIVER:

A. I don't remember any detailed discussion with her. It was basically a general tour of the pathology laboratory. We took her through the steps and processes. I had the communications person with me, and pretty well any question that Ms. Stokes asked, my communications person said that, yes, go ahead and answer it, and it was really no different than when I had you and Mr. Coffey in the lab to show you a tour of the lab. It was that general kind of structure.

CHAYTOR, Q.C.:

Q. And it goes on to again reference the equipment. It says, "The equipment is considered more accurate than the old

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methodology. All samples will be double checked by Mount Sinai Hospital in Ontario. Terry Gulliver, Director of Laboratory Medicine Program at the Health Sciences Centre, says that 90 to 95 percent of patients won't be affected, but for those who are, it means they've likely received the wrong cancer treatments. All testing should be complete in a month, and only those affected will be contacted". Mr. Gulliver, where would you be getting the 90 to 95 percent figure in the middle of October, 2005?

MR. GULLIVER:

A. Well, again that's my belief and that's my belief today, that in this eight year time frame, that almost 3000 patients were originally tested and assessed for treatment, for hormone therapy treatment. You know, three years later, after going through as you've seen the thousands of hours of work to identify, review patients, have patients retested that could be affected, we know now that approximately 300 patients results changed. We know that a lesser number than that had to require a treatment change. So

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based upon our original approximately 3000 patients that, you know, 90 percent of the patients were done correctly right from the beginning.

CHAYTOR, Q.C.:

Q. Where in October, 2005, would you get that figure, 90 to 95 percent of patients won't be affected?

MR. GULLIVER:

A. Where did I get it?

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. Well, I knew by that time how many patients we had done, I knew how many patients were already positive, I knew the numbers of patients that were going to be sent off for retesting, you know, I had a fair idea how many of those patients were zero/zero or true negatives, I knew that a percentage of patients would be false negative irregardless if everything was done perfectly, and, you know, with my overall experience and background, I felt quite confident even back then that 90 percent of all patients who had

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this test performed over the whole time frame would not be affected or have a treatment change.

CHAYTOR, Q.C.:

Q. How did your experience and background help you come with the figure 90 to 95 percent?

MR. GULLIVER:

A. Well, my experience in pathology, my experience as a technologist in pathology, my experience as a pathology manager, my experience as director, and during this three months prior in being so involved in this here, that that was my feeling then and it's my feeling today, and I think the numbers have shown that today how many patients have been affected by it and how many have been adversely affected by it, it's certainly 10 percent or less.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, I'm just--so by mid October, 2005, you would have had results back? There were results back.

MR. GULLIVER:

A. We had some results back, yes.

CHAYTOR, Q.C.:

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Q. And you've told us that you would not have had any knowledge about that because those would be -

MR. GULLIVER:

A. No, no, I told you that -

CHAYTOR, Q.C.:

Q. Going to Dr. Cook.

MR. GULLIVER:

A. No, I never seen the exact percentage result changes, so if something was sent up that was zero/zero and came back 20/20, I didn't see individual patient results, but I was certainly aware of how many results either changed or didn't change.

CHAYTOR, Q.C.:

Q. Okay, so you were aware then by mid October what percentage of tests were changed?

MR. GULLIVER:

A. Any result changes, yes.

CHAYTOR, Q.C.:

Q. What percentage were changing?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And in telling to Ms. Stokes at this point,

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"90 to 95 percent of patients won't be affected", who are you referring to, what patients are you referring to?

MR. GULLIVER:

A. I'm referring to the breast cancer patients who had ER/PR testing done.

CHAYTOR, Q.C.:

Q. Overall breast cancer patients?

MR. GULLIVER:

A. Overall, yes, for the province.

CHAYTOR, Q.C.:

Q. And do you recall did Ms. Stokes ask you a specific question in that regard as to how many patients would be impacted?

MR. GULLIVER:

A. I don't think she did, no, no, it wasn't in that detail. I think she might have asked me just a general sentiment, you know, how many patients are going to be affected by this.

CHAYTOR, Q.C.:

Q. And this says that all testing should be complete in a month, and only those affected will be contacted. Did you tell that to Ms. Stokes?

MR. GULLIVER:

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A. I didn't do that, no.

CHAYTOR, Q.C.:

Q. You didn't tell her that?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. So wherever she got that information, it was from someone other than yourself?

MR. GULLIVER:

A. It could have come from our communications person. They could have got something from -

CHAYTOR, Q.C.:

Q. Were you present when the communications person would have said that?

MR. GULLIVER:

A. I don't think so.

CHAYTOR, Q.C.:

Q. That it would be completed in a month and only those affected would be contacted?

MR. GULLIVER:

A. I don't think so. I don't remember.

CHAYTOR, Q.C.:

Q. If we could have, please, 2368. Another one of those lists that you were comprising, broken down, DAKO and Ventana, the total

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results--total test, total results, total positive and total negative/negative, and I believe I may have shown you one similar to this last day, and I'm not sure, though, if I asked you about up here in the corner there's May '07 and your initials, TG.

MR. GULLIVER:

A. Yeah, they're mine.

CHAYTOR, Q.C.:

Q. And why is that there, why May of '07?

MR. GULLIVER:

A. I think because May '07, I went through and just sort of recounted the numbers to verify numbers, and I think the final time I do this here might be February of '08 maybe of this year.

CHAYTOR, Q.C.:

Q. And how would you be using these charts to verify your numbers? What does it mean, I guess, what does it signify for you to have your initials put up in the left corner?

MR. GULLIVER:

A. Now I think back in May '07, I think it was myself and Heather Predham, Ms. Predham, who kind of went through the numbers again. I

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think by this time, May '07, is when Ms. Predham and Eastern Health were preparing for the class action lawsuit and it was something to do with Mr. Crosbie, had to be filed in court on a certain date, because I remember I was in--in May '07, I happened to be in Hamilton, Ontario, at our national CSMLS conference, and while up there, that's pretty well what I did for the couple of days was dealing with some questions back and forth to prepare for the class action lawsuit.

CHAYTOR, Q.C.:

Q. If we could have, please, P-0455. This is an e-mail--it starts at the bottom of the page where it originates. It's an e-mail from Mr. Dyer to yourself, May 23rd, 2007, and he writes, "Hi Terry, Trish was notified Wednesday, May 23rd, at 1240 hours. She does not want the report to go public. Barry. Importance is high". What do you recall about this, Mr. Gulliver?

MR. GULLIVER:

A. Well, again this is the time frame, May '07, where I think Mr. Tilley has been asked for copies of the reports and I think he goes to

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Dr. Howell, whose my vice president, who comes to the lab program and says that the peer review reports from Trish and Dr. Banerjee, we got some indication that they could be released, made public, and could we make contact with Trish to just kind of let her know.

CHAYTOR, Q.C.:

Q. I'm sorry, so who did you understand was asking Mr. Tilley for copies of the reports?

MR. GULLIVER:

A. I was not told that.

CHAYTOR, Q.C.:

Q. So who came to you with this information?

MR. GULLIVER:

A. Dr. Howell asked myself and/or Barry to contact Trish to let her know.

CHAYTOR, Q.C.:

Q. Okay, and what was it that Dr. Howell asked you to let Trish know?

MR. GULLIVER:

A. That the reports may go public.

CHAYTOR, Q.C.:

Q. And how did you understand that would happen, who was going to be making the reports public?

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Did you question Dr. Howell on that and say, well -

MR. GULLIVER:

A. It was--my understanding was it could be government, somebody in government.

CHAYTOR, Q.C.:

Q. And did you understand that government had the reports?

MR. GULLIVER:

A. I had no idea if they did or did not.

CHAYTOR, Q.C.:

Q. And did you ask then Dr. Howell, well, how could that happen, how could these reports go public?

MR. GULLIVER:

A. No, I didn't.

CHAYTOR, Q.C.:

Q. And what other discussion then did you have with Dr. Howell? Did that seem unusual to you, were you surprised by that?

MR. GULLIVER:

A. That he asked me to do this?

CHAYTOR, Q.C.:

Q. No, that these reports could be made public.

MR. GULLIVER:

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A. With all this ER/PR testing, nothing would surprise me.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, at the time when Dr. Howell comes to you and tells you this, that the reports could be made public and that you should contact Ms. Wegrynowski, did you have any discussion with Dr. Howell around that?
MR. GULLIVER:
A. Nothing in detail, just that he asked if we'd do this here, and we did it.
CHAYTOR, Q.C.:
Q. And so he came to you with that, that these reports could -
MR. GULLIVER:
A. I don't know if it was a phone call or an e-mail that he made.
CHAYTOR, Q.C.:
Q. Yes, and it doesn't matter, but he comes to you or communicates to you that these reports could be made public and that wasn't a cause of any concern, question, or surprise by you?
MR. GULLIVER:
A. I can't say that it wasn't any cause of concern that, you know, these reports up to

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this point, you know, to my understanding all along, you know, I had a copy of each of them and, you know, I wasn't to share those or copy those reports, and now, you know, I'm getting this information from Dr. Howell that reports may go public, and I don't know if this is the same day or around the same time where, you know, the Premier has Dr. Ejeckam's memos in the House of Assembly. It's around the same-- it's around the same time frame. I know there's an awful lot of public attention on Eastern Health, and in particular on Mr. Tilley, around this time with the Burin radiology review and in conjunction with the hormone receptor testing, so I'm just placing it in that environment, and why I said to you I wouldn't be surprised of anything from this here.
CHAYTOR, Q.C.:
Q. And Dr. Howell would have been a relative newcomer to the whole situation?
MR. GULLIVER:
A. I think he's been there about a year by this time.
CHAYTOR, Q.C.:

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Q. And did you have any discussion with him about, well, Dr. Howell, I understood those reports to be somehow protected or peer review reports, if that was your understanding?
MR. GULLIVER:
A. I didn't have a discussion. I didn't think I needed to have a discussion. I just think that was an inherent part of our--what we all just assumed right from the start.
CHAYTOR, Q.C.:
Q. So what did you ask then Barry Dyer to do?
MR. GULLIVER:
A. I just asked Barry--because he had been in contact with Trish, you know, several times during her first visit to St. John's, and her second visit, and I knew he'd be able to--he'd have her contact information, and he'd be able to do that fairly quickly.
CHAYTOR, Q.C.:
Q. And what was it you asked him to notify her of?
MR. GULLIVER:
A. I think it was to notify her that the reports may go public and if we needed her permission to make them public, would she grant her

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permission, and she said, no, that she did not want her reports to go public and she didn't want her name to be out there in the public domain.
CHAYTOR, Q.C.:
Q. And Ms. Wegrynowski has indicated that Mr. Dyer told her words to the effect of the premier may be reading her reports. Do you recall any discussion about the premier being involved at all in this?
MR. GULLIVER:
A. I don't think it was the premier at all, no. I think it was -
CHAYTOR, Q.C.:
Q. And when Dr. Howell--sorry, go ahead.
MR. GULLIVER:
A. I think it was, like, you know, some lower level government official. I never--the premier was never discussed around this particular issue.
CHAYTOR, Q.C.:
Q. And you didn't discuss that with Barry Dyer?
MR. GULLIVER:
A. No. The only time the premier was ever brought into question was when the premier had

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Dr. Ejeckam's memo in the House of Assembly.
CHAYTOR, Q.C.:
Q. Which I think may be probably a week after this?
MR. GULLIVER:
A. I don't know, but I know it was in may, somewhere around this time frame.
CHAYTOR, Q.C.:
Q. Later in May, I could be wrong, but I believe it may have been a week later. And then so, Mr. Gulliver, the other thing is that Mr. Dyer puts the date and time in the e-mail. What was the importance of that? Why would it be important to document the time in which he had a telephone discussion with Ms. Wegrynowski?
MR. GULLIVER:
A. Well I guess Dr. Howell asked if we could contact Trish, you know, sort of ASAP. I guess that's just Barry's way of verifying that yes, you know, today I spoke to her at 12:40 and this is the, you know, this is what she says.
CHAYTOR, Q.C.:
Q. So you understood this was something imminent, this was going to happen fairly quickly, that

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these reports could be out in the public domain?
MR. GULLIVER:
A. I didn't know if they were going to be imminent, I just knew from Dr. Howell that he felt it was really important, he asked me--he said it was a priority, could we get this done ASAP.
CHAYTOR, Q.C.:
Q. And then you send this on to Dr. Denic about an hour and a half later. And why would you do that? Why are you sending Barry's response to Dr. Denic?
MR. GULLIVER:
A. Just to let Nash know, he's our clinical chief.
CHAYTOR, Q.C.:
Q. And why wouldn't you go directly back to Dr. Howell with it if Dr. Howell asked you to do this?
MR. GULLIVER:
A. I think I called Dr. Howell and told him that it was done.
CHAYTOR, Q.C.:
Q. And did you then have any further discussion

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with Dr. Howell about this?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And then ultimately it goes from Dr. Denic to Dr. Howell and from Dr. Howell to Mr. Tilley and he writes, "FYI for what it's worth. Oscar." Mr. Gulliver, did you hear anything else about this in the next day or so when the reports don't go public, did you ask anyone any questions about it or what happened to all of this?
MR. GULLIVER:
A. I don't think I asked any questions in particular and again, I can't tell you if this information is something that I found out a few days after this here or it could have happened six months after, you know, through all this time frame. To the best of my knowledge after all this here, I think it was either the assistant deputy minister or deputy minister who had asked Mr. Tilley for a copy of the reports.
CHAYTOR, Q.C.:
Q. And who told you that at the time?

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MR. GULLIVER:
A. I don't know if it was anybody in particular or if it came up just at one of our meetings where I would be there and Dr. Howell would be there and Pat Pilgrim was there, you know, a group of key players dealing with this issue over this time frame.
CHAYTOR, Q.C.:
Q. And do you recall that being discussed, the fact that there had been a request of Mr. Tilley and whether or not the reports could be given to Cabinet?
MR. GULLIVER:
A. I don't know if it's as much of a discussion or it was just a matter of a statement that was made.
CHAYTOR, Q.C.:
Q. And nobody had any reaction to that?
MR. GULLIVER:
A. No, I think the next thing I remember, you know, I don't remember how much, how long after this here that Mr. Tilley submits his resignation, and again, I can't tell you the time frame -
CHAYTOR, Q.C.:

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Q. That's a couple of months later.
MR. GULLIVER:
A. - when I was made aware that it was like, you know, a lower level government official who had asked for a copy of the reports, I think it was the deputy minister.
CHAYTOR, Q.C.:
Q. And so that was discussed in a meeting or mentioned in a meeting.
MR. GULLIVER:
A. Probably mentioned more than anything as opposed to discussed, yeah.
CHAYTOR, Q.C.:
Q. And no discussion came out of that.
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. No discussion came forth as to well, you can't be giving the reports out, why would he make this request, nobody raised any concern?
MR. GULLIVER:
A. I can't say nobody raised concern, but I can't repeat to you what people's concerns were.
CHAYTOR, Q.C.:
Q. Or you can't recall any discussion about the

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issue?
MR. GULLIVER:
A. No, I just think it was just a matter of fact that that's the statement that was made, that the deputy minister or assistant deputy minister had asked for a copy of the reports.
CHAYTOR, Q.C.:
Q. And do you know whether or not that happened, whether or not any reports were provided?
MR. GULLIVER:
A. And I never heard anything, if it was either given or not given.
CHAYTOR, Q.C.:
Q. And you had no further discussion with Dr. Howell or anyone else as to what happened as to this request for the reports and you had to contract, or Barry on your behalf, had to contact Trish Wegrynowski and then over the next few days, the reports aren't public -
MR. GULLIVER:
A. Well I know the reports don't go public, I mean obviously I know that.
CHAYTOR, Q.C.:
Q. Yes, and do you discuss that or ask anyone what happened?

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MR. GULLIVER:
A. That wasn't discussed at my level, no.
CHAYTOR, Q.C.:
Q. And you don't, you don't have any conversation with anyone around that?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And you weren't curious, you didn't wonder about what had happened?
MR. GULLIVER:
A. I just think we had too many other things to be worrying about within the lab.
CHAYTOR, Q.C.:
Q. And if we could have, please, P-2676?
MR. GULLIVER:
A. Even, I think, Ms. Chaytor, you know, it's not long after this where I go to George Tilley's office and spend a considerable amount of time talking about Dr. Ejeckam's memos.
CHAYTOR, Q.C.:
Q. Yes, it's after this, yes.
MR. GULLIVER:
A. And, you know, even during that hour or two, it was never brought up or discussed about the

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peer review reports or the events around the week prior.
CHAYTOR, Q.C.:
Q. And do you know whether or not Mr. Tilley had even up to that point in time when you're sat down talking about Dr. Ejeckam's memos, whether or not Mr. Tilley had seen the peer review reports?
MR. GULLIVER:
A. I have no idea if he did or if he didn't and he never mentioned it. It was never discussed, no.
CHAYTOR, Q.C.:
Q. They weren't discussed with you at all.
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And this is an e-mail from Ms. Predham to Drs. Howell and Denic, May 24th, 2008. I've jumped ahead here, no, 2007, sorry.
MR. GULLIVER:
A. It's 2007, that's 8:00 in the morning.
CHAYTOR, Q.C.:
Q. 2007, it's up here, yes. "We never looked at regional differences before, what would you

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like me to have ready for 10. I'll see what I can do. Also Terry had a sheet done up of the numbers of tests by region on it. There were some error in the last one I received, but he did up a final one for Jamie Bussey. Do either of you have that or do you want me to get it from him? Do you want to chat before 10?" I should just take you to the original question, was Dr. Howell to -

MR. GULLIVER:

A. I think you see that that's the May '07 written on my spreadsheets to update the numbers for Ms. Bussey.

CHAYTOR, Q.C.:

Q. Yes. And the second question here, were there regional differences in results of retests? And he had been on a conference call with Minister Wiseman and then this says, "Please get numbers from Terry, otherwise, don't worry, we will chat, we will deal with it on the call." And do you know, Mr. Gulliver, whether or not there was any analysis of regional differences in the results of retests?

MR. GULLIVER:

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A. Not to my knowledge at that time, no.

CHAYTOR, Q.C.:

Q. And so what numbers is it that you would be able to -

MR. GULLIVER:

A. I think the numbers that Heather is talking about is what you see in my May '07, just to verify every year the total test, the positives, the negatives and the total numbers for ER/PR.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-2930? And these notes belong to Dr. Alteen and they're notes of a conference call May 24th, 2007. And were you on that conference call?

MR. GULLIVER:

A. I think this one here, I think I was over in Dr. Howell's office and so was Heather and Dr. Denic.

CHAYTOR, Q.C.:

Q. Yes, you're indicated, according to his notes that you are there.

MR. GULLIVER:

A. Yeah, we're over in Dr. Howell's office and I think this was some call they were talking

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about putting ER/PR testing back in place.

CHAYTOR, Q.C.:

Q. For the other regions?

MR. GULLIVER:

A. For the other regions.

CHAYTOR, Q.C.:

Q. Because you're already on line for St. John's, and what do you recall about this conference call?

MR. GULLIVER:

A. I guess it was just giving an update of that point in time where we were within St. John's for doing the ER/PR testing back in place, what kind of numbers we have seen from February up until this point in time in specimens that were being sent out and correlated with Mount Sinai. The bigger discussion here, as I mentioned earlier this morning, was more to do with are we ready to put testing back in place for the rest of the province. And the discussion centered more around the HER2/neu receptor test, as opposed to ER/PR. The sentiment outside St. John's was well, you know, if we got to send the block up to Mount Sinai for HER2/neu and send

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a block to Health Sciences for ER/PR, it would still be more efficient to send the original block to Mount Sinai, still have our ER/PR, HER2/neu done at Mount Sinai so we got the full picture, as opposed to doing, you know, sending them to St. John's, then Toronto, it would take a lot longer to get that done. And it was kind of felt that, you know, until St. John's has our HER2/neu full automated, that they would continue with this practice until that was done.

CHAYTOR, Q.C.:

Q. On page 3 then of the exhibit and you'll see throughout his notes he attributes his--this is Dr. Alteen again and he's attributing different comments to different people. And on page 3, he's got another comment that he attributes to you, "If tissue is over fixed, may cause issues with antigen/antibody and there is new information (? what year) around this that will be shared (this is part of quality improvement)". What do you recall having said on the conference call in that regard?

MR. GULLIVER:

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A. I would probably, and I mean, I certainly can't judge how he's taking his notes, oh you can see it down here, look. Up there, I would have talked about under fixation and/or over fixation.

CHAYTOR, Q.C.:

Q. Yes, but what new information, it says "there is new information around this that will be shared."

MR. GULLIVER:

A. I think the new information maybe came from myself or Nash in talking about like standardized fixation for the province and doing that kind of thing.

CHAYTOR, Q.C.:

Q. And that it would then be the intention of Eastern Health to share that with the other regions?

MR. GULLIVER:

A. Yes, yeah.

CHAYTOR, Q.C.:

Q. The standard protocol that you are developing.

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

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Q. Is that what that is?

MR. GULLIVER:

A. Yes, there was nothing in there about information about statistics or, you know, we found out this many changed results of over or under fixation, that was never--nothing like that.

CHAYTOR, Q.C.:

Q. Okay, and the comment here "This is part of quality improvement", and again, I understand this is someone else taking notes as to what you may be saying, but do you recall -

MR. GULLIVER:

A. I don't think I said that.

CHAYTOR, Q.C.:

Q. You don't think you said that.

MR. GULLIVER:

A. I think in his mind is probably, yeah, this would be part of a quality management system or program or something like that.

CHAYTOR, Q.C.:

Q. And then the second bullet that appears to be attributed to you is "Technological advances have helped with over/under fixation issues."

MR. GULLIVER:

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A. Yes.

CHAYTOR, Q.C.:

Q. What would that be referring to?

MR. GULLIVER:

A. That would be referring to that, you know, and this is just my belief and what you look at, that on the Ventana system, that you know, if you have the automated on-board antigen retrieval which is certainly a much more controlled environment than boiling on a hot plate on a work bench that we have seen that that can help compensate a bit more for either over or under fixation.

CHAYTOR, Q.C.:

Q. So you're saying that the introduction of the Ventana system may have helped with any issue of inadequate or over fixation?

MR. GULLIVER:

A. I don't think it solves everything, but I think it is still helps more than the old way and I think the Ventana system and again, I'm not--I never used the system, I think Ventana also uses a higher pH for the antigen retrieval buffer or citrate solution.

CHAYTOR, Q.C.:

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Q. And then you're quoted on page 4--note quoted, sorry, there's notes attributed to you, "when a pathologist who was responsible for this left the reporting of the slides were decentralized", I take it you're referring--if you made this comment, that's Dr. Khalifa?

MR. GULLIVER:

A. Dr. Khalifa, yes.

CHAYTOR, Q.C.:

Q. "And wished to centralize processing and interpretation again."

MR. GULLIVER:

A. Again, I think it was my opinion at this time and still is, that if St. John's is--the St. John's lab has always had--sorry, Newfoundland has always had one lab that performed this testing at the Health Sciences, so the technologists, you know, for many years it was Mary and Peggy, now, you know, we had one retire and Les and Ken moved in there, that I believe that if this province is going to have ER/PR testing, that it should be the one lab doing the testing and it should be one with the pathologist doing the interpretation for all the province, that we should not be doing

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slides and sending slides back across the province for other pathologists to interpret, it should be done on a provincial basis.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-1263? And Mr. Gulliver, this is an e-mail from Ms. Predham again and it goes to yourself and others and it's May 31st, 2007 and she's asking "In relation to recent developments, I'm going to need information from a claim's perspective ASAP. I'm just going to need a complete set of all the minutes of the surgical pathology review committee. Was there any other similar committee in existence before this? I also need a good description of the other antibodies listed. How many tests have been run using these antibodies when we dilly start and stop. I guess what I need is complete description of all IHC tests and what concerns have we been having in these areas." And did you provide any information to Ms. Predham in response to those questions?

MR. GULLIVER:

A. I'm guessing either I did or Mr. Dyer did from pathology.

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CHAYTOR, Q.C.:

Q. And would that have been provided in writing? Would there be a written document?

MR. GULLIVER:

A. I don't know if it did or not, Ms. Chaytor. It might have been that Heather came to the office and her and I and Barry talked about it. We may have given her, talked about the list of antibodies of April 4th, that's the eight that Dr. Ejeckam stopped and wanted to review and optimize. We may have just gave her a basic overview of how many tests are run in the IHC lab on a yearly basis. She wanted to confirm dates when testing stopped April 4th, '03, when did testing go back in place. So it may have been just a meeting in our office and just talked about those things.

CHAYTOR, Q.C.:

Q. And it's about those eight antibodies that were stopped back in 2003, is that what you understood this to be?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And why as of May 31st, 2007, had this become an issue?

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MR. GULLIVER:

A. Well reading this here, I think it's two things, I don't know the date where I had to go and see Mr. Tilley where the Premier had the memos up in the House of Assembly. Again, you know, side by side with all this here, we have requests coming in from both Mr. Crosbie's office looking for a verification of documentation and then we have our representatives in the Class Action lawsuit, Ms. Bussey, Mr. Boone, who were looking for information -

CHAYTOR, Q.C.:

Q. Okay, and you don't need to tell me about that, that's fine, Mr. Gulliver. If we could have, please, P-1418? And this is an e-mail from Ms. Predham, again June 20th, 2007 and it's to you, amongst others, and if we just scroll down on the bottom, I believe here she's looking for some assistance, "As you can see when you read the attachment, I'm going to need some assistance in answering interrogatories, there's a ten day time period."

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MR. GULLIVER:

A. Again, this is for a Class Action lawsuit.

CHAYTOR, Q.C.:

Q. Yes, and did you provide any assistance to Ms. Predham in answering the interrogatories?

MR. GULLIVER:

A. I don't remember exactly. She might have been, again, asking for statistics, I'm not sure.

CHAYTOR, Q.C.:

Q. She also writes, "I'm double checking the list at this moment to get it over to the lab, I've been a bit delayed with the other issues going on. One thing I did discover is that someone called last December about retesting their family member who was not even on our list and the block and report had to be obtained from Western as it had not been sent in for the review. I'm not sure if this was someone who was overlooked or did the regions not send in their known deceased." And then she directs that question specifically to you, Nash or Don. Do you know the answer to the question? Did the regions -

MR. GULLIVER:

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A. I think she answered it herself.
CHAYTOR, Q.C.:
Q. Did the regions send in their known deceased or not?
MR. GULLIVER:
A. I think some did and some didn't. I think central or Gander or Grand Falls, when they sent in their batches, one of them sent in their deceased patients or most of them, but the other regions, I don't think they sent them in until later on.
CHAYTOR, Q.C.:
Q. And in terms of the sharing of information between the group handling it back in 2005 and 2006, and Ms. Predham not being sure as to what the other regions may have done, looking back on it in terms of co-ordinating the effort, was there any lack of communication or difficulties in communication because there were multiple people dealing with different aspects?
MR. GULLIVER:
A. I certainly think that things would have been more smooth if we had to have a dedicated team in place who dealt with this issue from start

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to beginning (sic.). I don't think when we started this in July '05, any of us had any idea that we would be here three years later testifying at a Commissioner of Inquiry, going through all the legal stuff, but certainly, I mean if Eastern Health had appointed a team of people immediately and that was their fulltime job, I think it would have made things smoother. Whether it would have improved communications between St. John's and the other regions, I mean, I can't speak for it. One would think that it would have.
CHAYTOR, Q.C.:
Q. Or even in terms of within Eastern Health itself.
MR. GULLIVER:
A. Oh no, even--I've said to this day that myself, for example, and Barry and Heather and Dr. Cook and Dr. Denic, we've all done so much, you know, work on this and we've done our own pieces of it, that even if we all had to have been reassigned to work in a room like this, that we could actually easily just speak to each other instead of trying to voice mails or e-mails or getting Heather who was at the

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Miller Centre, I'm at the Health Sciences, Dr. Cook and Nash and Dr. Carter were at St. Clare's, you know, even if we all came together in one facility, it would have been much better.
CHAYTOR, Q.C.:
Q. And P-2379 please? And this is an e-mail that you sent to Ms. Pilgrim and others on July 9th, 2007 and you write that "Pat: Barry Dyer and I have now finalized the list that was given on Friday. We have cross-referenced each of the 80 plus patients with our original master sheets. We have reviewed all reports for each patient and documented or found why they were not sent for retest yet. We have created a new template like our originals with all the patient's info. We are now ready to start pulling original block slides for review and retest, so we need one, six patients on our original list that are deceased were not on the list given Friday. Should we retest them anyway? Two, some patients have already been retested with no result change. Do we need to retest again? Three, one patient has no evidence of breast cancer but is asking to

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be retested. And fourthly, several patients on the list are from out of town, so who should we call and request the blocks?" Mr. Gulliver, what's this about? First of all, you have cross-referenced each of the 80 plus patients with your original master sheets. What's happening in July of '07?
MR. GULLIVER:
A. Again, this is now getting finalized and the list of patients who were deceased who had not been retested and there were a few others on that list that were added and it was pretty well, what we call self identifiers, if a patient had called through either being informed through media contact or how, this whole issue, I was given a list of, I guess 80 plus patients from Pat and/or Heather to say here's our list that we have of patients who need to be retested who are deceased.
CHAYTOR, Q.C.:
Q. So these were all deceased patients, this 80 plus?
MR. GULLIVER:
A. Yes, and there were a few other ones that weren't, they were sort of self identifiers,

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so I, myself and Barry, we cross-referenced their list with our original master log spreadsheets. What came up there is that I had six patients in total from my eight years who on my list were identified as being deceased, but they were not on this list that Heather had gotten. And I think they got this from the mortality information or where they get them from, and again, there were some patients on there who already were retested. Again, I mention to you that some patients were sent up that retested, they weren't originally identified as being deceased.

CHAYTOR, Q.C.:

Q. You've indicated here that some patients have already been retested with no result change, do we need to retest again?

MR. GULLIVER:

A. Test them again, yeah.

CHAYTOR, Q.C.:

Q. Why would you do that if they had already been retested?

MR. GULLIVER:

A. Well, they were coming back to me on this list, so my question was if these patients

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have been done and there's no change in results, should we send them off again for another retest? And I remember this one here too, there was one patient who had called in and asked to have a retest done, but there was no records anywhere that this woman ever had breast cancer, so it was a different kind of cancer.

CHAYTOR, Q.C.:

Q. So she's someone who had an ER/PR test done.

MR. GULLIVER:

A. She never had an ER/PR test ever done.

CHAYTOR, Q.C.:

Q. And the patients who are self identified, when that would happen, that a patient would come forward and identify him or herself, would you then undertake any kind of a review to find out well why that person wasn't on your original list?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. And so what would you do and how would you go back and track through and figure that out?

MR. GULLIVER:

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A. Well I would go through, you know, if we did have a patient like that and obviously you're well aware we have had them. If the patient was from St. John's, I mean, I would go through my original spreadsheets to see if the patient was on my original spreadsheet. If the patient wasn't on my original spreadsheet, I would go back through the original reports that I printed off to see, you know, was it a matter of this patient's report was stuck to another patient's report, you know, and that's how I didn't get them onto the spreadsheet. And then I would go into our Meditech system, use the MCP number and print anything in pathology that this patient ever had done and try to figure out, you know, why, if this patient is coming forward--now lots of patients came forward and they were positive, but you know, the ones that would be most concerning were the ones who came forward who were, on reading their pathology reports, they were negative. And they should have been picked up, you know, in 2005 or early '06, through all the work that we've done. Again, I've testified that a number of patients

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weren't picked up because there was no ER/PR procedure ordered in the Meditech computer system. I remember coming across a couple that there was an ER/PR procedure ordered, but there was no result in the patient's pathology report. So you didn't know if it was positive or if it was negative, there was a couple of those.

CHAYTOR, Q.C.:

Q. And when that happened, when you came across those pathology reports like that, what did you do at the time?

MR. GULLIVER:

A. Well we'd go to--at the time it would go to Dr. Denic. We made sure Dr. Denic would pull the original slides and have a look at the original slides.

CHAYTOR, Q.C.:

Q. So no patient was missed because of that.

MR. GULLIVER:

A. No, no.

CHAYTOR, Q.C.:

Q. And if we could look at P-2129 please? And this is an e-mail from you to Reza on July 24th, 2007 and your re: is ER/PR clinical cut-

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off points. And you write, "Reza, as per your request, here is a summary of the guideline processes used from July 2005 onwards to select patients for possible retest at Mount Sinai." And then you have a list here of some ten points as to how you and Mr. Dyer went about selecting the patients for possible retests. Why in--this is July again now, 24th, 2007, why are you doing this at this point?

MR. GULLIVER:

A. Well this is, I think the first time I met Reza and I was waiting for you to pronounce his last name.

CHAYTOR, Q.C.:

Q. We'll just call him Reza, thank you.

MR. GULLIVER:

A. And I'm going to call him Reza too. This was when we first met Reza. He was--well NLCHI, as you know, were seconded by government to assist Eastern Health in creating a true database for ER/PR testing. This is their very beginnings and Reza's first assignment from and I guess it was Robert Thompson who was assigned this task, you know, by the

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Premier, was to sort of give him a review, a summary of what was done to identify patients right from the beginning and they were still in a decision-making mode of if we're going to create a database, how should we go about it, what information do we need to access and how complete should we have this database because there was some discussion about should the database be the patients who are retested or should the database be every patient who had an ER/PR test ever performed, positive, negative, weak positive, makes no difference what their status was. So this was my first introduction with Reza and giving him an update of what he asked for.

CHAYTOR, Q.C.:

Q. And so firstly you indicate that you and Mr. Dyer compiled by year every ER/PR test performed at the lab and I take it that's every ER/PR test done on primary breast?

MR. GULLIVER:

A. Yeah, well, the list included all ER/PR tests in the search. We narrowed it down then to the ER/PRs on primary breast.

CHAYTOR, Q.C.:

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Q. Now we had the 2700 number though that we referred to as being all of the pathology reports you've -

MR. GULLIVER:

A. That's pretty well the primary breast ones now.

CHAYTOR, Q.C.:

Q. Those were just primary breasts, right.

MR. GULLIVER:

A. There might have been 3000, total of all the ER/PR tests performed.

CHAYTOR, Q.C.:

Q. And this was all the tests done at the Health Science lab, including those done for the regions outside St. John's?

MR. GULLIVER:

A. Correct.

CHAYTOR, Q.C.:

Q. And you say, "We then reviewed each pathologist report and created a manual spreadsheet for each year using the following criteria that's decided by the oncologist." And then you give the cut-off points that were used, so from 1997 to 2000, every patient that was negative negative or 00 to be logged on

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spreadsheet and all patients with staining 30 percent and less.

MR. GULLIVER:

A. 30 percent and less.

CHAYTOR, Q.C.:

Q. To also be logged. Okay, so it was the 00's and patients with 30 percent and less.

MR. GULLIVER:

A. 30 and less, yeah.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. And then zero, zero and ten or less for the next four years.

CHAYTOR, Q.C.:

Q. And I guess my question is, again, was it zero, zero or was it--why, I guess, are you differentiating zero, zero or not just saying any one with an ER less than 30 percent? Wasn't that the criteria set by the oncologists?

MR. GULLIVER:

A. It makes no difference. If you say anybody less than 30 or, I guess, my point I'm making here to Reza is that anybody who had a

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negative, negative or zero, zero, they were automatically put on the spreadsheet and retested.

CHAYTOR, Q.C.:

Q. And then 2001 to 2005, every patient that was--and again, you say negative, negative, or zero, zero, and all patients with staining ten percent or less to be logged. These were the clinical cut off points provided. So again -

MR. GULLIVER:

A. Understand now, I'm doing this now for another brand new organization being involved in this issue, and this is trying to be very simple for Reza to understand the processes that we used.

CHAYTOR, Q.C.:

Q. Okay, and then thirdly you say, "once Barry and I finished the spreadsheets, we then reviewed with Dr. Cook to identify the patients that needed to then have their pathology blocks retrieved and sent to Mount Sinai for retesting. Dr. Cook chose Mount Sinai as they were still using the DAKO reagents equipment, as we were during the period of 1997 to 2004, and also they're an

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accredited lab and could handle this huge retesting task." So after you had finished your spreadsheets, you then reviewed with Dr. Cook to identify the patients that needed to have their blocks retrieved?

MR. GULLIVER:

A. And again, most of the ones we reviewed with Don were the ones that were sort of those, the grey zone ones.

CHAYTOR, Q.C.:

Q. The ones that the numbers were -

MR. GULLIVER:

A. 25 to 30, you know, those kinds of ones.

CHAYTOR, Q.C.:

Q. So then fourthly, "any patients with staining that was close to the cut off points were then taken by Dr. Cook to the oncologist to review patient to determine if the patient had already received hormone therapy. This was done pretty well a couple of times per week for several months until all patients were reviewed and then sent for retesting."

MR. GULLIVER:

A. Again, it's those grey ones. They're the ones I would give to Dr. Cook, and my understanding

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was, then he would speak to the oncologists to ensure did those patients, were they already receiving hormone therapy or not.

CHAYTOR, Q.C.:

Q. And again then, the ones that was close to the cut off points, what did you understand close to mean?

MR. GULLIVER:

A. Again, I just said, like 25 to 30 or the 10 to 15s or the five to tens, depending on the years.

CHAYTOR, Q.C.:

Q. And you understand -

THE COMMISSIONER:

Q. So is it your understanding that when Dr. Cook was eliminating those who had already received hormone therapy, he was doing that just for this group that was in that narrow band?

MR. GULLIVER:

A. Yes.

THE COMMISSIONER:

Q. So for example, for somebody who might have received hormone therapy because they were positive PR, you would not have eliminated that person?

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MR. GULLIVER:

A. And if they were negative ER?

THE COMMISSIONER:

Q. Yes.

MR. GULLIVER:

A. They wouldn't be eliminated, no.

THE COMMISSIONER:

Q. Okay.

CHAYTOR, Q.C.:

Q. And how did you know that was happening, that Dr. Cook was going to the oncologists with any -

MR. GULLIVER:

A. That's what he told me that he was doing.

CHAYTOR, Q.C.:

Q. He told you this was happening?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And again, it was only for those that were close to the cut off point?

MR. GULLIVER:

A. The ones that I would make sure put on top of the pile for him to make sure to check.

CHAYTOR, Q.C.:

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Q. Okay, and there was no other weeding out of patients on the basis of them having received hormonal therapy?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And then number five, "after this review by Dr. Cook and oncologists, Barry and I then cross referenced the retesting spreadsheets with the deceased list given by Heather Predham and removed them from the retesting. It was decided that we needed to retest the living first," and so the list that Ms. Predham gave you, where did you understand that list came from? Was that a list that had any kind of identifier on it to say who had compiled the list?
MR. GULLIVER:
A. I think Heather said she got them from the--I don't know if it was the Cancer Registry keeps a deceased list, something like that.
CHAYTOR, Q.C.:
Q. And was there any date, do you know, on the list that was provided to you?
MR. GULLIVER:

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A. I can't remember.
CHAYTOR, Q.C.:
Q. And have you ever heard of any concern regarding whether or not that was a complete list that you were provided?
MR. GULLIVER:
A. Oh, I've heard concerns that the list wasn't complete.
CHAYTOR, Q.C.:
Q. And you've since learned that, I take it?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. "We now had a final list of retests for the St. John's patients. When the lab technologists retrieved the original blocks and slides for each patients, these were reviewed by the pathologists to ensure the original testing block was acceptable for retesting." So in terms of, though, on the issue of the deceased, I take it by--you're writing this by July of 2007. Up to this point, when you're giving Reza this information, you weren't aware of any deficiency in the deceased list?

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MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. That's something you learn about later?
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay, and then "while Barry and I are doing all this for St. John's patients, Dr. Cook had written to all the other labs in the province informing them that we are going to retest all the province that had test performed. In Dr. Cook's letter, he outlined the guidelines used by St. John's to determine if a patient needed to be retested. He asked that if the pathologists, technologists in each lab review all their ER/PR results and send to Barry Dyer and myself. We received batches of patients and their original slides, blocks and control slides every week for a couple of months. Each batch received by Barry and I, we then made a retesting spreadsheet for the referring site." So you made a separate spreadsheet for each of the other sites?
MR. GULLIVER:

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A. For the Corner Brook send outs, yeah.
CHAYTOR, Q.C.:
Q. Okay, for example, you say Western Memorial.
MR. GULLIVER:
A. For example, yeah.
CHAYTOR, Q.C.:
Q. By year, and you did that by year. "This was exactly the same as we did for the St. John's patients." And then you go on to say that, "remember that Mount Sinai by then had already received hundreds of blocks for retest and we're starting to get results back from the St. John's patients and still packing up out of town blocks and sending." So while you're receiving in the blocks from outside regions and the slides from outside regions, the test results are coming back in for St. John's?
MR. GULLIVER:
A. We're starting to get some of the early St. John's batches.
CHAYTOR, Q.C.:
Q. And then you say, "the out of town patients were reviewed by the pathologists from the referring site to determine the clinical cut off, as provided by the oncologists. The

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block/slides were reviewed by our pathologists to ensure we had a good block for retesting." So the blocks and slides that came in from outside St. John's were reviewed by our -

MR. GULLIVER:

A. By our pathologists.

CHAYTOR, Q.C.:

Q. By Eastern Health pathologists.

MR. GULLIVER:

A. Before we sent them off, yes.

THE COMMISSIONER:

Q. So that (inaudible) of what you said this morning, just for the purpose of ensuring that -

MR. GULLIVER:

A. Ensuring it was a good block to send off.

THE COMMISSIONER:

Q. - it was a good block to send.

MR. GULLIVER:

A. A representative.

THE COMMISSIONER:

Q. And not for any purpose like Dr. Cook might have done for the St. John's patients?

MR. GULLIVER:

A. No, no.

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CHAYTOR, Q.C.:

Q. And by this point in time, it appears you are aware that--it says about the issue about the deceased patients.

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Discovered the out-of-town results.

MR. GULLIVER:

A. Yes, I think it was Central or Gander, one of them, sent in, with their original batches, all their deceased ones too.

CHAYTOR, Q.C.:

Q. Yes, okay, that they hadn't reviewed them to take away the deceased patients.

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. And "once results started to come back, they were reviewed by our pathologists and then the results, new results from Mount Sinai were added to the patient's original report and a new report generated." And after that, you say you and Barry had very little involvement after the results came back.

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THE COMMISSIONER:

Q. Ms. Chaytor, whenever you can find a spot, we'll take the afternoon break.

CHAYTOR, Q.C.:

Q. So I take it, Mr. Gulliver, this is still a fair representation of the process that you -

MR. GULLIVER:

A. Yeah, I think it is, yeah.

CHAYTOR, Q.C.:

Q. - you went through at the time?

MR. GULLIVER:

A. Yeah, and again, you can see, you know, the amount of time that this whole process was taking.

CHAYTOR, Q.C.:

Q. Yes. Mr. Gulliver, in terms of dealing with results coming in from out of town, for out-of-town patients, did you -

MR. GULLIVER:

A. Results you mean or blocks coming in?

CHAYTOR, Q.C.:

Q. I'm sorry, the blocks coming in.

MR. GULLIVER:

A. Okay.

CHAYTOR, Q.C.:

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Q. And contact that you would have had with out-of-town pathologists, did you have any discussions in the summer of 2007 with Dr. Baker from Carbonear about patients that may have been overlooked from that region?

MR. GULLIVER:

A. I don't think Gary--that wasn't the summer. I think that might have been September.

CHAYTOR, Q.C.:

Q. Okay. Were you involved in that then? Did you have discussions with him on that?

MR. GULLIVER:

A. No, I think Dr. Baker had a conversation with Dr. Howell and they were discussing other things and I think Dr. Baker informed Dr. Howell that he may have overlooked some patients when he reviewed the Carbonear ones.

CHAYTOR, Q.C.:

Q. But you had no direct involvement in it?

MR. GULLIVER:

A. Well, Dr. Howell asked me to contact Dr. Baker.

CHAYTOR, Q.C.:

Q. Oh, okay.

MR. GULLIVER:

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A. And ask him, and say "look, if you have any concerns, send the blocks to myself and Barry and we would have them sent off and retested immediately."

CHAYTOR, Q.C.:

Q. And is that what then happened?

MR. GULLIVER:

A. And that's what happened next, yeah.

CHAYTOR, Q.C.:

Q. Okay.

MR. GULLIVER:

A. And most of those, I think, were--I think there were ten from the Carbonear region, and I think most of them had a degree of positivity originally and they were those kind of grey ones, you know, like the 20-25, 25 to 30, that I think Dr. Baker assumed that they would have been interpreted as positive by the clinicians, by the oncologists and that's why he didn't put them in his first go around in 2005.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-3098? And this is an e-mail forwarded on behalf of Ms. Pilgrim to yourself and copied to Ms. Predham.

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It's September 20th, 2007. "Terry, please review the attached letter from NLCHI ASAP and call me tomorrow on my Blackberry" and then there's a letter here "five separate lists of breast cancer patients for which the Centre is asking for assistance in determining their status. Where possible, we ask that Eastern Health provide the Centre with one of three responses: documentation that addresses the request noted for each table, confirmation that the patient specimen in question was the responsibility of Eastern Health, but no documentation is available to address the Centre's request, or thirdly, the patient specimen was not provided to Eastern Health, and is the responsibility of the health authorities listed." And there's a number of those or a few anyhow of those letters that go back and forth around this time period.

MR. GULLIVER:

A. Again, this is during the database documentation and creation of it.

CHAYTOR, Q.C.:

Q. And what would your role be then in terms of going through when you would be faced with a

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letter like this? What was your role in trying to assess this?

MR. GULLIVER:

A. It would be a combination of--it would be just to verify that was this patient an original test that came from Western or Gander, Grand Falls? Was it a St. John's patient? Sometimes it involved going back into the Meditech computer system and get, you know, documentation to verify what was in this, in the table, because NLCHI would not sort of finalize or include a patient in the database unless they had the actual documentation, verify the documentation to include there. So for many different reasons, it could have been why they're asking.

CHAYTOR, Q.C.:

Q. Okay. Thank you, Commissioner.

THE COMMISSIONER:

Q. All right. We'll take the afternoon break.

(BREAK)

THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Registrar, if we

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could have, please, P-1602? And Mr. Gulliver, this is entitled "major changes, improvements for IHC lab." Did you prepare this document?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay, and why did you prepare this and do you know when it was prepared?

MR. GULLIVER:

A. I don't know exactly when I did that one.

CHAYTOR, Q.C.:

Q. Would it have been something that Dr. Howell asked you to do?

MR. GULLIVER:

A. I think Dr. Howell maybe, yeah, and it might have been September '07.

CHAYTOR, Q.C.:

Q. And in terms of putting together the information in it, would anyone else have worked on this or is this just within your own sphere of knowledge?

MR. GULLIVER:

A. I think that's just from my own, yeah.

CHAYTOR, Q.C.:

Q. Okay, and so the major improvements that

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you've indicated are under technology, and then under training, you've got "a tech spent two weeks at Mount Sinai and one spent two weeks at Jewish General. Three techs dedicated to IHC" and you've "secured annual funding for one tech to go to the NSH conference in the U.S. One tech was going to Arizona for training on Ventana. Dr. Ejeckam, ongoing training with staff for controls, and planning, at that point, to send Dr. Elms to Dr. Gown's lab for training."

Under your staffing, you "had approval for the four pathology assistants, approval for one QA tech" and what's a QA tech?

MR. GULLIVER:

A. Oh, that was the quality assurance technologist in pathology. So that would be an experienced pathology tech and now her new full-time role would be working with Dr. Bev Carter and starting the SOPs, policies, the writing, the templates and those kind of things.

CHAYTOR, Q.C.:

Q. And who was it? Was that Catherine Parnell?

MR. GULLIVER:

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A. That was Catherine Parnell, I think, at this time, yeah.

CHAYTOR, Q.C.:

Q. Okay, and who fills that position now?

MR. GULLIVER:

A. Ms. Bev Rowe, because Catherine Parnell retired in May, I think May of '07.

CHAYTOR, Q.C.:

Q. Okay, and approval for Dr. Carter, part-time QA pathologist. And then under proficiency, you're enrolled in the two different programs. In terms of any work done on internal controls or any education in that particular area, that's not mentioned here. Is there any reason why that would be, in terms of improvement of any knowledge of pathologists for example?

MR. GULLIVER:

A. Again, that would not really be my thing to put in here. That would have to come from the clinical chief.

CHAYTOR, Q.C.:

Q. And I believe that was on your spreadsheet of recommendations, the issue of internal controls?

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MR. GULLIVER:

A. Internal controls, yes.

CHAYTOR, Q.C.:

Q. And addressing that. So -

MR. GULLIVER:

A. And I think, at some point, Dr. Cook had sent out another memo to all pathologists talking about internal controls and then the proper selection and submission of tissue at the gross bench.

CHAYTOR, Q.C.:

Q. And when the tests resumed in February of 2007 and we realize that it was dedicated to a couple of pathologists were doing the reporting at that time, do you know, was there reference in the reports at that time to the fact that they had checked internal controls?

MR. GULLIVER:

A. I don't know exactly. I know that there was a standardized report format that was decided upon by the pathologists. I think Mr. Dyer facilitated the administrative side and set the new format up to the Meditech computer system, but I can't tell you exactly what is in there for each pathologist who reported

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them.

CHAYTOR, Q.C.:

Q. And Mr. Gulliver, there's no mention in here about any work that had been carried out on your SOPs up to this point in time. Is that because it was still in -

MR. GULLIVER:

A. I think this is the early stages of this, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Initial stages?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. Now this is something though that you would have done for Dr. Howell.

MR. GULLIVER:

A. It could have been for Dr. Williams. I can't tell you 100 percent. Do you know what date, what date this was?

CHAYTOR, Q.C.:

Q. I had understood that this was done on September 30th, 2007, but I don't see any date on the document to verify that.

MR. GULLIVER:

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A. If it was done September ’07, it would be for Dr. Howell.
CHAYTOR, Q.C.:
Q. You’ll see here, for example, the things that you already have had taken place. Although Dr. Ejeckam is doing ongoing training with staff for controls, and he would have been gone by then. So perhaps that’s not right. Maybe it’s before that. You don’t recall when it was done?
MR. GULLIVER:
A. Not the exact date, no.
CHAYTOR, Q.C.:
Q. Okay, and if we could have then, please, P-3077? This is an e-mail from Ms. Pilgrim to yourself and copied to Ms. Predham, October 23rd ’07. "Terry, I need to talk to you about the NLCHI lists," three exclamation points. "In going over the list with Heather, there appears to be information that we could have provided that we did not. There also appears to be another five patients who were on our original list that are not--that were not retested. These are to add to the three that we already knew about. They are on" and she

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gives the list numbers. "It is imperative that we have this information confirmed and we contact these patients. The clock starts ticking when we are aware of them. I have asked Diane to get you, me and Heather in the same room. Pat."
So Mr. Gulliver, what was the information--I take it you had follow up with Ms. Pilgrim, first of all, on this?
MR. GULLIVER:
A. Yes. Oh yes, yeah.
CHAYTOR, Q.C.:
Q. And what was the information she’s referring to here "that we could have provided that we did not"?
MR. GULLIVER:
A. I think this might be back from the other lists that you had showed me earlier. It might have been information that NLCHI was looking for to confirm that the patient could have been from a certain region, that was from Western or Central or Eastern or St. John’s, something like that, and I think those five patients, I remember reviewing those five patients.

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CHAYTOR, Q.C.:
Q. So "this is information that we could have provided," that you, Eastern Health, could have provided to NLCHI that had not been provided?
MR. GULLIVER:
A. I think there was some question about should--if it was information on patients that were from outside St. John’s, should NLCHI be doing the contact with the referral region or should we be doing the contact with the referral region to confirm information for NLCHI.
CHAYTOR, Q.C.:
Q. Okay. So even if Eastern Health had the information itself? So the issue was that there was information that you had from other regions that you didn’t provide to NLCHI because there was confusion as to who would be -
MR. GULLIVER:
A. I think so, yeah, and I think -
CHAYTOR, Q.C.:
Q. - responsible for providing it?
MR. GULLIVER:
A. - I think some of those five patients, you

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know, and I’ve had dozens of these e-mails and back and forth with lists from NLCHI for almost a year. I think this one here with those five patients, two of those five patients may have come from Clarenville, and see when we started all this down the road, you know, we’re Eastern Health and Clarenville is now under Eastern Health’s jurisdiction, but during all those testing years Clarenville was a separate--you know, part of Peninsulas Health Board, so I think that’s where some of the confusion arose from.
CHAYTOR, Q.C.:
Q. But were any of Clarenville’s tests sent for retesting which--if they had already been tested at Mount Sinai?
MR. GULLIVER:
A. No, what Clarenville was sent for retesting were ones that were done at the Health Sciences originally.
CHAYTOR, Q.C.:
Q. In ’97?
MR. GULLIVER:
A. ’97, and I think a few from ’98.
CHAYTOR, Q.C.:

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Q. And the discrepancy in having another five patients, she says, who were on our original list that were not retested, do you know how someone could be on your original list, but not sent for retesting?

MR. GULLIVER:

A. I think some of those were probably patients who were then identified as being DCIS, therefore, they didn't need to go for retesting.

CHAYTOR, Q.C.:

Q. So that's the explanation for this -

MR. GULLIVER:

A. I'm just assuming. I'm just thinking.

CHAYTOR, Q.C.:

Q. But if--were you weeding our originally people with DCIS?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. That was something that happened after -

MR. GULLIVER:

A. That was something that happened after the fact.

CHAYTOR, Q.C.:

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Q. They were all sent.

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. So you don't recall what this is about in terms of these patients, these -

MR. GULLIVER:

A. I can't tell you each individual patient. I will just tell you that whatever issue was there was done and solved and then moved on to the next list.

CHAYTOR, Q.C.:

Q. And if we could have, please, 3101.

THE COMMISSIONER:

Q. With respect to the DCIS, do I take it that because Mount Sinai would effectively send them back to you saying we don't need to--we won't do the retest because they're DCIS, you began eliminating DCIS before they went?

MR. GULLIVER:

A. That was some of them, Judge Cameron, but there were other patients that we put on the spreadsheets.

THE COMMISSIONER:

Q. Uh-hm.

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MR. GULLIVER:

A. And upon review before they were sent it, it was confirmed to be DCIS, therefore, we crossed them off our retest list.

THE COMMISSIONER:

Q. Uh-hm.

CHAYTOR, Q.C.:

Q. Okay, this one is then the same date, October 24th, '07 and "Update from our discussion this morning", this is yourself writing to Pat Pilgrim, Heather Predham, "I will check on the three patients tomorrow", and attached here, of course, is another list. So again this is trying to -

MR. GULLIVER:

A. Again this is going through all the patients who have been retested and trying to verify the database, get all the information that NLCHI required.

CHAYTOR, Q.C.:

Q. Yes, and if we look down through these patients in terms of origin, it seems list three then is St. John's patients, and then list number five has a mixture, St. Clare's, Health Sciences, and some Carbonear.

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MR. GULLIVER:

A. And there are deceased ones there.

CHAYTOR, Q.C.:

Q. And those are the deceased, okay. I won't take you--there's a number of these e-mail exchanges.

MR. GULLIVER:

A. There's a lot of them.

CHAYTOR, Q.C.:

Q. But you're being brought in to--I take it your role is to cross-reference with your original spreadsheet is the main focus?

MR. GULLIVER:

A. And then verify, where possible, in our Meditech computer system the information that NLCHI is looking for.

CHAYTOR, Q.C.:

Q. If we could have, please, 1543.

MR. GULLIVER:

A. Because -

CHAYTOR, Q.C.:

Q. Sorry.

MR. GULLIVER:

A. the NLCHI database, I guess the beginning of the database was my spreadsheets. NLCHI did

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an assessment through Reza of the information that was available from the laboratory side, from Heather Predham's side, from the Cancer Clinic side, when they started the database, and the decision was that the most--from what they seen, the most complete list of all patients retested were my spreadsheets, and that formed the beginnings of the basis of the database, and then we added and it grew from there.

CHAYTOR, Q.C.:

Q. Okay, and so it was from your database or your spreadsheets, as well as Ms. Predham's?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, this is an e-mail now from Ms. Bonnell and it's November 6th, 2007, to a number of individuals, including yourself and it says, "Report from tonight attachment. Why was Eastern Health unable to provide a complete and accurate list of all individuals retested for ER", and she says, "I haven't really proofed this yet for spelling, but I wanted to get it sent", and she welcomes your thoughts,

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and attached is then, "Why was Eastern Health unable to provide a complete and accurate list", and she writes, "Eastern Health uses the Meditech system and internally recognized medical records program to manage and store patient information. Meditech is the leader in the health care sector and it is considered to be industry standard. However, Meditech is set up to track and secure patient information, based not on the service the client receives, but rather on the clients themselves. It is simply not set up to do this kind of review. Hence, it would be easy to run a report of all services one client receives or for that matter to identify all women born in 1975 to whom we've provided treatment. What is complicated is mining through thousands of patient records to find commonalities especially when there is not a searchable field associated with the issue in question. There is no single field for ER/PR results", and Mr. Gulliver, did you agree with what Ms. Bonnell had put together here in terms of explaining the insufficiency of the Meditech system in looking to identify

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patients?

MR. GULLIVER:

A. Well, again our Meditech system is an excellent health system, and the laboratory information system within that, I feel, is excellent. What she's--what Ms. Bonnell is saying there is that--and you see the next paragraph, "We searched for the ER/PR ordered by test", which we picked up--you know, again there were some patients who--the test ordered, which was a data entry issue, it wasn't a Meditech computer system search issue. What we're saying there is that there's no field to search for ER/PR results because an ER/PR result, it's an interpretation by the pathologist, and as you realize now, there was no standard interpretation. We can go into Meditech and search for -

CHAYTOR, Q.C.:

Q. I'm sorry, no standard interpretation or -

MR. GULLIVER:

A. Yeah, there was no standard reporting.

CHAYTOR, Q.C.:

Q. No standard reporting.

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MR. GULLIVER:

A. Or a format for--even their interpretation wasn't standardized. Some people gave a positive, some gave some positive/negative, weak positive. There was a difference, but in other parts of the Meditech system, if you're just looking for a result, if you're looking for a cholesterol result, you could do a search and ask the system, give me every single patient who had a result for cholesterol, but when you're looking for in a path report, where it's subjective, there is no field in Meditech to search for that.

CHAYTOR, Q.C.:

Q. And has any changes been done to the system since to try and address this concern?

MR. GULLIVER:

A. Well, the biggest change is to--because within Meditech, you can actually do a word search, you can search by procedure, which we did, but you can do a word search. So you can say to Meditech, in all path reports, could you search for the word "estrogen", and the system will pick up every path report with that string of letters of how you spell estrogen or

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progesterone. The difficulty was in not having a standardized reporting format, therefore, you have confidence in if you're searching for a certain word, that you're going to find that word consistently in all the reports.

CHAYTOR, Q.C.:

Q. And this document goes on to refer to an issue that we've already discussed, "We have discovered that in some cases, although an ER/PR test was conducted, it was not typed into the original order entry. Handwritten orders for ER/PR tests not transferred to the electronic record contributed in a small number of cases to individuals not being included in the retesting process".

MR. GULLIVER:

A. That's true.

CHAYTOR, Q.C.:

Q. "We would not be aware of these patients had they not been either identified by their physicians or had the patients themselves not contacted us", and further on she says, "In fact, in 2005 when this retesting began, the laboratory program for Eastern Health was not

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yet created, and the director and the clinical chief of the health care program of St. John's were managing this process for Eastern Health".

MR. GULLIVER:

A. That's true.

CHAYTOR, Q.C.:

Q. Is that correct?

MR. GULLIVER:

A. When we started this in July, I didn't get appointed director for Eastern Health until, I think it might have been September/October '05 because--I was going through the interview process and recruitment process, as were my managers.

CHAYTOR, Q.C.:

Q. Was the laboratory program for Eastern Health in existence?

MR. GULLIVER:

A. In theory, but until I was put in place and my management team was rehired and put in place, that happened in October '05.

CHAYTOR, Q.C.:

Q. And did it make any difference in terms of trying to identify the patients, whether or

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not you were doing that in your role as director for the Health Care Corporation which -

MR. GULLIVER:

A. I don't think so.

CHAYTOR, Q.C.:

Q. That no longer existed -

MR. GULLIVER:

A. No, no. I just--I think what Susan is trying to allude to here that, you know, on top of the stress of dealing with the ER/PR issue, it's at the same time as, you know, we have no job really in theory, I had no job.

CHAYTOR, Q.C.:

Q. I take it you had a job, and then some, but you didn't have--you weren't--you didn't have the director's position for Eastern Health as such?

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. But you were continuing on, and we've heard a bit about that in terms of if there wasn't a new policy or procedure adopted, then you continued on under the policy and procedure

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that was in place for Health Care Corporation.

MR. GULLIVER:

A. For St. John's, we did.

CHAYTOR, Q.C.:

Q. Yes.

MR. GULLIVER:

A. For all the legacy boards, you had to continue on with the legacy board's policies and procedures.

CHAYTOR, Q.C.:

Q. So what did you understand? Was that similar then for if you hadn't actually been appointed as of July of 2005, what role did you think you were continuing on as until you formally became the director of the program?

MR. GULLIVER:

A. Oh, I--I acted as if I was still the director for St. John's.

CHAYTOR, Q.C.:

Q. And I take it you still gave direction to the people who you always had given direction to, such as Barry Dyer?

MR. GULLIVER:

A. Certainly did, yes, yeah.

CHAYTOR, Q.C.:

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Q. And it says, "Eastern Health was able to generate a list of all patients who had breast cancer from 1997 to 2005 and were tested in our laboratory for ER/PR using this process. However, one regret of the officials who compiled and verified the list is that Eastern Health did not cross reference our list of patients from outside the region with the data provided by other regions", and I think -

MR. GULLIVER:

A. And I think that's probably--I probably said that.

CHAYTOR, Q.C.:

Q. Yes, and I think you -

MR. GULLIVER:

A. And that's one of the things that I wished that we would have done.

CHAYTOR, Q.C.:

Q. And I think actually in your response to Ms. Bonnell, you probably looked for a change in wording on that. If we could look at P-1544, page two, paragraph eight, "This reflects my comment, and I would rather say, in hindsight, and if time had permitted, the laboratory at the Health Science Centre would have sent

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copies of all tests recorded in their Meditech system to the other regions so they could cross-reference with patient results in the Meditech system".

MR. GULLIVER:

A. Yeah, I think that more reflected what my opinion was.

CHAYTOR, Q.C.:

Q. Okay, and if we could go back -

MR. GULLIVER:

A. That if I had to send out my sheets to Corner Brook before they sent the blocks in and let Corner Brook cross-reference their list as opposed to Corner Brook sending in to me, and me cross-referencing the list that I had in my records, that would be more complete if the reverse were true.

CHAYTOR, Q.C.:

Q. Okay, and if we could go back then, please, to the other exhibit, 1543, and then I'll just take you to the end where Ms. Bonnell says, "We were not surprised that the number identified by NLCHI was higher, but we are disappointed that the implication is that we cannot manage patient data as a result. It is

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worth noting that even after having a dedicated team of ten or more statisticians with no patient safety, patient notification, or quality improvement responsibility, working on this file for more than four months, NLCHI itself is still unable to define an exact number, and moreover there are recognized issues with the data as it was presented to the Commission of Inquiry in late October", and Mr. Gulliver, this comment here about--and I take it this means about NLCHI's dedicated team?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Did you understand then to have ten or more statisticians working on this file?

MR. GULLIVER:

A. I think they had about 11 staff. Like, Reza had about ten, including himself, ten other staff that were able to assist him.

CHAYTOR, Q.C.:

Q. And working on this file?

MR. GULLIVER:

A. On this project. I think so.

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CHAYTOR, Q.C.:

Q. On the file?

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And what was the--do you know--the sentiment that's expressed there, were those your comments, or who was suggesting that?

MR. GULLIVER:

A. I don't know. I don't think they were my comments, but I certainly think, I mean, it's accurate, that, you know, here we were within Eastern Health and, you know, there's been all kinds of media releases about the numbers, the numbers, and the numbers, you know, and really from my perspective I wasn't that concerned about the total numbers, I was more concerned in making sure that any patient that we reviewed, and if we missed them, make sure that we found them and have them sent off for retest. We were doing our jobs, plus this, and what we're seeing here is that NLCHI has a dedicated team of ten or eleven people working on this file to create a database and after months we still could not come up with a final

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number.
CHAYTOR, Q.C.:
Q. And whose data was NLCHI relying upon?
MR. GULLIVER:
A. Well, they were pulling data from--again they started off with my spreadsheets, which would have been the majority of the patients sent for retest. They got data from Dr. Cook, data from Heather Predham, from the Cancer Centre, they got data from all the other regions. They asked for hard copies of all the reports to verify. Myself and Reza went through all the original reports that are in my office on these patients to double check and recheck. So, I mean, they pulled--they got data from wherever they could.
CHAYTOR, Q.C.:
Q. Okay, and if we could have, please, P-2712. This is in March, March 7th, 2008, and it begins with an e-mail from Mr. Thompson, Robert Thompson, March 7th, 2008, to Ms. Pilgrim and it says, "Re; HER2/neu testing. Thank you for the clarification. I realize this was discussed before. I'm told the only reason that these cases continued to be on the

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list was that Reza had received different opinions from Heather and Terry about why the tests were done. Heather has been clear in saying that they were done as a by-product of HER2/neu, however, Terry has been saying that some of them, I don't know which ones, were primarily sent for ER/PR retesting. Rather than having the Centre or my office decide whose opinion to accept, Debbie was asked to send the question back to you", and I'm just wondering, Mr. Gulliver, what this was about, why it was suggested that you and Ms. Predham were providing conflicting information?
MR. GULLIVER:
A. I just--I just think that--I don't think everyone understood all the issues. There were patients who were sent to Mount Sinai primarily--it was requested for HER2/neu, but Mount Sinai went ahead and did an ER/PR test along with the HER2/neu, and those patients were being put into the database. So there was some debate and question upon, you know, should those patients be a part of the database where the database was primarily--the primary focus was patients who had an original

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test in St. John's and then those patients who had a retest at Mount Sinai, but I think this was cleared up after, Ms. Chaytor.
CHAYTOR, Q.C.:
Q. I'm just wondering too, Mr. Gulliver, what patients would have fallen into that category?
MR. GULLIVER:
A. It varies. There were some patients--some were new patients because up to this point, from August '05 to February of '07, all of our primary ER/PR testing was being performed by Mount Sinai and HER2/neu, but I know there were a couple of patients that didn't--they had an original ER/PR test done in St. John's and then it was sent away by Dr. Carter or Dr. Cook and they asked for HER2/neu only, but they didn't ask for a repeat ER/PR, but Mount Sinai did the repeat ER/PR.
CHAYTOR, Q.C.:
Q. And, I guess, Mr. Gulliver, should the patients have been sent away originally, though?
MR. GULLIVER:
A. According to out data, the patients should not have been sent away for ER/PR, but it was now

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being sent away for HER2/neu, and Mount Sinai just took it as being a consult and repeated, did the whole hormone receptor -
CHAYTOR, Q.C.:
Q. So they weren't people who met your original cutoffs?
MR. GULLIVER:
A. Right, yeah.
CHAYTOR, Q.C.:
Q. But they had repeats on their ER/PR because Mount Sinai didn't realize they were just being sent for HER2/neu?
MR. GULLIVER:
A. Right. I also know there were--I think there were one or two.
CHAYTOR, Q.C.:
Q. Why were you retesting HER2/neu?
MR. GULLIVER:
A. No, no, they never ever had HER2/neu done either before. They had an ER/PR done before, but no HER2/neu. I do know that there's been one or two patients that never had an original ER/PR test done and was sent away.
CHAYTOR, Q.C.:
Q. Yes.

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MR. GULLIVER:
A. And was asked only for HER2/neu to be done.
CHAYTOR, Q.C.:
Q. And why is that?
MR. GULLIVER:
A. I don't know. That was the pathologist--I mean, I'm just saying I just--because I'm involved in this here, I just know that it was, but it was not a decision I had made. It was a pathologist decision.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. So the way that these patients were panelled, two ER/PR tests, one in St. John's, and one for whatever reason -
MR. GULLIVER:
A. Yes, there are, some -
THE COMMISSIONER:
Q. In Mount Sinai?
MR. GULLIVER:
A. Yeah. It's a small number.
THE COMMISSIONER:
Q. Yes, but when you were determining who should go to Mount Sinai for retest, they did not

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fall within the category -
MR. GULLIVER:
A. There was a couple like that, yes. The big debate here was from NLCHI is should these patients be a part of the database.
THE COMMISSIONER:
Q. Uh-hm.
MR. GULLIVER:
A. Because the database protocol was any patient who had an original ER/PR test in St. John's, and a repeat in Mount Sinai.
THE COMMISSIONER:
Q. Yes, okay. So presumably these would be patients who were positive originally by your standards, and then because there was a request for HER2/neu and Mount Sinai proceeded to do it, you had a second -
MR. GULLIVER:
A. Exactly.
THE COMMISSIONER:
Q. Result in respect of ER/PR.
MR. GULLIVER:
A. Yeah.
CHAYTOR, Q.C.:
Q. Mr. Gulliver, would there have been many

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patients in your review from 1997 through to 2005 that did not have an ER/PR test originally?
MR. GULLIVER:
A. Handful.
CHAYTOR, Q.C.:
Q. And what's your definition of a handful?
MR. GULLIVER:
A. Less then ten, you know, out of the 3000.
CHAYTOR, Q.C.:
Q. And they were then sent for having an ER/PR test for the first time?
MR. GULLIVER:
A. Some of--yeah, yeah.
CHAYTOR, Q.C.:
Q. And do you know some of the reasons why they didn't originally have an ER/PR test for these DCIS patients or was there any -
MR. GULLIVER:
A. No, they were never ordered, never asked for by the pathologist or the oncologist. But again, it's a small number.
CHAYTOR, Q.C.:
Q. Ten or less?
MR. GULLIVER:

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A. I would say less than ten, yes.
CHAYTOR, Q.C.:
Q. If we could have, please, P-3119? And Mr. Gulliver, I take it you've had an opportunity now to review this report. It's the review by Mr. Bryan Hewlett and Mr. William Parks, September, 2008, which was commissioned -
MR. GULLIVER:
A. That was my stat holiday yesterday.
CHAYTOR, Q.C.:
Q. That was your homework for your holiday, okay. Well I guess I'll ask you overall your impression of the report and whether or not there's anything that you take issue with in the report.
MR. GULLIVER:
A. Well, I mean, obviously these two people testified Friday. While they were in St. John's, I did have the opportunity to, you know, to speak with them briefly. Mr. Hewlett is someone who I've known professionally for 25 years, certainly respect his opinion and to come into our lab and do this review. I think overall, as I read the report, you know, I think it's a good assessment of the

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laboratory. Obviously there are some things there that I think are excellent, you know, reading through this yesterday with Mr. Dyer, there are, you know, a few details that we need to shore up in the lab, you know, through all this process, since Trish, you know, since Trish was here and Dr. Banerjee was here and all of the new staffing and resources that we put into the laboratory, you know, our whole pathology lab, in the main pathology lab, we were really in a huge transition period where we have a lot of new staff into the lab that are being trained and skilled up, but most of our focus in the last year and a half has really been on standardizing our fixation and our grossing, ensuring that the quality of the specimen being submitted to the lab is of the best calibre that we can make it. And then we focus a lot of attention on our IHC lab and it means like your policies, SOPs and documentation. So when I met with Bryan and reading his report, I was certainly really pleased for those two really critical parts of our lab that he's given us really high marks, you know, just personally he made some real

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good comments to me personally before he left. But then there's other parts of the report that we need to make sure that all staff in the lab are well aware of it, but overall, I thought that it was a fairly good assessment of our laboratory.

CHAYTOR, Q.C.:

Q. Okay, and the issue in terms of the tissue processor and I take it you were well aware that prior to Mr. Hewlett putting it in writing in this report, the issue that came up and was discovered regarding your tissue processor.

MR. GULLIVER:

A. Yes, and it was a Monday morning that Bryan came and spoke to me, you know, and told me over the weekend when they were in, that they--over in the grossing room where the tissue processors sit, the two of them and where the overnight schedule is run for all the tissues, that, you know, that they noticed a higher than normal smell of xylene in the gross room than what you would expect and they physically took out two of the--station 13 and 14 of the paraffin wax baths and, you know, said they

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physically smelled them and I actually went over to the lab with them that morning and smelled them myself and said yes, it's higher than normal. Certainly appreciated the fact that he called Mr. Coffey on a Saturday and as we are well aware that they were both in at Commissioner counsel's request, you know, apparently he told me he called Mr. Coffey and felt that, you know, he should make us aware of this here so we can change our--address the issue sort of immediately and not wait for the report to come out.

CHAYTOR, Q.C.:

Q. So I take it it was a potential patient safety issue?

MR. GULLIVER:

A. No, no, there's--I mean, again, I think somewhere he says this here that you know, this really has nothing to do which would affect patient diagnosis or patient safety, again he verifies because our tissues are being grossed extremely well and fixed extremely well by protocols by the pathologist assistants, really the issue here what would happen is twofold, one, it could be workplace

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safety issue for the staff working in the area with the xylene fumes, but the critical issue here would be in the routine technologists when they are cutting each of those blocks and doing their routine H&E stainings on them, the technologists there, they may have a more difficult time getting a good quality section onto the slide once they put it onto the water bath and it's cut. But really this does not affect anything to do with--compromise patient safety or patient diagnosis or prognosis.

CHAYTOR, Q.C.:

Q. He says, "It's fortunate the tissues have been optimally fixed for sometime according to the records. This fact mitigates any potential tissue compromised due to inadequate processing on these instruments."

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. So I take it if there were a fixation issue with any given sample, then his opinion would be otherwise, that there could in fact be an issue -

MR. GULLIVER:

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A. Oh my opinion would be otherwise too if we still had fixation problems.

CHAYTOR, Q.C.:

Q. Yes. So then, Mr. Gulliver, what happens? How do you go about addressing this issue?

MR. GULLIVER:

A. Well I guess, neither myself or Bryan or Barry and, I think Mr. Sparkes, Dave? The guy with Bryan from Ottawa.

CHAYTOR, Q.C.:

Q. Bill Parks.

MR. GULLIVER:

A. Bill. Actually the four of us talked about it and we all pretty well thought that it could have been that these were two new tissue processors that we had purchased in December and we thought maybe when the company came in and put the new tissue processors in place, that it could have been a set up error by the manufacturer because we went through all the possible causes and we went through, could it be the pressure volume cycle, it could be the degassing cycle on the instrument, so what Mr. Dyer made sure was done that every single solution or reagent on the instruments were

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all discarded and all fresh put on. We immediately called Somagen Diagnostics and they had to send a technician in from Edmonton. They came in within a couple of days and did a, sort of re-verification of the system and pretty well what they came back and said is that in one of the containers on this instrument, there's a charcoal box that filters away xylene fumes and that the charcoal had not been changed since March and really it should be changed--they recommend every twenty runs and it all depends how often you use your tissue processor. So for us, that would mean that pretty well, you know, maybe once a month, once every five, six weeks, you should change your charcoal filter box and it had not been changed since March, and that's been done since.

CHAYTOR, Q.C.:

Q. Yes, and Mr. Gulliver, did you make inquiries of the staff or have Mr. Dyer make inquiries of the staff as to how that could have been the case?

MR. GULLIVER:

A. Well what I've done, I mean, yesterday, as I

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just said to you, myself and Mr. Dyer went into work, we both read through this report. I've asked Mr. Dyer as the pathology manager to give me sort of a full assessment of this report and, you know, how could have the lab assistant who takes care of the maintenance on the two tissue processors had not changed the charcoal filter since March. And what Mr. Dyer gave me last night was a document to submit today just to show you the daily maintenance chart on the tissue processors and what's there, it shows the charcoal filter, but it doesn't indicate it should be changed monthly. And certainly in the manufacturer's guidelines, they say you should change the filter every 20 runs and for our busy lab, that would mean you should change it monthly.

CHAYTOR, Q.C.:

Q. And so in setting up then the record sheet for the daily maintenance, who would have come up with how often it should be changed?

MR. GULLIVER:

A. I'm not sure. I got to wait until--again, I just got this yesterday.

CHAYTOR, Q.C.:

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Q. So Mr. Dyer is still investigating it to find out how that -

MR. GULLIVER:

A. And you know, I'm assuming that when I get something from him, Ms. Chaytor, that I'm going to submit that to Dan Simmons and I'm assuming that he will pass it on to the Commission also.

CHAYTOR, Q.C.:

Q. So in terms of that -

MR. GULLIVER:

A. Again, I mean, it's something that, you know, it's something, to me, that should be done, you know. If they have a sheet done up there, as I showed you, and I think the practice, what Barry told me, the practice was we change it ever three months, and there was an extra charcoal filter box there waiting to go on and it should have been changed sometime during the summer, but it wasn't changed.

CHAYTOR, Q.C.:

Q. And instead of it being done, as per the manufacturer's recommendations, every 20 runs, somebody set it up to happen every three months regardless of how many runs had

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occurred?
MR. GULLIVER:
A. To my knowledge, yes.
CHAYTOR, Q.C.:
Q. And you don't know who did that?
MR. GULLIVER:
A. No.
CHAYTOR, Q.C.:
Q. And if we could look at P-3049, please? And is this the exhibit that you're referring to that was just passed to us this morning?
MR. GULLIVER:
A. Yes, yeah.
CHAYTOR, Q.C.:
Q. And the charcoal change, we see here.
MR. GULLIVER:
A. And I asked Barry to--out of the log book, to just make a photocopy of it to show when the charcoal change was made and I think it was March something. It's over here on the end, just March 3rd.
CHAYTOR, Q.C.:
Q. February 2008, and then it's -
MR. GULLIVER:
A. But March 3rd was the charcoal filter change,

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end of February, early March.
CHAYTOR, Q.C.:
Q. Okay, and if we look back -
MR. GULLIVER:
A. But you can see here, this is the--this is all the different reagents on the tissue processor and when they're changed and written in, documented when they're done, and you see all the weekends, because there's no--the weekends it just sits in retort until it starts to process. So this is your Monday to Friday schedule.
CHAYTOR, Q.C.:
Q. I guess my question then, Mr. Gulliver, is in light of everything that's happened in terms of the ER/PR issue and how much focus that's brought upon your lab, how could it be that there would be a situation that routine maintenance wouldn't be carried out in your lab as frequently as it's required?
MR. GULLIVER:
A. Well, I guess you can see from this sheet that, you know, there is routine maintenance carried out every single day. You know, all I can say is that the person who should do it,

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it wasn't changed and that will change.
CHAYTOR, Q.C.:
Q. And I guess then I'll ask it to you this way, Mr. Gulliver, is what practices have you put in place to ensure that the requisite maintenance is being carried out?
MR. GULLIVER:
A. Well, I think the document that I just showed you, that you have submitted here, shows you that since all this ER/PR started, the level of documentation that all the maintenance is being performed on the tissue processors, that this was not done before.
CHAYTOR, Q.C.:
Q. So there was no record sheets of maintenance done before?
MR. GULLIVER:
A. Right. I mean, when Trish was here, since Trish has been here and gone, this is some of the documentation that's taken place just for the tissue processors.
CHAYTOR, Q.C.:
Q. Who is responsible for ensuring that the maintenance is carried out and that these forms are filled out?

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MR. GULLIVER:
A. Well, it's the assistant who's assigned to do this duty.
CHAYTOR, Q.C.:
Q. And I take it then there's nobody overseeing that in terms of a quality control check within the laboratory?
MR. GULLIVER:
A. Well, one of our--I mean, the senior technologist in the lab day to day oversee the work flow of the whole laboratory, and again, I mean, I need to get an assessment from Mr. Dyer. I guess the next question is going to be that even though, for the tissue processors, they have developed and followed this here every single day, you know, do you need to have someone else come behind that employee to verify that they've actually done and signed off what they're supposed to do.
THE COMMISSIONER:
Q. (Inaudible) are these kind of maintenance sheets then submitted to somebody who is in a quality role, to determine whether or not they, in fact, are properly done?
MR. GULLIVER:

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A. Well, what we have now, Judge Cameron, in pathology, we have that one technologist whose primary function is quality.

THE COMMISSIONER:

Q. Um-hm.

MR. GULLIVER:

A. And really, I mean, Ms. Rowe, I mean, all she does all day and all week is we're in the-- still in that early mode of finalizing all of our SOPs and policies where she's trying to get to all the staff, making them aware of new policies and procedures. She's also doing the auditing of pathologists correlations, interpretations, and really, it's not something--we have these kinds of sheets in pathology at all the work benches, you know. There's a certain point where you have to assume that your staff are doing what they're supposed to do.

THE COMMISSIONER:

Q. Well, that's my question, whether or not there is somebody with, if not every sheet being submitted, does an audit from time to time to see whether or not the--now that person would obviously have to know what the requirements

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were.

MR. GULLIVER:

A. Right.

THE COMMISSIONER:

Q. Which presumably, with the new procedures and new manuals and new SOPs, then all of that would be readily discernable. I'm just asking whether or not that's part of the process.

MR. GULLIVER:

A. I think they do. Mr. Dyer would have to answer it more correctly, but I think they do. But I think the issue with this one is not that the person who's following the protocol is not following the protocol properly or do you need to have another senior employee to come behind this employee to say "okay, did you change the alcohols? Did you change the paraffins?" and it's all written, verified they have. I think what the issue here is that we don't have the frequency of charcoal change on the sheet.

CHAYTOR, Q.C.:

Q. Not written on your sheet.

MR. GULLIVER:

A. Right, and that needs to be updated and

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changed.

CHAYTOR, Q.C.:

Q. And you understood that it was being done every three months?

MR. GULLIVER:

A. To the best of my knowledge, yes.

CHAYTOR, Q.C.:

Q. And who told you that?

MR. GULLIVER:

A. That's what Mr. Dyer told me last night.

CHAYTOR, Q.C.:

Q. And this gets checked off here for February 28th, 2008?

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. So it hadn't been done in over six months.

MR. GULLIVER:

A. No, the machines came in in December.

CHAYTOR, Q.C.:

Q. Machines came in in December.

MR. GULLIVER:

A. Yeah.

CHAYTOR, Q.C.:

Q. And the charcoal was changed in February.

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MR. GULLIVER:

A. And then there was another set of charcoal there, a clean one, a clean box.

CHAYTOR, Q.C.:

Q. And it's September 2008, so between February 28th, 2008 -

MR. GULLIVER:

A. The charcoal didn't get changed.

CHAYTOR, Q.C.:

Q. So that's over six months.

MR. GULLIVER:

A. But there was new--there was two new charcoals there that you could have changed them and that sometime in the summer, the person who would have changed them on the three-month cycle didn't change them.

CHAYTOR, Q.C.:

Q. And that's what I'm saying. So not only was it supposed to be being changed every 20 runs, it was set up for three months, which was incorrect. The three-month period was missed too because you're now in over six months when this is discovered in September 2008.

MR. GULLIVER:

A. And again, I would have to say to you is that

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this has nothing to do with patient safety, nothing to do with patient's diagnosis or interpretation.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, can you say that?

MR. GULLIVER:

A. Yes, I can.

CHAYTOR, Q.C.:

Q. In terms of if there were to be tissue processed -

MR. GULLIVER:

A. Well, Mr. Hewlett stated that in his report.

CHAYTOR, Q.C.:

Q. As long as there was no fixation issue.

MR. GULLIVER:

A. Right, and he verified our fixation. He said it was fantastic.

CHAYTOR, Q.C.:

Q. Mr. Gulliver, so what you're saying is that you made inquiries as to how it could be that it wasn't set up on the correct frequency in the beginning?

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

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Q. Why the frequency is not indicated to be on the form, and why then it was missed, the charcoal change taking place when it should have taken place three months prior?

MR. GULLIVER:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, and all of those questions right now, as of right now, remain unanswered?

MR. GULLIVER:

A. Well, I just gave you the best, my best answer, but I have asked for a written submission from the pathology manager, which I will submit to you.

CHAYTOR, Q.C.:

Q. And Mr. Gulliver, why is it that the smell from the xylene wasn't apparent to the people using the processors?

MR. GULLIVER:

A. Well, if you walk into the pathology gross room, you smell xylene and formaldehyde all the time. So it's just something that--and actually, if you walked into the pathology lab right now, you would smell these fumes immediately. If I walked into the pathology

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lab, where I've been working for years, I don't even notice them any more. So it's just something that you're just used to. It's an everyday common smell that you used to work with.

CHAYTOR, Q.C.:

Q. Well, Mr. Parks, it was apparent to Mr. Parks and Mr. Hewlett that this was something stronger than the norm.

MR. GULLIVER:

A. I know, but Mr. Hewlett hasn't worked in a pathology lab in a number of years.

CHAYTOR, Q.C.:

Q. Well, Mr. -

MR. GULLIVER:

A. So it's like it's new, fresh, coming into him.

CHAYTOR, Q.C.:

Q. But not Mr. Parks. Mr. Parks is still in his job.

MR. GULLIVER:

A. He's a manager up in Ottawa. I don't think he actually works on the bench in pathology.

CHAYTOR, Q.C.:

Q. And it was apparent to you when you went in?

MR. GULLIVER:

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A. No, when I went over, I actually had to take--go to the instruments and take the paraffin bath and pull it out of the instrument and Barry and I both smelled it along with Bryan and them, and we could say, yes, to me, I could smell more xylene in this paraffin wax than what should be there.

CHAYTOR, Q.C.:

Q. And I had understood, though perhaps I'm wrong, I had understood that Mr. Parks is still engaged in laboratory work in his institution. But what you're saying is that it wouldn't necessarily be apparent to someone who's there doing this work every day?

MR. GULLIVER:

A. All the time, yeah, because you just smell xylene all the time. You smell alcohol all the time. You smell formaldehyde all the time.

CHAYTOR, Q.C.:

Q. And is there anything that can be put in place or any safeguard then, if it's not easily detectable, that such issues such as that could then be otherwise detected, if you can't rely on the individuals to be able to do it?

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MR. GULLIVER:
A. The other thing that's done on a regular basis with facilities management is that they do formaldehyde and xylene checks of the air quality in pathology to ensure that our staff are not being over exposed to xylene and formaldehyde.
CHAYTOR, Q.C.:
Q. If we could go back, please, to 3119? And on page eight, this is back to Mr. Hewlett and Mr. Parks' report, and he outlines issues regarding staffing at page eight, and was this also discussed with you in your meetings with them?
MR. GULLIVER:
A. No, we didn't discuss staffing really with Bryan. I just read this through the report yesterday.
CHAYTOR, Q.C.:
Q. And you'll see here that he has--they mention "staff in the histology lab is in constant flux as a result of the accepted culture of laddering and staff bumping. Considerable effort and resources are being expended on bench training, only to have the person move

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out of the division and then require retraining upon their return months or years later" and he also referred to, and they spoke about it in their evidence, to people not seeing the whole process through, but being assigned one particular task and working at that particular task without seeing the process through. So I'm just wondering what--having had a chance now to review this and hear what Mr. Hewlett and Parks have said, if there's any response you have to this issue?
MR. GULLIVER:
A. Well, I mean, what he's--this is an observation made by them and it's certainly very accurate. Our pathology laboratory, for the last three years, has been in a state of transition. And really what's happened is since the ER/PR issue, as you're well aware, that we've taken technologists and we've retrained them to be pathologist assistants. Our two senior IC techs have retired. We have a new quality position for laboratory. So, what's happened is that--and he's talked about the routine histology lab; he commends the pathology assistants and the IHC part of the

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lab--so, what's happened is we started off with the pool of pathology technologists who have a fair bit of experience in routine pathology and the new positions created requires people to have pathology knowledge and experience. So, our pool of about 15 staff in total, that pool has been cut in half because they are now in new positions that have been created. And the people coming in to replace the backfill of those are medical lab technologists who got lab experience maybe in other parts of the program, in hematology, in chemistry or blood collection. They're now new technologists to pathology and all those staff have got to be trained to be a routine pathology tech, while all the other senior staff are being trained new roads in pathology. So, we are in a major state of transition here within our pathology department.
I certainly appreciate all the new resources that are coming in, but it takes time for all those staff to be skilled in all areas of pathology. And I also submitted to you that Mr. Dyer gave me a list of compensies

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(sic.) that all the new staff in the routine pathology lab must obtain before they move from one station into the next.
So, what Barry is trying to do is keep, sort of, stabilized workforce in the main pathology lab, is get people skilled in cutting, in bedding, staining and those functions and then move on to another part of the pathology lab.
CHAYTOR, Q.C.:
Q. And Mr. Hewlett and Mr. Parks write, "the laboratory action plan"--which is Appendix 3--"is an interesting document with lofty, but obtainable goals. Regrettably however, we consider the objectives to be listed in the wrong order" -
MR. GULLIVER:
A. Now, I -
CHAYTOR, Q.C.:
Q. "We believe the last objective is the most critical in obtaining the first three. The recruitment training, maintaining of qualified staff has to be the primary goal in the histology division".
MR. GULLIVER:

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A. And they seen that--this is from 2003--our laboratory planning day, our goals, objectives for the lab medicine program in St. John's, we had four major goals with an overall vision. I had those laminated and, sort of, posted through all parts of the laboratory for staff to see what our programs, goals and visions are. That was still on the wall in the IHC lab and that's where Mr. Hewlett got that. So, really he' commenting on something that's five years old.

CHAYTOR, Q.C.:

Q. So, is there a new plan?

MR. GULLIVER:

A. I'm in the process now of--we're now in the next stage of development Eastern Health plan. I'm months overdue for my plan because all my time is dealing with ER/PR and the Inquiry.

CHAYTOR, Q.C.:

Q. So -

MR. GULLIVER:

A. So, however, I certainly appreciate Bryan's comments on the goals/objectives because they're not listed in any order or priority. There were four and we just had them listed,

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one, two, three, four. I certainly believe that, I don't care if you work in a medical laboratory or if you work in a law firm, your key resource are your people; your human resources and that always must be your number one priority. It doesn't make a difference to me if they're ranked--if they're listed one, two, three, four on a piece of paper.

CHAYTOR, Q.C.:

Q. So, the issue of this being posted is as a 2003 document as your action plan, it's still posted in your laboratory as your action plan and there isn't -

MR. GULLIVER:

A. I guess the staff in IHC lab still have it on the wall down there.

CHAYTOR, Q.C.:

Q. Is it or is it not your current action plan until another one is adopted?

MR. GULLIVER:

A. No, we had one the last two years, our first two is for Eastern Health; however, the focus was more on integration and regionalization, they weren't as detailed as what we had done from 2003 to 2006.

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CHAYTOR, Q.C.:

Q. And he writes here, "The implementation of new technologies require much more than purchasing new instruments. It requires a strong core group of experienced technologists with intimate knowledge and deep understanding of the current technology and willingness to learn and apply the new technology. The application of any new technology without this experience, knowledge and understanding can have dyer consequences." And, Mr. Gulliver, do you take any issue with that?

MR. GULLIVER:

A. But that applies to every laboratory, that's just basic laboratory knowledge.

CHAYTOR, Q.C.:

Q. And I take it then the Laboratory Program Action Plan -

MR. GULLIVER:

A. And these were before the, yeah.

CHAYTOR, Q.C.:

Q. - that he rearranges in this manner, putting human resources ahead of technology and putting the human resource qualified staff to the top, you take no issue with that and what

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you're saying -

MR. GULLIVER:

A. None whatsoever, no.

CHAYTOR, Q.C.:

Q. - you didn't have them in any particular order in any event.

MR. GULLIVER:

A. No.

CHAYTOR, Q.C.:

Q. What about the issue of, he changed the number three, he's suggesting to make available the most appropriate up-to-date laboratory technology.

MR. GULLIVER:

A. I think we had the word "available" before, I'm not sure.

CHAYTOR, Q.C.:

Q. I think the word "appropriate" is what's different, you would have had to make available the most up-to-date laboratory technology.

MR. GULLIVER:

A. Right.

CHAYTOR, Q.C.:

Q. And do you take any issue with that as to it

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being the most appropriate?
MR. GULLIVER:
A. Really it's the same thing, just worded differently.
CHAYTOR, Q.C.:
Q. Thank you, Mr. Gulliver, those are all my questions.
THE COMMISSIONER:
Q. It's getting towards the end of the day. Let's do the rounds of the room and see how much time we require. Mr. Pritchard?
MR. PRITCHARD:
Q. Thank you, Commissioner, at this point I don't anticipate any questions.
THE COMMISSIONER:
Q. Mr. Browne.
BROWNE, Q.C.:
Q. Twenty, twenty-five minutes.
THE COMMISSIONER:
Q. Mr. Pritchett?
MR. PRITCHETT:
Q. I don't anticipate any at this point.
THE COMMISSIONER:
Q. Ms. Newbury?
MS. NEWBURY:

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Q. I only have a couple of questions.
THE COMMISSIONER:
Q. Mr. Crosbie?
CROSBIE, Q.C.:
Q. Hour and a half.
THE COMMISSIONER:
Q. Mr. Simmons?
MR. SIMMONS:
Q. Very little so far. Depends on -
THE COMMISSIONER:
Q. Depends on what the questions are in the morning, is that it? All right then, I suggest then that we adjourn for the day and we can make arrangements for the next witness in the line up to come in light of those estimates of the time required, two and a half hours roughly in the morning, we would estimate maybe a little more. So thank you. 9:30 tomorrow morning.

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 14th day of October, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.
Dated at St. John's, Newfoundland and Labrador this 14th day of October, A.D., 2008
Judy Moss

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